Strategizing as protective interrupting

Preliminary insights from two case studies on strategic change within hospitals

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24th EGOS Colloquium 2008, Amsterdam

Sub-theme 05: Strategy-as-practice: Stability and Change in Strategizing Routines

Abstract

Taking a practice-based perspective on strategy and strategic change, this paper aims at contributing to the current discussion about the interface between organizing and strategizing. Drawing on the concept of strategic episodes, we specifically explore practices and processes conducive to a fruitful interruption and suspension of operational routines allowing the differentiation of strategizing from organizing. The focus is on strategic initiatives, conceived of as series of episodes related in time by a general overarching theme. Based on a preliminary analysis of two longitudinal case studies in hospitals, the paper delineates the concept of "protective interrupting" as an approach that enables strategizing.

Introduction

Attention to stability and change of and in organizations has recently been revived by a body of research within the emerging area of strategy as practice. Building on the concepts of *strategizing* and *organizing*, these studies advance the discussion on stability and change in two important ways: First, strategizing and organizing are conceived of as ongoing accomplishments, as indicated by their verbal form. Second, both dimensions are seen as being closely interrelated. According to Whittington and Melin (2003) "strategizing activity is shaped by organizing; organizing is a crucial variable within the strategizing task" (47). In this vein, a body of research has investigated how this *interrelation* is or should be accomplished.

While following these studies in the conception of strategizing and organizing as two ongoingly interrelated sets of practices, we posit that one aspect of this interrelation, though implicitly assumed, has been underemphasized so far: the question of *differentiation* between strategizing and organizing. We argue that it is only through their differentiation that strategizing and organizing can fruitfully *re*-late and inform each other to effectuate strategic change, just like learning occurs, when the external stimuli are "proximal to, but outside, the actors's existing experience" (Jarzabkowski 2004, 543; ref. to Inhelder 1969).

Further, we suggest that differentiating strategizing from organizing is as much an effortful and ongoing accomplishment as is relating these two spheres. This becomes (empirically) evident in situations, where actors involved in strategic change contribute to the strategizing discourse as much as playing a crucial role in the ongoing operational routines of an organization – for example nurses and doctors in a hospital who are involved in a strategic

change initiative and at the same time are responsible for the cure and care of patients. The question of differentiating becomes even more relevant, when organizations or actors cannot "simply" draw on existing strategizing discourses but rather have to develop these discourses at the time when being confronted with the need to undergo major change.

The article explores the question of interrupting organizing and differentiating strategizing from organizing based on a preliminary analysis of two longitudinal case studies on strategic initiatives within hospitals. In both cases, strategizing, in the sense of a deliberate, collective and reflexive effort to significantly alter the way of organizing, represented a new challenge for the surgical clinic and the nursing department under study. Referring to the concept of strategizing episodes (Hendry & Seidl 2003), *we specifically examine processes and practices involved in interrupting organizing and in developing a strategizing discourse aimed at creating a difference to organizing*.

In a first section, we outline the theoretical background of our study, starting from the research on strategizing/organizing and the concept of strategizing episodes (Hendry & Seidl 2003). We then present our methodology and introduce the two case-studies. The third section describes and analyzes key moments of the two cases and gives tentative insights in what we conceptualize as "protective interrupting". Finally, we discuss our findings and draw conclusions for further research.

Theoretical Background

In examining processes and practices involved in fruitfully interrupting organizing and in developing strategizing in difference to organizing, the paper explores the interface between strategizing and organizing. It draws on two streams of research: the growing body of literature about "strategizing/organizing", and a "systemic-discursive" approach to strategy and strategic change.

(Inter)Relation of strategizing/organizing

The first stream of research is represented by studies which mostly position themselves in reference to the concept of "strategizing/organizing". They form part of a wider approach, which has come to be known as "strategy as practice" (Jarzabkowski 2004, Johnson et al. 2007, Whittington 2006). Strategy as practice (s-as-p) draws attention to strategy and strategic change as a form of "social practice" (Whittington 1996, 731), following a broader "practice turn" in social theory (particularly Bourdieu 1980; Giddens, 1984 Schatzki et al., 2000).

Two aspects of the s-as-p approach are of special relevance for this paper: First, while the focus of the traditional strategy process research is on firm level sets of change events and the question of how organizations as a whole achieve strategic change (Whittington 1996), a practice based approach to strategy process drills further down into the "internal life of process" (Brown & Duguid 2000, 95). The interest is on practices of "doing...strategy" (Jarzabkowski et al. 2007, 8) and of "doing change" (Kappler 2007, 8) and how these practices influence and get influenced by the organizational and institutional context (Johnson et al. 2007, 7). Second, as Jarzabkowski et al. (2007) point out, while traditional research on strategy process focuses on performance and outcome at the firm level, strategy as practice also seeks to explain "some aspect of shaping activity that is a 'micro-mechanism' in transforming wider strategic activity" (18). In accordance with these two aspects of s-as-p, in this paper we take a closer look at two empirical processes of strategic change and on instances that contributed to strategizing in difference to organizing as such. Comments on the "outcomes" of the two strategic initiatives will be made, but the overall performance is not our primary concern.

The rhetorical question of Baden-Fuller (2006) "Why do we separate Organizing from Strategizing?" (577) can be interpreted as a basic driving question for a body of research within the s-as-p approach that explicitly investigates the relationship between organizing and strategizing (e.g. see Special Issue of Long Range Planning 39, 2006). Taking this perspective, researchers have for example studied how the way strategy is organized has an impact on the strategic outcome (Whittington et al. 2006), the role of leadership in the relation between strategizing and organizing (Achtenhagen et al. 2003; Colville & Murphy 2006) or the managerial consequences of different relationships between organizing and strategizing in pluralist contexts (Jarzabkowski & Fenton 2006).

These studies differ in their empirical focus and/or specific conceptualization of strategizing and organizing. What they share, though, is to depart from organizing and strategizing as two *"given" phenomena* and to investigate their *interrelation*. While giving rich insight into how strategizing and organizing *are* or *should* be related, these studies underemphasize a second aspect of this relationship, though assuming it implicitly: the difference or (*ongoing) differentiation* of strategizing and organizing.

Differentiation of strategizing/organizing

The aspect of differentiation might not be crucial for every empirical situation alike. Indeed, and this is convincingly being shown by the empirical studies within the

strategizing/organizing stream, to reorganize an organization (Colville & Murphy 2006) or to develop a consistent strategy within pluralistic contexts (Jarzabkowski & Fenton 2006) often brings with it the question of how to fruitfully, or at least non-destructively, *align* organizing and strategizing processes. But questioning the *differentiation* between strategizing and organizing is not just a theoretical twist. Indeed, it is a practical and ongoing challenge for practitioners during strategic change initiatives, as we could witness during our research in different hospitals.

Thus, in order to capture the differentiating aspect between strategizing and organizing and to conceptualize strategizing and organizing within strategic change, we draw on a second body of literature, which is informed by a "systemic-discursive" (Seidl 2007) perspective on strategic change.

Within this constructivist approach, organizations can be conceived of as recursively-reproduced repertoires of discursive practices (cf. Orlikowski 2002). They emerge from an ongoing enactment process by a multitude of actors and "communities of practice" (Brown & Duguid 1991) which in turn are enacted by discursive practices. As for their "composition", we follow Reckwitz (2002) who describes practices as conjunctions of three interrelated dimensions: patterns of everyday activities and interactions, like sequences of encounters; ways of understanding and virtual structures like reference systems or self-conceptions; and ways of "using things" (255) like writing a paper on the computer or examining a patient with a stethoscope.

We hold with the systemic-discursive approach to conceive of *strategizing* and *organizing* as discursive practices. In the ongoing organizational becoming, these processes are closely interwoven. Organizing and strategizing are characterized mainly by a "*ready-to-hand* mode of engagement" (Weick 2003, 467; original emphasis; ref. to Heidegger, 1962), meaning that actors are immersed in the daily flow of activities and perceiving the world as a holistic whole. When it comes to any kind of *interruption*, an unexpected event, a problem or new opportunity, a shift in what has been perceived as given, then actors' experiences change into an "*unready-to-hand*" or even "*present-at-hand*" mode (ibid), they step out of the "action mode" and into a different mode where they reflect about the way they are engaging in the ongoing flow of discursive practices.

When we think of this "reflection mode" in a collective form, as a totality of discursive practices that a group of actors engage in and/or that is accomplished in relation to a joint purpose, this is what we conceive of as a *reflexive form of strategizing* (just *strategizing* for

the remainder of this paper) and assume to be constitutive for *deliberate strategic change*. As such, strategizing can be the outcome of interruptions of organizing. But as soon as it differentiates from organizing it also has the potential to be the source of interruptions of organizing.

An answer to how strategizing can be thought of as the outcome of interruptions of organizing and how strategizing itself can become a form of interruption can be derived from the concept of "*strategizing episodes*" (Hendry & Seidl 2003). First, a strategizing episode, according to Hendry and Seidl (2003), is an event or a sequence of events which is marked by a beginning and an ending. The ending can consist in a goal and/or a certain point in time and goals and time limits are up to modifications during the course of an episode. Members of an organization and participants within an episode recognize beginnings and endings as a difference from the endless organizational time horizon. It is this difference – which we conceive of as a kind of interruption of organizing - that has the potential to effectuate a switch from an action mode of organizing/strategizing to a reflection mode of strategizing.

A second kind of interruption is accomplished, when strategizing episodes are only *loosely coupled* with the ongoing organizing discourse (Hendry & Seidl 2003). Loose-coupling means to temporarily suspending certain aspects of organizing while keeping others in place. This allows on the one hand that the difference between organizing and reflexive strategizing is big enough for a "switching of contexts" (von Krogh & Ross 1996): participants step out of day-to-day organizing and engage in a (reflexive) discourse about whether, which and how strategic changes need to be undertaken. On the other hand, though, there is no complete de-coupling: reflexive strategizing is not detached; it has something to do with what is going on in the organization and therefore also has the potential to fruitfully inform organizing.

Altogether, from a theoretical point of view, strategizing episodes are a possible starting point of strategic change. In practice, though, the differentiation of strategizing from organizing, even when supported by deadlines or objectives, is a precarious endeavour. As we found by two case studies on strategic initiatives in hospitals, the empirical challenge specifically lies in balancing the differentiation and relation of organizing and (reflexive) strategizing: Strategizing needs to interrupt organizing (suspend certain aspects). But it has to do so in a *protective* way: strategizing may not disrupt, destabilize or paralyze organizing; at the same time, strategizing may not be determined by organizing nor completely de-coupled from organizing. Our case studies show that keeping this balance is an ongoing effortful accomplishment. How this balance within strategizing was being accomplished is what we

will summarize by the concept of "*protective interrupting*". We empirically derive the concept by following the call of Hendry and Seidl (2003) for a systematic and comparative analysis of the accomplishment of strategizing episodes. We draw on two longitudinal case studies on strategic initiatives and explore, *to what extent it was possible, to fruitfully interrupt and suspend daily organizing for the sake of (reflexive) strategizing, and more concretely, which processes and practices allowed the differentiation of strategizing from organizing while keeping a kind of relation.*

Conceptual framework

For the purpose of this paper, *strategic change initiatives*, such as the two studied, are conceptualized as a series of episodes related in time by a general overarching issue. They represent periods of deliberate change, where strategizing has the potential to intervene in trigger change in the ongoing organizational discourse. This conceptual view on strategic change initiatives resonates with a situated view on change (Langley & Denis 2006), modified insofar as strategizing as the trigger for change is not so much conceived of as a given of external force per se. Rather, it is developed by interruption out of the ongoing strategizing and organizing discourses ("initiation") and is then ongoingly differentiated (during "conduct") and related until the termination of the strategic initiative. Every r*e-lating* of the strategizing discourse to organizing begs the potential to further trigger deliberate change.

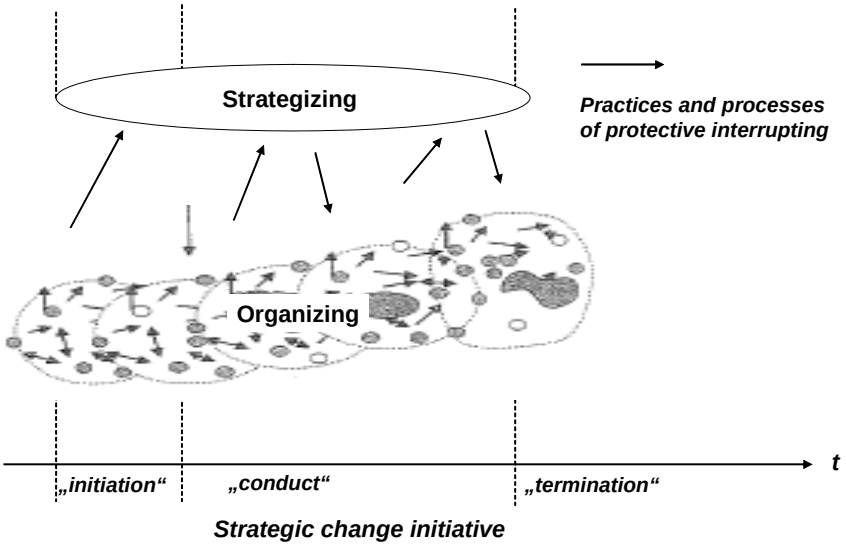


Figure 1: Conceptual framework (in reference to Langley and Denis 2006, 141)

Methodology

Our overall research design was in the tradition of contextualist research (Pettigrew 1990; 1997). This is in accordance with our conceptual framework, where we conceive of strategic change (content) as being carried out through an ongoing, recursive differentiation and relation between reflexive strategizing (process) and organizing (context). Similar to Mintzberg's strategy of "direct research" (Mintzberg 1979), we were studying strategic initiatives in real-time, from their beginning until their ending, in direct contact to the field. With varying intensity of field contacts (number of field contacts within a certain period of time, methods with greater or fewer immersion in the field), we aimed to explore the sequence of events and actions over time (Van de Ven 1992). In addition to our real-time studies, retrospective research was conducted in order to understand the historical embeddedness of the two initiatives within the broader development of the respective hospitals. Due to the contextualist approach and the underlying constructionist epistemology, data collection and data analysis followed an iterative process (e.g. see Pettigrew 1990).

Data Collection

The two cases presented in this paper – named Unihosp and Regionalhosp (see next section) – form part of a larger ongoing research project that encompasses data of four longitudinal, interpretive case studies on strategic initiatives within hospitals. They were chosen for comparison for the following reasons: The cases are similar in that the initiatives could not draw on existing strategizing practices but had to develop strategizing over the course of the change process. In both cases, interrupting of organizing and the development of a parallel, strategic discourse had effectively been accomplished over the long run. The cases are different insofar as strategizing was approached in different ways – in the first case in a more formalized way and distinct from organizing, in the second case in a less formalized way and closer to day-to-day operations. A longitudinal, comparative study (Pettigrew 1997; Yin 1994; Eisenhardt 1989) on these two cases allows comparing practices and processes that have contributed to the effective differentiation of strategizing from organizing despite the different approaches to strategizing. Specifically, it allows comparing these practices and processes in terms of similarities and differences and their patterns over time.[1]

[1] Following a replication logic (Leonard-Barton 1990) and the comparison of polar types (Pettigrew 1990), the insights from the first two studies will serve as a starting point to interpret two further case studies. In these two other studies, the differentiation of a strategizing discourse from daily organizing was less obvious or was considered difficult.

A triangulated methodology (e.g. Pettigrew 1990) was chosen in terms of multiple researchers and multiple data sources. Working as a team of researchers with their different perspectives was perceived as being crucial to get hold of the complex phenomenon of our study; using multiple data sources should allow benefiting from the specific strengths of different data sources and to enhance the overall trustworthiness (Guba & Lincoln, 1994) of our results.

The studies were conducted by a team of two researchers. Data collection comprised multiple data sources, such as semi-structured, open-ended interviews, participant and non-participant observations as well as internal and external documents, complemented by ongoing field notes (see table 1 for an overview). Internal documents at Unihosp included numerous emails. At Regionalhosp, data collection also included several days of shadowing nurses and doctors in their everyday organizing processes. Such ethnographically informed research (cf. Barrett & Heracleous 2001) enhances the understanding of the organizing context. Furthermore, it allows observing practices and the "use of things" that might not be detected by interviews or by the observation of more formal episodes like meetings.

	Unihosp	**Regionalhosp**
Duration of real-time study (months)	39 months, from Dec. 2004 until March 2008	22 months, from Apr. 2004 until Feb. 2006
Interviews	23 (Physicians, nurses, IT, administration, external facilitators, hospital management)	32 (Physicians, nurses, administration, hospital management) (and another 48 interviews in the context of other case studies in the same hospital)
Observations	25 meetings of the steering committee; several internal events and other meetings	27 (team meetings of nurses, management meetings etc.) (and another 46 observations in the context of other case studies in the same hospitals)
Documents	Around 60 emails; 20 minutes; numerous project documents etc.	32 (e.g. minutes...), numerous internal documents, both technical as well as managerial (standards of care, leadership principals etc.)
Other	Numerous informal conversations	8 days organizational ethnography on nursing wards; numerous informal conversations

Table 1: Data sources and event coverage

The interview schedule was wide ranging, both functionally and hierarchically. All (professional) disciplines involved in the change initiatives were covered, people with different roles within the initiatives (e.g. sponsor, project leader, project team members, members of the steering committee) as well as participants or "observers" of the initiatives inside and outside the clinic and the department under study. All interviews, except two, were tape-recorded and transcribed verbatim. The interview guide consisted (1) of questions, focusing the "what" and "how" of the initiative (its history and course, observed changes and major events) and (2) of "why"-questions asking the interviewee e.g. for reasons and explanations of major events or perceived challenges.

Data Analysis and Interpretation

In the case of Unihosp, data analysis drew on the primary data sources displayed above. In the case of Regionalhosp, data analysis primarily departed from the thick case description developed in a fellow researcher's dissertation (cf. Tuckermann 2007). Where this seemed reasonable, the secondary data was complemented by probes into the primary set of data.

In a first step, using coding software, we developed a chronological overview of events, similar to the method described by van de Ven and Poole (1989), but less formalized. This chronology included the time of an event, the meanings interviewees and other practitioners ascribed to the event, how it was explained and which connections were made with other events. Complemented by rich observational material and documentary data, a written narrative manuscript of the change processes within their historical settings was developed, in the sense of a first order analysis (van Maanen 1979).

In a second, interpretive step, we started searching for processes and practices connected to interruptions of organizing and to the differentiation of a strategizing discourse. In order to approach the question of *processes of protective interrupting*, we identified points of interruption in time by looking for discontinuities within the change processes as well as for events and issues that people in the field connected with some kind of disruption, difference, novelty or the like. Then, in order to approach the question of *practices of protective interrupting*, we compared prevalent structures of the emerging strategizing practice with organizing within the identified points of interruption over time. At this point, the first two dimensions of practices as conceptualized by Reckwitz (2002) – ways of understanding or virtual structures and patterns of activities and interaction– turned out to be fruitful dimensions of comparison. Literature, specifically on professional and pluralist organizations, was helpful for plausibilizing our findings.

We finally structured the narratives on the two strategic change initiatives according to a temporal bracketing strategy (Langley 1999).

In the following empirical sections, we will give first insights into what still runs through the process of interpretive scientific sensemaking, iterating between deductive and inductive steps and including a portion of imagination (Langley 1999). After an overview over the two cases, data presentation will be divided into descriptive, analytic and interpretive sections according to our first- and second-order analysis.

Case Study Overview

In what follows, we give an overview over the two initiatives, organized according to our conceptual framework and the content, context (initial conditions and organizing) and process (strategizing) dimensions of change (Pettigrew 1990; 1997). The overview is meant to ease following the description, analysis and interpretation of the cases within the subsequent empirical section. We first briefly outline the *content and outcome* of each initiative. We then sketch each of the historical contexts, which allows delineating the initial condition for change as well as prevalent virtual structures and interaction patterns of *organizing*. These prevalent structures and patterns of organizing represented the (internal) context for strategizing and dimensions addressed by interruptions during the course of the initiatives. The *motivations for change* identify both initiatives to be strategically relevant. Finally, overall strategizing will be sketched which as such was the result but also the source of "protective interrupting" within the two initiatives. Quotation marks indicate words and expressions used by people in the field.

Process optimization and restructuring at Unihosp

Content: Unishosp describes a change process within a surgical clinic of a high standing children's university hospital in Switzerland between 2004 and 2008. The change addressed the question of *differentiation and integration* along two dimensions: along a structural and more explicit dimension, patient processes were optimized and the organizational structure was adapted to conform to sub divisions of specialized surgical teams (specialized units of senior and assistant physicians with own registry). Along a management dimension, strategizing developed into an integrative practice to support coherent operations within the clinic beyond the initial change initiative.

Organizing and initial conditions within the historical context: Since its foundation in 1874, the hospital has witnessed constant growth. In 2004, the surgical clinic is a favoured employer and distinguished service provider. For long years, the clinic was headed by a chief surgeon of the *old school*: generalist in terms of surgical expertise and "patriarch" in terms of leadership style. He led the clinic in a strictly hierarchical manner. On the level of daily operations, the wider *trend of sub specialization* of medical praxis already started to get informally expressed in an ongoing tendency of surgeons to gain expertise in a certain subspecialty of surgery. While admitting the various sub specializations, the chief surgeon preserved the hierarchical structures and top-down decision-making processes. Accordingly, patterned interaction beyond each doctors' personal realms mostly consisted in technical encounters like ward rounds[2] rather than in joint communicative settings to discuss organizational issues.

In 2003, a new directorate, consisting of a chief surgeon and his representative, a leading surgeon, is appointed. They had made their career within the clinic, but represented a *new school of proficiency and leadership*. In addition to their general surgical competency, they had developed expertise in distinct sub specialties. While the clinical hierarchy with its distinct levels of proficiency and responsibility stayed in place, both surgeons were known for their openness towards changes and developments. In their management styles they complemented each other: whereas the chief surgeon tended to approach challenges with a lot of "creativity", his representative, a leading surgeon holding an MBA (whom we call 'MBA-surgeon' for the remainder of this paper), was characterized by handling decisions and processes in a very considered manner.

Motivation for change: In 2004, the directorate decides on the development of specialist sub divisions within their clinic. Such divisions would be in line with the *broader trend of sub specialization* of medical sciences and reflect an ongoing development within the clinic. Moreover, a sub specialization would be *strategically important* as begging the potential to attract high qualified medical personal and a rising number of patients.

Strategizing approach: Strategizing in this initiative was formally institutionalized in the form of a "parallel organization" (Kanter 1983). A core-team was set up, consisting of the directorate and the directorate assistant, who at the same time led the clinic's registry. A multi-disciplinary steering committee also included surgeons from lower hierarchical levels as well as representatives from the nursing department and from IT. Different, temporary project

[2] Ward round = Visite

teams were charged with the conception and implementation of specific areas of change. An external coach facilitated the change process in the sense of “help for self-help”. He supported the preparation and conduct of most of the steering committee’s meetings, various workshops and important events. He also could be called in for specific problems or questions. Strategizing work was complemented by documentation and communication. Altogether, strategizing was characterized by an attentively organized form of reflexive and participative practice not being known within the hierarchical structure before.

Developing management and caring praxis at Regionalhosp

Content: Regionalhosp describes a strategic initiative within a regional public hospital in the context of its merger with a central public hospital between 2004 and 2006 (cf. Tuckermann 2007). As such, on a more implicit level, the initiative touches the *identity and self-concept* of the regional nursing unit. On an explicit level, the initiative aims at the repositioning and transformation of a regional hospital’s nursing unit, including the introduction and adaptation of *professional standards* and the strengthening of organizing, communication and management practices.

Organizing and initial conditions within the historical context: The regional hospital used to be a small supplier of basic healthcare services over more than a hundred years, with low internal specialization and differentiation. Medical departments embraced just three basic medical domains (in comparison to the central hospital whose medical departments were divided into a dozen single clinics). The nursing department was represented in the hospital management by a head nurse, but beneath and in its everyday operations, nurses were hierarchically subordinate to the medical departments and doctors. The strong internal interconnectedness together with *high personal caring ethics of nurses* was often described as contributing to the hospital’s “familial atmosphere”.

Beginning in the 1990s, public hospitals in Switzerland witnessed increasing cost pressure. Being in close distance to a central hospital, the regional hospital was repeatedly threatened by closure. Cost cutting measures and the quitting of the chief surgeon initialized a *down-turn spiral* of reputation damage, difficulties in recruiting high qualified personnel and decreasing patient numbers. Nurses increasingly narrowed their attention to at least *hold up patient care*. Struggling with the ever tightening conditions absorbed precious time and resources and impeded the hospital to keep pace with the current advancements in medicine and care. In 2003, the cantonal health department decided on the “merger” between the central hospital and the regional hospital.

Motivation for change: In 2004, an independent patient survey underlines the need of substantial improvements and changes of the regional nursing unit. High-end nursing not only would be indispensable in terms of patient care but also in terms of reputation and finally in respect to the regional hospital's long-term continuity.

Strategizing approach: Strategizing was mainly pursued by a head of ward of the central hospital, delegated "change agent" and backed up by the central hospital's leading nurse. She undertook the changes in close relation to the nurses' operational work, initiating and developing new communicative settings which bit by bit were transferred into daily organizing and management practices. First delegated change agent to move forward the merger she later was appointed head of the regional nursing department. In comparison to *Unihosp*, strategizing was characterized by a less formalized, more reactive step-by-step approach close to day-to-day operations.

Table 2 summarizes and contrasts the overviews over the two case studies. As to the *initial conditions for change*, the table reveals Unihosp to start within a favourable or "receptive context" (Pettigrew et al. 1992) in contrast to a challenging context at Regionalhosp. *Organizing* in both cases can be traced back to the historical trajectories of the hospitals. Further, it reflects elements of hospitals as pluralist organizations (cf. Denis et al 2001; Denis et al. 2007) as expressed in professional autonomy and knowledge-based work processes of different professionals "worlds" (Mintzberg 1997), in our cases surgeons and nurses. The *strategizing approaches* are different within the two initiatives. The question of how these approaches differentiated from and (protectively) interrupted organizing (cf. arrows in table 2) as to effectuate the respective *contents and outcomes of change* over the course of the initiatives will be subject of the next empirical section.

	Unihosp	**Regionalhosp**
Content and outcome	• Formation of sub divisions (units of senior surgeons, assistant surgeons and specialized registry services) • Reorganization of patient processes → *strategic relevance of differentiating but at the same time integrating the clinic*	• Introduction & development of professional standards of care to meet central hospital standards • Development of managing and organizing practices and structures → *strategic relevance of making the regional department an integrated part of the merged nursing department but at the same time strengthening it as a distinct unit*

Initial conditions for change	• High standing university clinic with constant growth • General openness for changes → *position of strength / favourable context for change initiative*	• Almost closed down regional hospital having felt threatened by big central hospital, continuous downturn spiral • Nursing attention confining their work on at least upholding patient care → *position of weakness /challenging context for change initiative*
Organizing	• Virtual structure: professional autonomy, further strengthened by trend of sub specialization • Patterned interaction: Communicative settings on the clinic level traditionally confined to technical issues within surgical domain • V.s. & p.i.: Transition from traditional hierarchical structures and top-down decision making towards a more participative style of leadership → *Organizing practice characterized by historical and professional context*	• Virtual structure: Familial atmosphere of a regional provider with high personal caring ethics • Patterned interaction: No distinct management and organizing structures within nursing unit; nurses acting and interacting around patients' and nurses' needs; nurses historically subordinate to the medical departments and doctors → *Organizing practice characterized by historical and professional context*
Overall strategizing approach	• Formally organized & distinct from day-to-day organizing • Communicative platforms: Steering committee (covering different disciplines and hierarchical levels), temporary project teams • External facilitator → *"platform-bound strategizing"*	• Less formal & close to day-to-day operations • Change agent (from the overtaking hospital) • Head nurse of the overtaking hospital, formally responsible for the change process → *"role-bound strategizing"*

Table 2: Content, context and process of the two strategic initiatives

Protective Interrupting – Findings of a Comparative Case Analysis

This section will show strategizing to take different forms over time (*strategizing as a process of protective interrupting*), with varying ways and capacities to protectively interrupt organizing (*strategizing as a practice of protective interrupting*). Figure 2 displays a tentative framework of protective interrupting as derived from our inductive analysis and inspired by the conceptualization of practices by Reckwitz (2002).

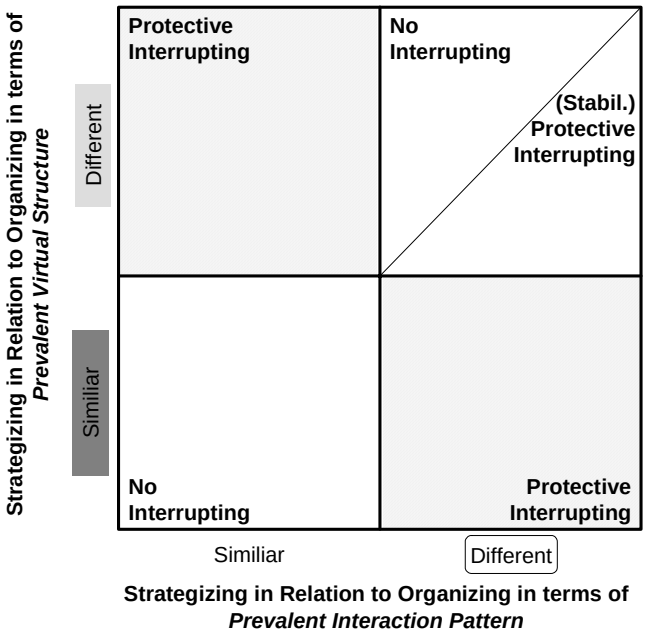


Figure 2: Tentative framework of strategizing as protective interrupting

The matrix results from two dimensions of the strategizing practice – virtual structures and interaction patterns – in their relation to organizing – either similar to the virtual structure and interaction pattern of organizing practices or different to them. Strategizing turned out to be "*protective*" – that is interrupting organizing but neither disrupting organizing nor being too close or too detached from it as to effectuate changes – when different to organizing in only *one* of the two dimensions of the matrix. In the case of strategizing being different to organizing in *both* dimensions, the protectiveness of interrupting turned out to be a matter of time and process: Differences in both dimensions at the beginning of a change initiative resulted in *no interrupting* (as will be the case at Regionalhosp). In comparison, moving to a difference in both dimensions over time not only turned out to protectively interrupt organizing but also to do so in a *stabilized* way – strategizing more or less kept this two dimensional differentiation from organizing over the further course of the initiatives. It also seemed to be with this stabilized form of protective interrupting that most deliberate changes were effectuated.

When looking on how the different forms of strategizing had been accomplished over time we found smooth shifts as well as major turning points. We label the turning points "*crises*": they temporarily jeopardized organizing as well as strategizing and represented an *interruption of the change process*. At the same time, they seemed to be contributing to the further differentiation and stabilization of strategizing over time.

In what follows, we describe and analyse *extracts* of the two change initiatives according to our framework (cf. figure 2). We will not describe and analyze the cases in detail over their full length. Out intention is to focus on developments which we assume as being key to address the research questions of this paper. For *Unishop*, we receive two phases, characterized by different forms of strategizing – which we label U^1 and U^2 – and connected to either smooth shifts or a crisis. For *Regionalhosp*, we also receive two phases, characterized by strategizing R^1 and by R^2 and R^3 forms of strategizing respectively and also connected to either a crisis or smooth shifts between these different forms. The extracts begin with the decision to start the initiatives. They end at the point in time where accounts of the field indicate strategizing to be stabilized. The extracts are contextualized by a short introductory section and are completed by summarizing the subsequent course of action, the effectuated changes and the termination of the initiatives.

Process optimization and restructuring at Unihosp – Description

In 2004, the directorate of a surgical clinic of a high-standing Swiss university hospital decides on the development of specialist sub divisions within their clinic. The challenge of the reorganization would be to balance differentiation and integration: On the one hand, an explicit differentiation should allow increased medical autonomy and high-end services. On the other hand, the directorate recognizes the importance to prevent the development of multiple "little kingdoms[3]" within the clinic as well as possible inefficiencies due to small team sizes and incoherent working procedures between the divisions. Without prior experience in conducting major change initiatives and expecting a complex and challenging change project, the directorate of the surgical clinic engages an external facilitator to coach the initiative.

Phase One: Shift from organizing to "strategizing U^1"

Forming the steering committee – Defining members and project goals. An initial meeting with a wider group of people takes place in December 2004. One of the first points to be discussed is the composition of a steering committee which would be in charge of directing and supporting the project. Some surgeons vote for an extended group: Every leading surgeon should participate in the committee for it would be her/his domain to be affected by the

project. And furthermore, every domain would work differently. Referring to his experience in other projects and suggesting the complaining surgeons to represent the voices of the non-attendees in the committee, the facilitator can convince the group to form a committee of *10 instead of 20 persons.* The group agrees upon *rules of the game* as guidelines for their future work as a steering committee. The facilitator also introduces practices like the clarification of expectations at the beginning of a session and a short debriefing at the end.

The second aim of the meeting is to specify the *goal of the project*. Originally, the directorate approached the facilitator with the wish of forming a new organizational structure. The facilitator initiates a group work and discussion to identify the main current problems of daily work. A clustering of these problems makes obvious that most of them are related to sub optimal patient processes rather than to an inadequate organizational structure. Based on that, the group agrees on the optimization of critical patient process in addition and prior to a reorganization of the clinic structure.

Mobilizing the organization After the formation of the steering committee, there are several internal events and workshops to inform a number of further key people about the project. The facilitator and a second external coach conduct interviews with employees throughout the clinic and on this basis reconstruct the flow and form of two critical patient processes that the steering committee has decided to optimize. In July 2005, the clinic organizes a big event to role out the project within the organization. About 50 employees from throughout the surgical clinic and the hospital and from different disciplines and hierarchical levels are invited on a two-day away-day. The away-days are facilitated by the external coaches. With the help of two big sized process-mappings, which cover the walls almost all around the meeting hall, intra- and interclinical, multidisciplinary working groups are invited to analyze the processes, to develop roadmaps for the envisaged process optimization and to suggest short-term improvement measures. A registry worker remembers that “everyone was listened to and taken serious. You could communicate your needs”.

It is the first time that the hospital staffs get to see the processes they are involved in every day. They recognize their stake within the processes but also the interdependencies among each other and experience joint work which “transcends the functional barriers that used to

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[3] The metaphor of „kingdom“ is used by hospital employees in this case, but also in other of our studies, to describe the phenomenon of head physicians tending to conceive of their clinics or departments as their proper sphere of influence with no other force to intervene. Alternatively, the expression “little garden” is used.

block changes" and mutual understanding. The two days end with a roadmap to work on identified challenges and to realize possible short-term improvements.

Following the event, employees observe an increased appreciation of each others work and a bigger willingness to cooperate in day-to-day operations. Reports a doctor:

> … that the nurses realized: Wait, right, the doctors also have a lot of things to do besides operating. They also have consultations. The nurses did know this before, of course, but the appreciation of our work had increased… And now, we usually do not have to telephone as often as before to discuss a problem, and in general, the nurses are also more patient (An assistant doctor)

Project groups – formation, training, project plans. In its first meeting after the event, the steering committee discusses the formation of four project teams. These teams will be charged with the conceptualization of the changes within two major patient processes which are to be implemented in a second step. In her field notes, the observing researcher[4] describes the atmosphere of the meeting as "markedly relaxed and constructive".

Without prior experience in organizational project management, the future project leaders receive a two-day-training by an external coach and are also supported in working out the project plans. The time requested for the project work means a high investment for the participants and project leaders, who are also very much absorbed by their daily medical and nursing work. Still, as one of the external coaches reports in an internal email, they work intensively and "in the evening they are tired but happy" (Email, September 14th, 2004).

Project work and specially set-up project room From September 2005 on, the meetings of the steering committee and the project teams take place within a specially set up project room, situated in an outbuilding of the clinic. The room allows working on the project in distance to day-to-day operations and the participants try to minimize their responsibilities for the time of the meetings. The external facilitator attends most of the sessions, moderating the discussions and reminding the agreed rules of the game. The members of the steering committee mostly appreciate the interdisciplinary and multi-hierarchical work. But on the other hand, some also miss a stronger orientation within the project. Remembers an assistant doctor and member of the steering committee:

> I think it was a brave idea, that the directorate did not just say how they want things to be. But that they formed this group of people [the steering committee; the authors] and wanted all of them to have a say. Because, you know, this is something you can't control.

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[4] The first author of this paper.

> But on the other hand, they should sometimes set more guide rails or say: This is the way we do it. This would help to more quickly move on and not get stuck with ongoing discussions. (Assistant doctor)

Finishing the conceptual project work The December session takes place without the facilitator. The steering committee adopts the project plans. The meeting protocol announces the implementation of the project plans to be discussed in its next meeting in February 2006. It also informs about having basically decided to "definitely go ahead with the development of sub divisions" (Minutes, December 16th, 2005).

First signs of challenges ahead At about the same time, the facilitator reminds of keeping the organization informed about the proceedings of the initiative and expresses his concern for an increased attention to the implementation of the conceptualized changes. What is more, the assistant of the directorate approaches the facilitator: In a confidential talk she encourages a leadership training to strengthen assertiveness and the ability to give orientation within this change process.

Phase Two: "Crisis"and shift from "strategizing U^1" to "strategizing U^2"

The question of implementation In February 2006, the next session of the steering committee takes place. The facilitator asks the attendees for their impressions about the proceeding of the project. Some surgeons report about observing certain surgical teams to start demarcating themselves from the rest of the clinic, resulting in part in a more competitive atmosphere but also in confusion about responsibilities. The MBA-surgeon picks up this comment as an "important point" and reminds that "the clinic may not break apart". Then he passes over to the next person to speak.

The next agenda item leads to some disappointment on the side of the directorate. The leading surgeons of the clinic, as future sub division leaders, had been given the assignment to develop a job description for their future assistant doctors, but some of them had only marginally worked on that task. The chief surgeon complains about the poor results and lax involvement of the surgeons:

> We give space to the people [the leading surgeons; the authors] who wish to be autonomous and then they do not fill out this space (Chief surgeon)

In the subsequent discussion, the facilitator can work towards the insight that the poor results could also be the consequence of an under specification of the task. The chief surgeon concludes that obviously he had not insisted enough.

Then, the two externals push the question of implementation. The discussion results in further steps to take but also reveals heavy time and technical constraints that would have to be handled. The committee agrees on an event in April 2006 to inform the clinic about the proceeding of the project.

"Crisis meeting" In March 2006, some weeks after the steering committee meeting, the external facilitator is approached by the directorate at short notice: The chief surgeon and the MBA-surgeon report unexpected tendencies of sub dividing going on in their clinic. There would be high confusion within the organization about how all this should fit to the upcoming process optimization; people wonder about responsibilities and the distribution of work between different surgical teams and other disciplines. The facilitator meets the directorate for a "crisis meeting", as he calls it later. They thoroughly analyze the situation and conclude that it would not be too late to stop the differentiation tendencies, to further delay the restructuring and to keep going on with process optimization. Further, the facilitator and the directorate discuss their mutual expectations within this change initiative and come up to specify more clearly each others role.

"Vacuum" in leading the change process and the question of project ownership On April 7th 2006, the external observer takes part in another meeting of the steering committee. The reallocation of assistant doctors, as part of the restructuring of the clinic, is officially delayed. So also is the implementation of two of the four process optimization projects due to time and resource restrictions. One of the project leaders expresses that she wishes a confident talk with the directorate in terms of project progression. In her field notes, the external observer describes the atmosphere as "low in energy".

On April 10th, the information event takes place in the hospital cafeteria. A lively designed letter invites clinic members and everyone interested to get informed about the proceeding of the change initiative, to have some direct discussion with members of the steering committee and to give feedback. After a short break, most doctors have left, whereas nurses and other staff members still attend the meeting. For the facilitator this reflects who feels concerned by the project and who doesn't. What is more, the event prompts the question what apart from conceptualizations has actually been changed so far.

> It became evident that no preparations had been made for any form of implementation. Their [clinic directorate / steering committee; the authors] implicit assumption seemed to be 'They [the organization; the authors] will handle that'. There was a complete vacuum (Facilitator)

Adapting the project structure and concretizing project ownership. The time after the information event is later described as the most critical of the project. In April and May, the facilitator initiates changes in the project structure. The project structure is transformed into an "implementation structure", defining mentorship roles for the members of the steering committee in respect to the projects that have to be implemented. Another change consists in the specification and definition of the leadership of the project. The facilitator suggests the MBA-surgeon to take over this position – touching a delicate point. Remembers the facilitator:

> I tried to make clear very smoothly, that the project needs someone at its top. This was a quite subtle process. Because hierarchy had always been so strongly associated with power. I had to argue a lot that [the chief surgeon] wouldn't be disempowered, if [the MBA-surgeon] took the ownership of the change process. I had to make clear, that ownership would mean to systematically monitor the process and to always look ahead on the next steps to take. Within major change projects you can't say 'we leave it to the organization and its self-organizing capacity' to handle that. (Facilitator)

Apart from the new project structure, project tools are developed that cut the big project plans into more fine grained working packages to support the employees in implementing the conceptualized changes. Employees are allocated to the working packages and to the respective mentors of the steering committee.

At the end of May 2006, the first working packages are approved for implementation by the steering committee. In his invitation to the steering committee's December meeting – two years after the initial meeting of 2004 – the MBA-surgeon mentions the proceeding of the implementation and that people now would say "we can and we do" instead of "we could and we would" (Email by the MBA-surgeon, December 6^{th,} 2006).

Further course of the change process: Key moments and effectuated changes

In January 2007, the postponed optimization projects are started. A meeting of the project leaders can be terminated after half of the estimated time – the participants realize that due to an increased mutual understanding of each other's work area and the development of a "common language" they are able to very quickly discuss all the necessary aspects. In summer 2007, the directorate meets the facilitator to discuss the issue of leadership and their role within the clinic. Until the end of 2007, the organizational structure is adapted to form sub divisions. In its final meeting in March 2008, the steering committee reviews the change process. The attendees diagnose still outstanding changes within patient processes but an adapted clinical structure. They appreciate the steering committee as having been a helpful

communicative setting to direct and support the project; and as having connected people from different disciplines around organizational issues of relevance to all of them. In one of its last agenda items the steering committee discusses a first draft of a similar kind of communicative setting under the working title “steering committee 08” for managing future projects and for constantly monitoring topics of relevance for the clinic as a whole.

Strategizing and Interrupting at Unihosp – Analysis

Strategizing over the course of the Unihosp initiative took two distinct forms, accomplished by a smooth shift in the beginning and related to a crisis later on, and effectuating interrupting in different ways (figure 3). The different forms of strategizing and interrupting will be analyzed in the following.

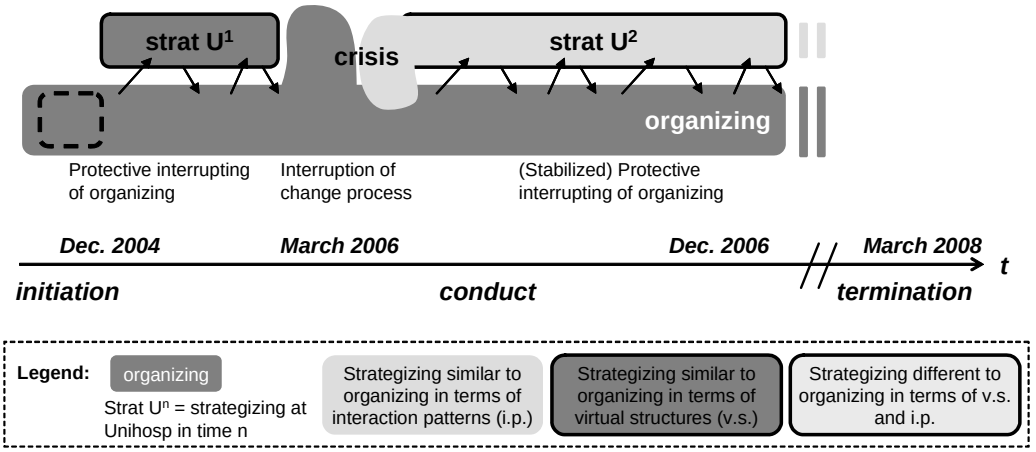


Figure 3: Strategizing and organizing over the course of change initiative at Unihosp

Initial conditions: Strategizing was set up under favourable initial conditions – out of a position of strength and a general openness toward changes. The organizing context can therefore be described as receptive to a change related discourse, or to put it differently, to strategizing. This is indicated by the dotted rectangle within organizing at the beginning of the initiative. The smooth shift from initial organizing to strategizing U^1 (see below) further supports the interpretation of a receptive initial context.

Strategizing U^1 in relation to organizing: Strategizing U^1 was different to the clinic’s prevalent characteristics of organizing in terms of its interaction pattern and similar in terms of its underlying virtual structure (cf. table 2):

Interaction patterns: Traditionally, communicative settings within the clinic were more or less restricted to technical aspects of professional work. Further, there were no institutionalized interdisciplinary settings within the clinic. Within the *steering committee*, though, strategizing on the upper level was characterized by interdisciplinary work dedicated to issues on the organizational level. So was the *joint work on process plans* as well as the realization of the process optimization *projects*.

Virtual structure: The underlying virtual structures of strategizing can be characterized as gradually but not distinctly different from organizing. On the one hand, the surgeons' *self-conception as autonomous professionals* was touched already within the very first meeting. This self-conception was subtly expressed in some surgeons' claim to nominate every surgeon a member of the steering committee; and it was expressed in the wish to realize an organizational structure that would reflect and strengthen professional autonomy. On the other hand, the optimization of processes as a first goal of the initiative to start with did not contradict a new clinical structure or professional autonomy. What is more, the work on processes did not represent a detached content but was in very close relation to people's and also surgeons' day-to-day organizing experiences. The question of *leadership* in the sense of giving more direction to the process appeared. But it did not become a critical issue within strategizing U^1.

Protective interrupting: Strategizing U^1 represented an interruption of organizing mainly in terms of interaction patterns, while keeping prevalent virtual structures of organizing in place. Thus, organizing was protected from a major disruption. At the same time, strategizing was not detached from organizing. It fruitfully re-lated back to organizing as can be inferred from effectuated changes e.g. in interprofessional day-to-day collaboration.

Smooth shift: The shift from initial organizing to strategizing U^1 itself required the interruption of certain aspects of organizing. These interruptions were mainly accomplished by the external coaches and supported by the clinic directorate. The interruptions took *very subtle forms* without noticeable disruptions: As was illustrated in the very first meeting, interruptions could be accomplished by means of argumentation, rational procedures like the joint conduct of a cause analysis, and supported by visualization. Agreed rules of the game and basic meeting-principles structured the work of the steering committee. And it was not necessary to openly address more fundamental and therefore also potentially more destructive political or emotional issues. At the same time, the interruptions could build on a receptive context. The multidisciplinary setting of the steering committee was new, but many of the

participants knew each other. They generally appreciated the joint work on clinical issues, as was illustrated by the relaxed atmosphere within their first meetings or the statement of the assistant doctor. In addition to that, the MBA-surgeon, who was a key figure in the change process, can be interpreted as having taken a boundary position and mediated between the known technical gathering and these "new" forms of meetings, motivated by organizational and management issues (cf. Denis et al. 1996, 680).

Crisis: By March 2006, the change initiative as such got temporarily interrupted. Organizing revealed developments that were not yet envisaged and at the same time didn't reflect any signs of implementation concerning the conceptualized changes. Virtual structures of organizing emerged on the surface that had only been implicitly touched before: So did the surgeons' self-conception as *autonomous professionals* when day-to-day organizing showed signs of further differentiation into sub divisions. And so did the issue of *leadership* when the question had to be handled who should be in charge of the change process and the implementation. In reaction to that, strategizing was temporarily destabilized as expressed by the crisis meeting and the direct questioning of fundamental issues like the directorate's and the facilitator's roles within the process.

Shift from strategizing U^1 to strategizing U^2: Until the crisis, the change process could build on the clinic's openness toward changes without the necessity to address hot potatoes. But the crisis could only be resolved and the change process re-stabilized by explicitly addressing and interrupting virtual structures of organizing and strengthening strategizing in relation to organizing. Accomplishing the shift necessitated interruptions that took a more *relational and emotional* character. The coach was increasingly busy with moderation and dialogue. Strategizing could be re-stabilized, leading to the U^2-form of strategizing.

Strategizing U^2 in relation to organizing: Strategizing U^2 represented an interruption of organizing not only in terms of interaction patterns anymore but also in terms of prevalent *virtual structures* of organizing. The existing understanding of *leadership* was specified in terms of leading the clinic vs. leading and organizing the change process. The latter form of leadership found its expression in giving strategizing an "implementation structure": The MBA-surgeon was explicitly charged with the ownership of the change process and the members of the steering committee were assigned mentor roles for specific parts of the project.

Stabilized protective interrupting: Strategizing U^2 was more distinct from organizing than had been strategizing U^1. Still, it was neither detached from organizing nor did it have any

destructive effects on organizing. In fact, the relation between strategizing and organizing was now specified much more explicitly and strengthened through the implementation structure. At the same time, strategizing became stabilized: Over the further course of the initiative, the form of strategizing did not see any noteworthy modifications in reference to organizing any more. At the same time, it fruitfully re-lated back to organizing, supporting the implementation of the envisaged changes.

Developing management and caring praxis at Regionalhosp[5] - Description

Preceding attempts to effect changes in the regional nursing unit Since the beginning of the efforts to merge the regional hospital and the central hospital, the regional nursing unit has revealed manifold deficiencies. Specifically, it turns out markedly behind the professional standards of the central hospital. At the beginning of 2004, a central hospital nurse responsible for further education is delegated to the regional unit. The regional nurses "are motivated and give him a warm welcome" (157). For two months he accompanies and trains the regional nurses. At the end of the two months period, though, he still sees a lot of areas in need of further development. The regional nurses are invited to a final meeting: Representatives from the central hospital "present the situation and outline further changes that need to be undertaken" (157).

To many regional nurses, this presentation is "almost like a menace" and "gives the impression if everything was wrong within their unit" (158). Furthermore, the critique does not fit their personal experiences with patients, who generally report back to be satisfied and to appreciate the "familial" and "snug" (160) atmosphere within the regional hospital.

Phase One: "Strategizing R[1]" and Crisis

Negative survey results prompt the delegation of a change agent. In spring 2004, an independent patient survey reveals deficits in the regional nursing unit. From the point of view of the central hospital's head nurse, this affirms that former attempts to bring about change have failed. Her explanation is that the regional nurses themselves are obviously still not aware of the problems.

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[5] If not indicated differently, the description is based on Tuckermann (2007), specifically pages 194-206. Literal translation is indicated by quotation marks.

The negative results prompt her to delegate one of the central hospital's head of ward[6] as a change agent to the regional nursing unit. Between April and July 2004, the envisaged six months mission is prepared.

Within the six months, the change agent is expected to support the regional nursing unit in implementing changes that would allow an adaptation of the regional nursing praxis to the standards and processes of the central hospital's nursing department. Her tasks include the evaluation of service schedules and concepts of further education and management structures on the ward level, the evaluation and revision of different professional standards of care, and the quantitative and qualitative evaluation of human resources on the ward (194f.). The change agent's understanding of her mission is to

> put the people on track, but then they have to go on on their own. My job is to get an overview over the situation and to put the people on track. Then I will leave (Change agent) (195)

Tense atmosphere upon the change agent's arrival "On 28th of June 2004, the change agent introduces herself to the heads of ward of the regional nursing unit" (195). When she starts working a couple of days later on July 5th, she notices "mistrust" on the part of the regional nurses and feels to be "out of place"(Change agent) (195). It also seems that the regional nurses cannot place her and her role as a change agent.

At short notice, the central hospital's head nurse thereupon determines a further information event. On July 7th, she introduces the change agent to the attendant regional nurses and outlines the change agent's tasks which are visualized on a transparency. While doing so, she explicitly refers to the negative results of the independent patient survey. From the change agent's point of view, this is the first time that the regional nurses are so visibly confronted with the envisaged changes and the referring time line. The nurses silently follow the presentation while seeming to be veritably struck.

Phase Two: Shifts from Organizing to "Strategizing R^2" and "Strategizing R^3"

The change agent inspects day-to-day organizing In the days that follow, the change agent introduces herself to every single ward within their respective team meetings. "She reviews the upcoming changes together with the nurses, but without referring to the negative results of the patient survey" (196). She also emphasises her independency from the central hospital's

[6] Head of ward = Stationsleitung

head nurse. At the same time, the change agent meets with the central hospital's head nurse on a weekly basis to keep her informed and discuss current issues.

Within the regional hospital, the change agent starts conducting one-on-one interviews with every single nurse of the wards and systematically analyzes the interviews afterwards. Her aim is to get to know the day-to-day from the nurses' point of view and to signalize that she takes seriously the nurses' opinions, wishes and fears.

The interviews make evident the resource restrictions and difficult work conditions in the regional hospital, which force nurses to focus all their attention to uphold daily operations as much as possible. But the interviews also reveal the nurses' distinct caring ethics to contribute to the insufficient structuring of organizing and management processes, blurry responsibilities and competencies and a day-to-day that is characterized by improvisation. The nurses seem to work as they think would best meet the specific day-to-day situation and needs of the single nurses. Decisions are often made in group by the ward team and less by the head of ward on her own. Service schedules are arranged by the heads of wards as much as possible according to the needs and preferences of the nurses rather than following generally agreed procedures in planning the work, often leading to imbalanced work loads at the expense of the heads of wards and a loss of overview. The heads of ward justify these procedures with the character of their day-to-day business: care would be a relational practice. And this would hold true toward patients as well as toward nurses. Besides their formal head of ward tasks, they would also have to look after a good atmosphere within their teams, specifically in times of high work load.

In accordance with high caring ethics, the interviews also reveal that many nurses fear the envisaged changes, such like an extended documentation of patient histories. From their point of view, this would significantly increase administrative work for the sake of an already limited time for patient care, a work that they highly appreciate.

Assuring day-to-day operations, postponing the envisaged changes Taken together, the inspections of the day-to-day operations within the regional nursing unit reveal the necessity to hold up, reorganize and support day-to-day operations first. Only then it would be possible to introduce the initially envisaged changes. To accomplish this task, from August 2004 on, the change agent is supported by a colleague of the central hospital.

The next four months are dedicated to stabilize day-to-day operations, both professional and managerial. The change agent and her colleague work in close contact to the nurses. Twice a

day, they visit the wards in order to demonstrate presence, to answer questions or to detect problems. They are soon accepted and respected for their practical and competent help.

Building up and strengthening management and organizing practices. At the same time, the change agent works towards strengthening management and organization practices among the heads of wards. She does so by "sticking to her principles" (201) and make these principles and the underlying management experience visible and comprehensible. Toward the nurses, she for example explains that and why certain issues are to be decided by the head of ward and not necessarily by the whole team. The change agent also introduces procedures for writing the service schedules. By-and-by the nurses begin to accept and to follow the advices. In October 2004, the change agent reports positive developments regarding her relation to the regional nurses.

Change agent and head nurse. In November 2004, the change agent is appointed head nurse of the regional hospital as of February 2005. The regional nurses are not very much surprised. To them, this is a natural consequence of the past developments.

Further course of the change process: Key moments and effectuated changes

From 2005 on, the newly appointed head nurse constantly works towards a clearer structuring of management and organizing and builds up and further develops different communication platforms like rapports, meetings and regular talks. In May 2005, nurses observe positive developments in the way they collaborate and communicate. The attentiveness of nurses is not limited to patient care anymore. Rather, heads of wards recognize the importance to think more "globally" and to also account for "administrative and managerial aspects" (224) of their work. In the course of the year, the regional nursing unit can catch up with results of the central unit concerning the application of standards of care. It also develops a standard of care itself that is adopted by the central hospital. The former change agent starts working toward a stronger emancipation of the nursing unit in respect to the regional medical departments.

Strategizing and Interrupting at Regionalhosp – Analysis

Strategizing over the course of the Regionalhosp initiative took about three different forms (figure 4). In comparison to Unihosp, not all of these forms are not so clearly distinguishable: This is partly due to very smooth transitions over time, especially between R^2 and R^3, and partly due to an overall strategizing approach that was more "role-bound" in comparison to a more "platform-bound" form at Unishop (cf. Table 2). The different forms of strategizing and interrupting will be analyzed in the following.

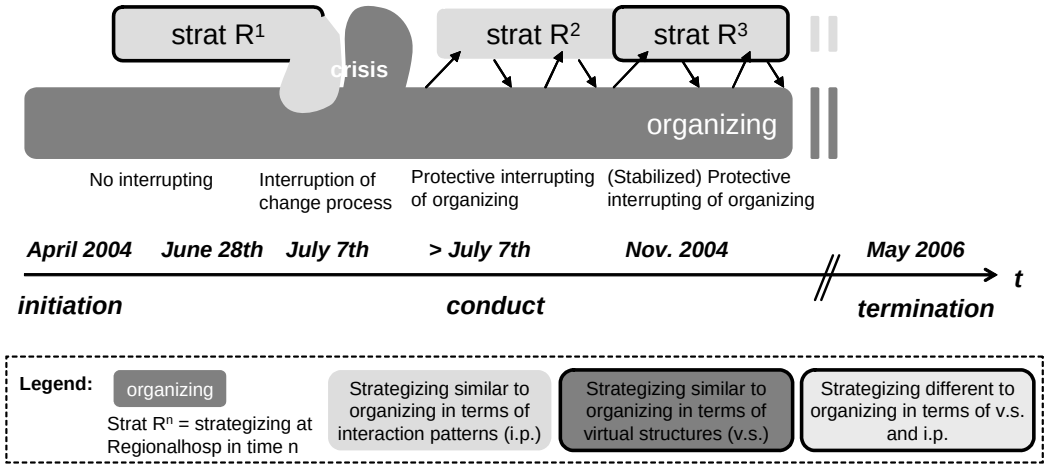


Figure 4: Strategizing and organizing within the change initiative at Unihosp

Initial conditions: Strategizing was set up under quite unfavourable initial conditions – a context struggling with the consequences of an ongoing downward spiral and nurses investing all their energy in upholding the day-to-day and specifically the care of patients. The organizing context can therefore be described as non-receptive to a fundamental, change-related strategizing discourse. This seems to have contributed to the failure of the initial form of strategizing R^1 to effectuate changes.

Strategizing R^1 in relation to organizing: Strategizing R^1 began in April 2004 with the preparation of the change agent's mission and ended after just two days of her work at the regional hospital. As can be inferred from the historical context of the regional hospital and the nurses' reactions toward the arrival of the change agent, strategizing R^1 was different to prevailing organizing structures in both, virtual structures and interaction patterns:

Virtual structures: The regional nurses *strongly identified with the regional hospital praxis*. In contrast to that, the central hospital was repeatedly perceived as a threat in the past, be it in connection with hospital closures hanging in the air or with negative assessments of the regional nurses' professional standards. It seems related to this that the change agent as a delegate from the central hospital and with a mission to bring about change in patient care had a difficult start within strategizing R^1.

Interaction pattern: The change agent's experiences during her first days at the regional hospital and the regional nurses' reactions indicate that the *role of a change agent* was obviously new to the nurses of the regional unit. It seemed that the regional nurses could not place her and accordingly the change agent felt "out of place". A first reason seems to be that the change agent was neither a training nurse, supporting the day-to-day operations, nor was

she assigned a formal position on a permanent basis. Second, within the years before, the regional unit had more and more confined its *attentiveness on holding up day-to-day operations*. No distinct changes had been undertaken; the nurses had no experience with change related project structures and roles.

No interrupting: Within strategizing R^1, no interruptions of daily organizing at the regional nursing unit took place. The reactions from the side of the regional nurses can be described as a closure rather than an openness toward any kind of novelty, change or new situation. This seems to be due to the lack of relation between strategizing R^1 and organizing at the regional unit: virtual structures and interaction patterns were too different.

Crisis: Two days after the change agent's arrival at the regional hospital, the change initiative as such got temporarily interrupted. Strategizing R^1 was suspended – it was the central hospital's head nurse who intervened and tried to fortify the urgent need for action by explicitly referring to the negative results of the patient survey. This intervention by the part of strategizing strongly interrupted organizing, touching on the *nurses' self-conception* and belief in delivering good patient care as could be inferred by their reactions to the presentation. In the following, destabilized organizing had to be re-stabilized again.

Strategizing R^2 in relation to organizing: Strategizing R^2 started right after the crisis. It can be characterized as different from the nurses' organizing in terms of the underlying virtual structure but very similar in terms of interaction patterns.

Interaction pattern: Instead of pushing her role as a change agent sent by the central hospital, the delegated central nurse explicitly distanced herself from the central hospital, stressing her independence from the central hospital's head nurse and explains her *role as being there to support* the regional nurses in realizing the envisaged changes. She corroborated this definition of her role by starting her mission in *very close relation to the nurses' day-to-day operations*, attending their team meetings and regularly visiting the nurses on the wards. Thus, the change agent's way of interacting with the regional nurses smoothly mingled with their daily interaction patterns. Her interacting can even be interpreted as a form of caring – and therefore being very close to the nurses' appreciated interaction with patients.

Virtual structure: Virtual structures, specifically the nurses' self-conception of delivering good patient care, were strengthened and at the same time interrupted. On the one hand, the change agent began her work with interviews and with attending meetings of the nurses to get to know the day-to-day from the nurses' point of view and as a consequence initiated the assurance of day-to-day organizing. On the other hand, she soon started to use daily occasions

to touch upon the nurses' all encompassing *caring ethics*. These not only were related to the care of patients, but also expressed in a high concern about good work relations between the nurses. As such, though, they impeded e.g. the set up of standardized service schedules instead of schedules reflecting the nurses' personal preferences.

Protective interrupting: Strategizing R^2 represented an interruption of organizing as much as a stabilization of organizing after the crisis. Strategizing was very much bound to the change agent's role – and so was interrupting. Prevalent interaction patterns of organizing were kept in place while virtual structures of organizing were interrupted in a non-disruptive manner. The change agent touched on the nurses all encompassing caring ethics in very *subtle ways*: She for example explained and encouraged different ways of decision making on the ward, thereby not just condemning the existing practices but rather offering alternatives. This subtle way of proceeding was supported by an organizing *context now more receptive to changes* in contrast to the beginning of the change agent's mission. The crisis had sensitized the nurses that fundamental changes were past due. Altogether, strategizing R^2 managed to further move on the change process.

Shift from strategizing R^2 to strategizing R^3: Bit-by-bit, the delegated nurse could strengthen her role as a change agent. She did so by *"sticking to her principles"*, principles of coordinating, communicating and changing, which originated in her former work experience, and which as such had not existed within the regional nursing unit before.

Strategizing R^3 in relation to organizing: With the strengthening of the delegated nurse's role as a "change agent", strategizing R^3 not only was distinct from organizing in terms of prevalent *virtual structures* anymore (as was strategizing R^2) but also connected to specific *interaction patterns* of coordinating, communicating and changing. Still, it was not detached from organizing as had been strategizing R^1 at the beginning of the change initiative.

The strengthening of the role "change agent" was expressed by the positive developments regarding the relation between the change agent and the regional nurses. It was further underlined by the fact that her appointment as the new head nurse of the regional hospital was perceived just as a natural development by the regional nurses.

Stabilized protective interrupting: With strategizing R^3, strategizing at Regionalhosp became stabilized: The relation between strategizing and organizing was now specified more explicitly and strengthened through the appointment as head nurse. Over the further course of the initiative, the form of strategizing did not see any noteworthy modifications in reference to organizing any more. What happened, though, was that strategizing merged into a new way of

leading the regional nursing unit. It was specifically during this transition period that the implementation of the initially envisaged changes took place.

Strategizing and Interrupting at Unihosp and Regionalhosp – Interpretive Comparison

The case studies clearly show that there was no one way of conducting change initiatives as to allow the differentiation and fruitful re-lation of strategizing. The approach within Unihosp was characterized by a formally institutionalized steering committee and temporal project groups, distinct from organizing in terms of social composition, explicit time frames and local settings (away-days, project room). At Regionalhosp, strategizing was much more bound to a change agent role and realized closer to day-to-day operations. We had labelled these two approaches "platform-bound strategizing" and "role-bound strategizing" respectively (cf. table 2).

Still, although the overall strategizing approaches were different within both initiatives, in both cases deliberate changes had been accomplished. Further, both cases show similarities concerning *practices* and *processes of protective interrupting* that will be described in the following. The comparison is based on figure 5.

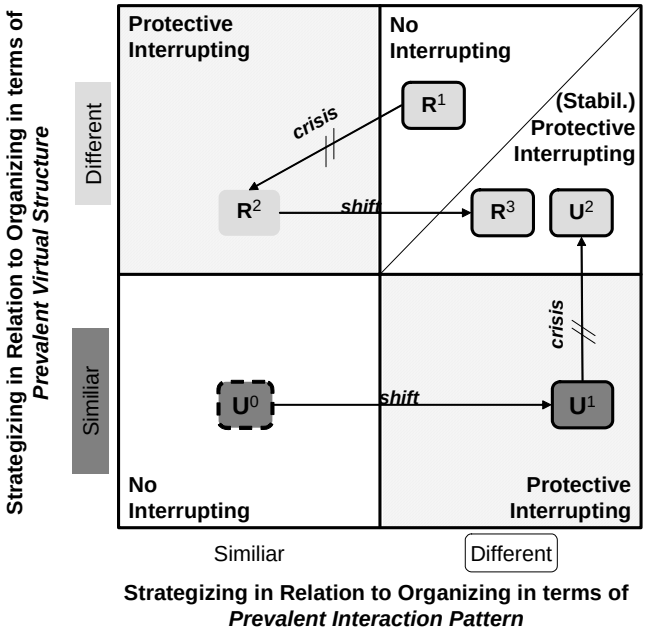


Figure 5: Matrix of practices and processes of protective interrupting within Unihosp (U) and Regionalhosp (R)

Strategizing as a *practice* of protective interrupting – Matrix fields

In order to address strategizing as a *practice* of protective interrupting, we compare forms of strategizing in the two cases within the four fields of the matrix (for details see table 3). Altogether, the comparison shows that changes are likely to be effectuated and at the same time organizing to be protected from disruptions, when strategizing is different to organizing in only one of the dimensions or when a two-dimensional differentiation results from an incremental process over time.

This is in accordance with the concept of connectivity in information theory and the idea of proximal stimuli in learning theory. Connectivity describes a relation in information theory that is characterized by a mix of novelty and confirmation (von Weizsäcker 1986). Information leads to practical consequences, when it is neither too different nor too similar to existing information. Transferred to the context of deliberate change, strategizing seems to protectively interrupt organizing, when it neither completely confirms nor completely disconfirms (the structures of) organizing, thereby preventing operational routines from being disrupted (Hendry & Seidl 2003) and at the same time allowing envisaged change. Our findings are also in accordance with learning theory, which holds that learning occurs when stimuli (=strategizing) "are proximal to, but outside the actors' existing experience [=organizing]" (Jarzabkowski 2004, 543; ref. to Inhelder 1969).

No interrupting	When strategizing does not significantly differ from organizing in any of the two dimensions, no interruptions are effectuated and no changes take place. This is virtually the situation before strategic initiatives are set up. Still, a reflexive form of strategizing can be vested in the organizing/strategizing context – or to put it differently, the context can be receptive to upcoming (reflexive) strategizing. This was the case at Unihosp and is indicated within the matrix by the dashed rectangle ($\mathbf{U^0}$).
Protective interrupting	Within both initiatives, strategizing was protectively interrupting organizing within either one of two constellations of the matrix: • ... when strategizing was different from organizing in terms of prevalent interaction patterns but similar in terms of prevalent virtual structures of organizing – $\mathbf{U^1}$: multidisciplinary steering committee dedicated to organizational issues in comparison to mostly technical gatherings within surgery / professional autonomy and question of leadership only slightly touched • ... when strategizing was similar to organizing in terms of prevalent interaction patterns but different from organizing in terms of prevalent virtual structures – $\mathbf{R^2}$: delegated nurse working in close distance to nurses' day-to-day while not stressing her role as a

	central hospital delegate and as a "change agent" / understanding of care redirected from including team and patients to primarily address patients
No interrupting / (stabilized) protective interrupting	When strategizing was different from organizing in both dimensions the protectiveness of interrupting was a matter of time. When strategizing was different from organizing in terms of prevalent interaction patterns and virtual structures • ... at the *beginning* of an initiative, neither interruptions nor changes had been accomplished – **R**[1]: regional nurses who were not familiar with a "change agent role" and who confined their attentiveness to holding up day-to-day patient care / delegated nurse attached to central hospital praxis while nurses strongly identified with regional praxis • ... *later on* within the course of an initiative, strategizing seemed to stabilize in this position and to allow the realization of envisaged changes – **U**[2]: addressing questions of leadership and professional autonomy leading to implementation structure, explicitly defining strategizing in relation to organizing; – **R**[3]: delegated nurse more and more fulfilling the role of the change agent and being accepted as such by the regional nurses

Table 3: Practices of strategizing and protective interrupting – in detail

Strategizing as a *process* of protective interrupting – Transitions between the fields

The processes of how strategizing differentiated from organizing within Unishop and Regionalhosp over time are characterized by different trajectories, specifically differing in their starting points. At the same time, the trajectories share relevant similarities (for details see table 4):

First, they are similar concerning their *final points*. In both cases, strategizing in the end takes a form where it differs from organizing in both, virtual structures and interaction patterns. This form was characterized by a stabilized differentiation/relation between strategizing and organizing. It was also in connection with this stabilized form that further changes took place. One possible interpretation for that might be that strategizing and organizing had passed through a kind of co-evolutionary process before, settling down one to the other.

Second, both processes are characterized by crises as well as shifts as forms of transitions between different fields of the strategizing matrix. *Shifts* represented mostly unnoticed transitions from one form of strategizing to a next one. They were accomplished by practices which themselves effectuated small interruptions of organizing. *Crises* represented major interruptions – interrupting the change process as such. They might notify themselves through small signs in advance (cf. Unihosp) but not necessarily so. At Regionalhosp, the irritation on part of the nurses was hardly assessable in advance (Tuckermann 2007). On the other hand,

crises have the potential to further propel a change process. This is the case, when the object of destabilization – strategizing (Unihosp) or organizing (Regionalhosp) – is re-stabilized again.

Final points *Stabilized differentiation /relation* *Effective interrupting*	Within both initiatives, strategizing stabilized when it took a form which was different to organizing in both virtual structures and interaction patterns. Two observations seem worth noting: First, strategizing at these points was all but detached or decoupled from organizing. Indeed, its stabilization seemed to result from a finally *very clearly "defined" differentiation and re-lation between strategizing and organizing*. At Unihosp, the differentiation/relation was more explicit and formally expressed in the new implementation structure of the project; At Regionalhosp, the stabilization was (also) bound to mutual expectations, understandings and the acceptance of roles and therefore much more implicit. Second, this stabilized form of strategizing seemed to be the position which *most effectively interrupted* organizing in a protective way and supported deliberate change. Maybe because both, strategizing and organizing, had passed through a kind of co-evolutionary process before, settling down one to the other – which brings us to the question of transitions.
Shifts *Rational and affirmative "Interruptive practices"*	Shifts represented rather smooth transitions from one form of strategizing to the next, or, as in the case of Unihosp, from a change receptive organizing to a first form of strategizing. The shifts themselves were accomplished by what might be called "interruptive practices" – rational ones like the facilitator's cause analysis or visualization by which he interrupted influences of professional autonomy on the change process within the first meeting; or "affirmative" practices of interruption, like the change agents explanations and outlines of alternatives by which she touched the nurses' all encompassing caring ethics.
Crises *Interrupting the change process – of strategizing and organizing* *Bringing virtual structures to the fore*	Crises were turning points within the course of the strategic initiatives, *interrupting both, strategizing and organizing*. At Regionalhosp, this interruption was initiated from the part of strategizing with the central hospital's head nurse intervening at the regional nursing. The reaction was a destabilization of organizing – the nurses were struck by the head nurse's presentation. At Unihosp, the interruption was initiated from the part of organizing, when surgeons self-organizingly started to further demarcate their area of professional autonomy. The reaction was a destabilization of strategizing – the facilitator was called up by the directorate who feared that they could not stop or reverse what was already going on. In relation to the crises, prevalent *virtual structures of organizing came to the fore* which were then addressed by strategizing so that the change processes could proceed: At Regionalhosp, the crises touched on the nurses' high personal caring ethics. This was only

	implicitly expressed through the nurses' calm reaction to the presentation. The change agent handled this, not necessarily consciously, by starting a form of strategizing R^2 in which she showed that she cared about the nurses' situation. At the same time, she worked toward a new understanding of care, differentiated between care for patients and managing a ward team of nurses. At Unishosp, the crises brought up the question of implementation together with the questions of professional autonomy and leadership. In the case of Unihosp, these questions had already popped up in advance to the crisis. But it was only then, that the questions could be addressed and handled – in comparison to Regionalhosp in a very explicit and conscious way – through the project's new implementation structure.

Table 4: Processes of protective interrupting – in detail

Strategizing as protective interrupting – Summarizing implications

At the outset of this paper, strategizing has been characterized as being protective when it interrupts organizing and differentiates from it – by neither disrupting it nor getting detached from organizing. The comparative analysis of two case studies identified practices and processes, through which strategizing as protective interrupting had been accomplished.

Strategizing is protective, when it relates to organizing either by its virtual structure or by its interaction pattern. It arrives at a stabilized form of protective interrupting, when it is gradually differentiated from organizing in both dimensions. Sometimes, this interruption and differentiation process does not seem possible without a crisis that touches on prevalent virtual structures of organizing. Attentively managed, it is the crisis that can further propel a change process.

For the management of change initiatives, specifically where strategizing can not draw on existing strategizing routines but has to be developed in parallel to the change process, this implicates to start strategizing in a form that is close to existing organizing and/or to draw on strategizing-receptive moments of organizing where possible. Crises not always can be detected and avoided in advance. At the same time, they offer a source of change.

Very concretely, but not less demanding, the idea of strategizing as protective interrupting asks for putting attention on prevalent moments of organizing in its historical context when setting up strategic initiatives. Or, to put it more poetic, strategizing starts with the past and the present as much as with the future.

Discussion and Conclusion

Within this paper, we approached the fundamental question of stability and change in and of organizations. Our specific interest was in the interrelation of strategizing and organizing over time. While acknowledging the relational aspect, we aimed to shed light on the underemphasized differential aspect of the relation. The comparison of relevant periods of two strategic initiatives provided examples of practices and processes that allow the differentiation of strategizing from organizing and its fruitful re-lating. These examples were abstracted and integrated into a framework of strategizing as protective interrupting.

The framework cannot be but tentative. We suggest further comparative research into deliberate change initiatives that differ from the case studies in this paper specifically with regard to the effected degree or ascribed success of change, respectively.

We also see further potential in research in what seems to be the “becoming of strategy practices”. Within the two hospitals we studied, strategizing did not exist as a distinct, reflexive form of addressing issues of importance on a clinic of department level. Instead, it had to be developed out of and with the existing organizing context.

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