MULTIPLE WAYS OF DECISION-MAKING IN A HOSPITAL
– A PROCESS VIEW ON DECISION-MAKING IN PLURALISTIC ORGANIZATIONS

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1. The fragility of decision-making in pluralistic organizations

Organizations become more and more pluralistic (Jean-Louis Denis, Langley, & Rouleau, 2007). Decision-making in such a setting is subject to dispersed power and knowledge and involved actors enjoy considerable autonomy from each other and across hierarchical levels to pursue their respective strategic interests (Bower & Gilbert, 2007). Decision-making involves divergent goals, diffuse power structures, and knowledge-intensive work processes (Jean-Louis Denis, et al., 2007; Paula Jarzabkowski & Fenton, 2006). Therefore, particularly organization-wide decisions, like developing strategy or conducting a merger, turn into a fragile process in pluralistic organizations (Jean-Louis Denis, Lamothe, & Langley, 2001). Such processes often fail, as studies on change initiatives in hospitals demonstrate (Lozeau, Langley, & Denis, 2002; McNulty & Ferlie, 2004).

The fragility of decision-making mainly arises due to the pluralistic character of these organizations (Jean-Louis Denis, et al., 2007). In pluralistic organizations, decision-making is embedded in different rationalities. Such worlds imply a coherent set of norms, understandings, activities and organizing (Glouberman & Mintzberg, 2001, p. 57). A world or rationality may be coherent inside a professional domain, like that of a clinic or department. Organization-wide decisions however, involve different worlds. Their differences lead to ambiguity, misunderstanding, and sometimes conflict (Bate, 2000; Ericson, 2001; Lozeau, et al., 2002; McNulty & Ferlie, 2004). These effects express the fragility of decision-making in pluralistic organizations.

Extant empirical research has explained the fragility of decision-making in pluralistic organizations in three ways. The first explanation is *divergent interests*. Studies on universities that take a micro-perspective highlight the importance of divergent strategic goals that interact in organization-wide decisions like budgeting (P. Jarzabkowski, 2003). Divergent interests come particularly into play within context of diffuse power structures so that decision-making is distributed between different autonomous actors on different levels of hierarchy (Paula Jarzabkowski & Fenton, 2006). Divergent interests influence organization-wide decisions in two ways: On the one hand, local decision-making in one part of the organizations affects other parts and the overall organization, while corporate decision-making is limited by local autonomy (Bower & Gilbert, 2005). On the other hand, organization-wide decisions that are attributed to top management like that of a hospital depend on the consent of those who are affected by these decisions (Jean-Louis Denis, et al., 2001). Also, divergent interests are associated with power struggles. This is particularly the

case in pluralistic organizations, like hospitals. Here, knowledge-intensive work processes provide for a considerable degree of autonomy of actors due to their expertise. Along these lines, Lozeau et al. (2002) explain the failure of change initiatives in hospitals because those affected by them are able to dilute or to corrupt the initiative.

Failed sense-making among participants within organization-wide decision processes has been a second way to explain the fragility of decision-making (Ericson, 2001). Failed mutual understanding does not allow developing a shared sense of an issue requiring decision but leads to misunderstanding and sometimes conflict. Failures of sense-making are often attributed to the incompatibility between the world of medicine and administration (Doolin, 2001; Iedema, Degeling, Braithwaite, & White, 2003; Llewellyn, 2001), but also between clinics (Bate, 2000). Most of the hospital studies take on a dyadic focus between two rationalities. As an exception, Glouberman & Mintzberg (2001) open up the pluralistic dimension conceptually. They differentiate four worlds of medicine, nursing, administration and the community that differ in their understanding, interest, and ways of organizing. We therefore discern that differences between these worlds could provide a pathway to understanding the fragility of decision-making. The actual decision-practice, however, remains outside the scope of the conceptual presentation of Glouberman & Mintzberg (2001).

The above two explanations of divergent interests and failed sense-making hardly consider the *dimension of time*. Interests and sense-making may shift over time. Furthermore, organization-wide decisions may feedback on the decision-makers. Denis et al. (2001) highlight that past decisions affect future ones by undermining or enhancing the reputation of those responsible. This creates dilemma between the legitimacy for a decision on the one hand, that depends on the consent of others. On the other hand, organization-wide decisions, like a hospital merger, risk the necessary consent because these decisions often involve local disadvantages to a certain degree, while aiming for benefits of the whole. Decision-making becomes fragile as it is situatively embedded in a specific context of evolving expectations, sense-making and interests. This context shapes the decisions while the decisions shape this context. Thus, the relationship between a (pluralistic) organization and its external environment (Tsoukas & Papoulias, 2005) is recursive as well as with its internally involved stake-holders.

These studies have advanced our understanding of fragile decision-making in pluralistic organizations enormously. On a critical note, however, none of these studies have elaborated in detail on how decisions are enacted in practice by taking a detail look at how the different

actors with their respective worlds enact decisions. Following this path would help us to further understand the fragility of decision-making and why the fragility prevails.

Therefore the goal of this study is to explore the practice of decision-making of different autonomous actors within a pluralistic organization. We investigate decision-making of different professions during a hospital merger and show their differences. The differences suggest that decision-making is heterogeneous. Heterogeneous means that the practice of decision-making varies among the professional groups within a hospital – not only within the daily practice of the respective group but also, as this study shows, in inter-professional decision-making processes. This observation offers a novel explanation for the fragility of decision-making in pluralistic organizations.

This insight of our study speaks to three discussions in organization studies: Regarding hospitals, we move beyond the common dichotomy of management and medicine and demonstrate the heterogeneity of decision-practice that complements the insights on the professional worlds the literature has provided (Doolin, 2001; Glouberman & Mintzberg, 2001; Iedema, et al., 2003; Llewellyn, 2001).

Regarding our theorizing on pluralistic organizations, we suggest the heterogeneous practice of decision-making as a defining component. The heterogeneity of decision-practice provides an alternative understanding as to why organization-wide decision-making often fails, complementing arguments of diffuse power (Lozeau, et al., 2002), of failed sense-making (Ericson, 2001), and of fragile stakeholder relations (Jean-Louis Denis, et al., 2001), thus complementing their processual perspective on decision-making as a collective and temporal phenomenon.

Furthermore, our study may contribute to process theories on decision-making (March, 1991; Mintzberg & Waters, 1990). We suggest acknowledging the actual practices of decision-making as integral to theoretical concepts. Doing so, helps us to understand how decision-making unfolds (process) recursively with a certain rationality or world (structure). This focus helps us to understand in more detail, how garbage can processes (Cohen, March, & Olsen, 1972) or decisions as unfolding patterns (Mintzberg & Waters, 1990) play out. Due to the heterogeneity of decision-making practices, fragility and hence ambiguity are integral to decision-making.

In the next section, we elaborate on how process oriented studies explain the fragility of decision-making in pluralistic organizations. Drawing on these insights together with ideas

from March (1991) and Mintzberg & Waters (1985), we specify our understanding of decision-making for the empirical investigation. In the method section, we justify the organizational setting, and describe the data gathering and analysis. The way we present our results correspond to our analytic strategy. We first provide an overview on the merger process. Then we elaborate on the decision-practice of the four involved professions in relation to their daily treatment practice. Our analysis highlights the differences and similarities of the decision-practices to explain the fragility of the hospital merger. Additionally, we show by what means the fragility was handled. The discussion concludes the paper by elaborating on our three contributions, before concluding with the limitations and suggestions for future research.

2. A process view on decision-making and its implications for researching it

To study in detail the practice of decision-making within a pluralistic organization, we adopt a process perspective. Process views on decision-making depart from traditional models like rational choice by criticizing their individualistic perspective of decisions that are atemporal and subject to a more or less bounded single rationality of cause and effect (March, 1991).

Instead of assuming a coherent or single rationality, a process view on decision-making in pluralistic organizations involve different rationalities within which decisions are made. Studying decision-making implies to avoid pre-conceptualization of strategic decision-making (Chia & MacKay, 2007), but rather to explore decision-making empirically and in detail. From a process perspective, a rationality – we call it world in this paper - is not an existing object, but an enactment within specific situations. Worlds are in the making and temporal social orders, like organizations (Hernes, 2008). Thus, there is not a stable rationality or world within which decision-making takes place (Chia, 1994, p. 791). Rather worlds are enacted as a duality in specific processes of decision-making as a duality.

For our empirical study we therefore include the daily practice of the different medical and nursing professions. In our results, we relate the *merger practice* as the situative enactment of a decision-process with the *world* of a profession, expressed by their respective idea of patient treatment.

Instead of decision-making in pluralistic organizations as individual, it is collective (Jean-Louis Denis, et al., 2001). This is particularly the case for organization-wide decisions that involve different autonomous actors. As collective endeavor of autonomous professional

actors, decision-making in pluralistic organizations is subject to the consent of those affected by decisions. Due to the expected differences of the respective worlds, we assume decision making to differ between professional domains. Empirically exploring these decision-practices lies at the core of our result section.

Instead of viewing decisions as atemporal acts, we assume decisions to be process, thus highlighting the time dimension. In our view, the time dimension involves two aspects: First, decisions are processes that unfold as events over time (van de Ven, 1992). Such processes are patterned in the sense that patterns allow us to expect certain events rather than others (Mintzberg & Waters, 1985). Decisions can even follow routinized patterns, which are expectable sequences of events forming decision-making as process (Hernes, 2008, p. 96). Thus, decision as process involves two mutually dependent components forming a duality (Feldman, 2000): Decisions are enacted situatively as events while they simultaneously draw on and reproduce patterned structures. These structures serve as premises for decisions in the sense that they concern *who decides on what, when, and how* (Luhmann, 2000). These premises express the rationality of a professional world. These elements of who decides on what, when, and how provide the analytical focus on our study.

The second aspect of time addresses of *when* decisions occur. According to the garbage can model (March, 1991, p. 199ff.) the temporal proximity of a decision's components shapes decisions, i.e. the proximity of the decision components which are problems, solutions, choice opportunities and decision-makers. Thus, decisions occur not solely due to rational cognitive activity of some decision-maker, but also as a matter of temporal relations between the components of a decision. This perspective suggests decisions arising without design or pre-planning. For our empirical investigation, we are therefore interested in when and why different professional actors engage in decision-making.

Mintzberg & Waters (1990, p. 1)argue that decisions are commitments to act and as such they are hardly observable for researchers. What we can detect, however are the effects of decisions within the organization, which these authors call the traces decisions leave in an organization. Therefore, we understand decisions inseparable from their effects. This inseparability resonates with the insights of Denis et al. (2001) regarding the temporal effects of decisions, which is why Pettigrew (1990, p. 6) suggests to focus on change rather than choice when studying decision-making. Accordingly, our further investigation is situated in an organization-wide change initiative.

3. Method section

Our purpose is to gain an in-depth understanding of the fragility of decision-making in pluralistic organizations. For that matter, we described our approach to decision-making and the analytical focus of our empirical study in the previous section. This method section contains our strategy for gathering and for analyzing the data; and the selection of a hospital merger as a single setting.

3.1 Analytic Strategy: gathering and analyzing data

The exploratory guiding research interest implicates a case study design (Eisenhardt, 1989). The research is interpretive (Pentland, 1999). The longitudinal case study is ethnographically informed leading to a comparison of four sub-cases within one setting. The field phase lasted from April, 2004 and until February, 2006. Data was gathered in multiple ways by a two person team to allow for triangulation. A journal contained our field notes on observations, of meetings as non-participant observers, own interpretations and numerous informal conversations. 73 observations were made, including ward meetings, meetings of nurse leadership and a one-week ethnographic visit on a ward of surgery and of inner medicine in both hospitals. These observations were validated with practitioners throughout 28 feedback sessions. We conducted 80 semi-structured interviews of one to two hour length each, regarding the interviewee's understanding of the hospital merger in their work and organizational context. The interviews encompassed the three professions involved and all hierarchical levels. Interviews with key informants were repeated between two and six times. All interviews were transcribed. Access was granted to 69 documents including conceptual papers, protocols, annual reports and email correspondence.

Each data source was taken one at a time and triangulated to the others systematically. The analysis contained three phases (Langley, 1999): The first phase was to develop the overall case history of the merger. After analyzing the documents, we included our field notes to connect events, decisions and on-going developments. In order to understand the arising case history from the practitioners' perspective, the informal conversations and the interviews were incorporated, according to their temporal appearance, sorted broadly into directly involved actors and those providing context information. Then, the case history was summarized by means of visual mapping.

The second phase concerned the different professional actors. In a first step, we aimed to identify their merger practice as well as the professional worlds by analyzing their daily work

with patients. In the case of administration, we compared their merger practice with how they conducted other interdisciplinary projects, like developing a strategy report, introducing the effects of a new labor law for medical doctors, and further developing the emergency care unit. In each profession, we coded the data to our decision-categories of who decides on what, when, and how. We did the same for the daily practice, although these findings are not presented in similar detail in the result section. In a second step, we conducted a cross-case analysis to identify the differences and similarities of decision-making between the professional groups. This comparison highlights that each professional domain enacts their respective practice of decision-making as part of their professional world but with significant differences between them. Although not reported in the paper, we compared these insights with other initiatives we researched in this hospital, particularly the development of a palliative care center (inner medicine), and the introduction of a new treatment regime in surgery in order to validate our findings. Based on this internal cross-validation, we wrote the case study as a narrative. The narrative itself showed to us that decisions are much like patterns of action (Mintzberg & Waters, 1990). The narrative is about achieving changes during a hospital merger, but less about explicit choices of alternatives (Pettigrew, 1990).

The third phase was to validate the findings with peers and practitioners. The authors cross-checked the empirical material, and searched for alternative interpretations in other hospital studies, like the ones cited above. More importantly, we discussed the case study with the practitioners in workshops with each of the professional domains to enhance the reliability of our findings by means of member validation. The practitioners approved of the actual narrative but also of the insights regarding their professional world as well as that of the other professions.

3.2 Organizational setting of a hospital merger

A hospital merger provides a promising research setting to study decision-making in practice. With regards to decisions, a change project allows to explore the traces of decisions (Mintzberg & Waters, 1990) which is why Pettigrew suggests to replace choice with change when thinking of decisions (Pettigrew, 1990). Particularly a merger project is a setting within which decision-practices are expected to become salient for observation. Mergers involve the altering of professionally attached patterns of behavior and interaction, that have developed within a specific context over time (Langley & Denis, 2006: 144). Furthermore, the hospital merger encompasses a considerable time period of nine years and involves a range of professional actors, like administration, nursing, surgery, and inner medicine. The case

therefore allows us to study the distinct decision practices and compare them within a single setting.

4. Results: The hospital merger of ReHo and LaHo

We understand decision-making as a collective process of different autonomous actors who become involved and un-involved in a project like the studied one over time. We relate the respective decision-practice to the professionals' daily. We present our empirical data and analyses of a hospital merger in three parts:

The first part contains the overall hospital merger. We highlight here, *when* and for how long the professional actors involved themselves. The point of engagement resonates with the idea of temporal proximity (March, 1991). The length of stay indicates the particular merger practice the professional actors enacted. From this perspective, the hospital merger is driven by timely proximity and less subject to a rationality of cause and effect.

The second part explores the merger practice of each professional actor. Within each, the focus lies on the scope of *what* they regarded important, on *how* they integrated one clinic or department into the other, and on *who* they involved during the process. For each professional actor, we elaborate on the *respective worlds*, expressed in their patient treatment practice. In case of the administration we used other interdisciplinary initiatives like developing a strategy report and the executive's board away-days as points of comparison.

4.1 The merger as an emerging process following temporal proximity

In the first part our result section, we provide a historical overview of the merger, highlight moments of fragility, and provide an initial interpretation of the hospital merger as a rather emergent process, structured along temporal proximity of solutions, problems, and decision-makers.

Historical overview on the hospital merger

The hospital merger is the integration of a small regional hospital (ReHo) into a larger one (LaHo). They form a so-called hospital region over a period of nine years. The following figure provides an overview:

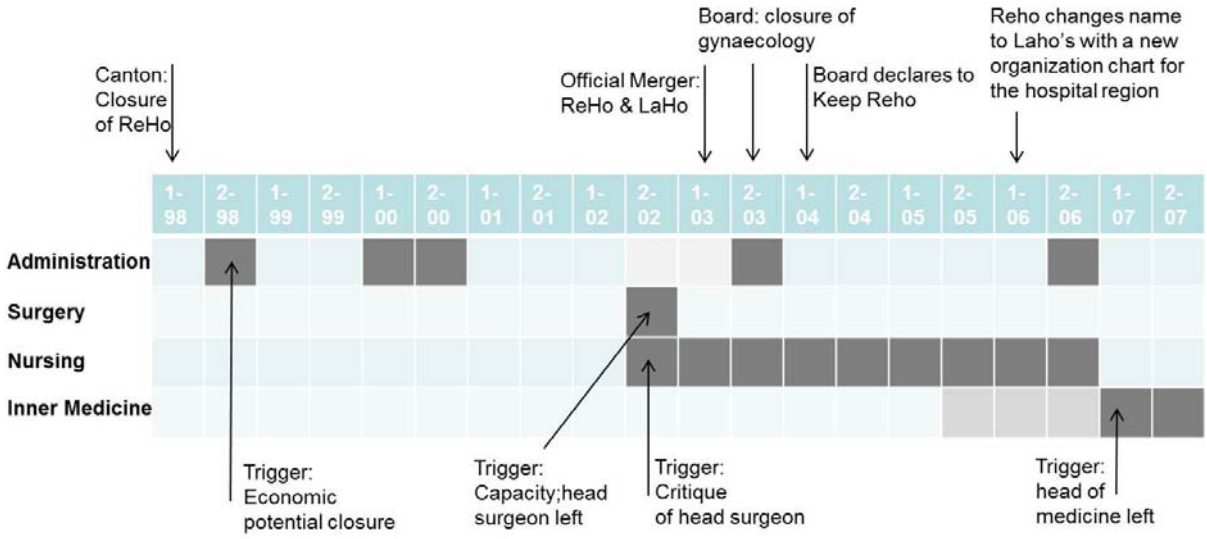

Figure 1: hospital merger

Historically, the hospital merger begins in 1998. The cantonal government as the owner of the hospitals announces to close ReHo to reduce costs. After a period of public demonstrations the cantonal government withdraws the decision. Reo and LaHo decide to cooperate more closely, based on principles for engagement, the CEOs of both hospitals agree upon. The CEOs initiate a project team consisting of equal numbers of administrative, nursing and medical representatives of both organizations. The project team suggests integrating ReHo's administrative departments into those at LaHo. In 2000, the departments of technical support and IT are closed at ReHo and operated from LaHo. Two years later, the same happens with the emergency care unit. First, ReHo's CEO disagrees and states: "Without it, we are not a primary care hospital anymore". However, due to cost pressure, ReHo finally accede the suggestions.

In spring 2002, LaHo's surgery faces excess capacity while that of ReHo struggles with a lack of capacity of their surgery clinic. ReHo's nursing director and LaHo's head surgeon agree on renting surgery rooms to LaHo. After a few months of room sharing and with ReHo's head surgeon leaving the hospital, LaHo's head surgeon proposes to take over ReHo's surgery. ReHo's executive board agrees, and within a period of six months, ReHo's surgery adapts to the standard operating procedure of LaHo's. LaHo's head of surgery declares the integration successful in fall, 2002, using the slogan: "One clinic – two sites". It indicates that ReHo's surgery now operates as that of LaHo, and means that it is run by one of LaHo's leading surgeons.

On January 1st, 2003, the cantonal government announces the hospital region of ReHo and LaHo. In spring, 2003, LaHo's head surgeon complains to LaHo's nursing director about ReHo's surgical nurses. The critique concerns nursing standards, ways of working, and levels of qualification which do not fulfill the surgeons' expectations. After a prior analysis of the surgical wards and a report on areas for improvement, LaHo's nursing director deploys a one of her employees as a change agent for ReHo. In summer, 2004, she is positioned along-side ReHo's nursing director. She is responsible for all wards at ReHo and is supposed to adapt ReHo's nursing practice and organizing to that of LaHo. The change agent involves all employees by interviewing them about the current situation. She coaches ward leading nurses on a weekly basis and supports all wards in matters of daily patient treatment. In fall, 2004, she is declared the new nursing director at ReHo, commencing the position, in February, 2005. She alters meeting structure, work shifts at ReHo, offers qualification programs for ReHo's nurses on management and ward leadership, initiates groups of nurses to advance their own practice with the result that ReHo's nurses engage in development their own organization. By the end of 2006, she considers the integration as completed.

In summer, 2006, LaHo's inner medicine begins to approach the integration of ReHo's inner medicine. LaHo's head internist takes part in a so-called structure committee, a monthly meeting group of clinic heads of inner medicine, anesthesiology and orthopedics of both hospitals. These clinics are still to be integrated. The committee aims to discuss ways to integrate each clinic and to coordinate among each other. LaHo's head internist discusses the meetings internally with the group of leading internists of his clinic during their regular meetings. They decide to "wait and see what emerges, so that we know how to position ourselves and what to do" in summer, 2006. They also consider important to reach consensus with the ReHo's head internist about the integration. He retires in 2007, and LaHo's internists meet with their ReHo colleagues, adapt their work procedures, hold joint meetings on difficult cases, and install a mutual rotation system for internists to work at the respective other site.

In December 2006, the executive board publishes the organizational chart of the hospital region. In that chart, for the first time, ReHo is granted the status as one of the five large departments and uses the name of LaHo as it became that of the hospital region. During the executive board's annual retreats, the hospital merger was a regular agenda topic, at least during our field phase of 2004 until 2006. Here, the board members discussed past year's achievements and developments, without addressing future steps along the path of integrating the two organizations.

With inner medicine integrated in 2007, the executive board of the hospital region declares "integration completed". The yearly report uses the surgeon's slogan of "One clinic – two sites" to describe the overall idea of the hospital merger.

Moments of fragility during the hospital merger

The previous overview may let the hospital appear like quite a tranquil process. But it was a fragile process. The fragility came to the fore at several moments:

The first fragile moment was the planned closure of ReHo, at the end of which the two hospitals decided to cooperate more closely. During this first period, particularly closing the emergency care unit at ReHo raised concerns of the identity of the regional hospital. ReHo's CEO pointed out: "Without the emergency service 24/7, we turn into a private clinic or something. But we no longer are a primary care hospital."

In summer 2003, the newly formed board of directors decides to close down gynecology in order to improve the cost situation at ReHo. For the director board's head, this project explicitly demonstrated the board's task, namely to strengthen a company-like style of management. Despite public demonstrations, gynecology was closed in December, 2003. According to the yearly report, all employees were shifted to LaHo being offered similar or new jobs.

A third fragile moment occurred between September, 2004, and February, 2005 during the merger of the nursing departments. LaHo's nursing director proposed to replace ReHo's nursing director with the LaHo nurse the former sent - the so-called change agent - to integrate ReHo's nursing. While ReHo's nursing director suffered a burn out, LaHo's change agent commented informally of her anxiety to take the new job. We observed increased conflicts between the two. The replacement proved difficult not only within ReHo's nursing department, but also on the level of the hospitals. ReHo's CEO complained informally about the unjust intervention into "his" hospital. His disagreement with LaHo's nursing director reached the executive board on the away-day in November, 2004. Here, ReHo's CEO raised the issue in the executive board. LaHo's nursing director turned to the first author angrily: "This does not belong here. We do not discuss such issues in public". Instead of responding to the concerns of ReHo's CEO, LaHo's nursing replied that they would handle the topic in bilateral conversations. The executive board moved on to the next point on their agenda.

Later during the merger of the nursing department, conflict arose with ReHo's inner medicine once again. From fall 2005 until summer 2006, the new nursing director aimed to change the

way in which the two departments cooperated. She demanded a more autonomous nursing, whereas inner medicine aimed to continue to raise their issues directly with the wards, thus bypassing the nursing director. Despite weekly meetings to quickly handle emerging questions of cooperation, the issue remained and subsided only after inner medicine had been integrated by 2007.

A cue suggesting a fragile hospital merger on the level of the executive board is the publication of the organization chart. It took the board three years from 2003 until 2006 to do so. By granting ReHo the status of one of the five main departments within the hospital region, the relationship between the two hospitals as parts of the hospital region was fixated almost at the end of the entire merger process.

Analysis: Four observation on the hospital merger

The data so far tells us how and why each profession participated in the merger process and that the duration of their involvement differed significantly. More specifically, the data allows us to raise four observations: First, the hospital merger worked, but provided several moments of conflict pointing towards the fragility of the entire process. The fragility cannot be comprehensively explained by what the literature suggests: Surely, divergent interests played a role, for example in the conflict around deciding on the new nursing director. But regarding the hospital merger as such, the hospitals executive boards as well as the involved clinics, departments, and nursing agreed upon the merger in general. Failed sense-making may provide an explanation. Within the executive board for example, we did not detect explicit moments of sense-making, as would be suggested by the proponents of the approach (e.g. Weick et al., 2005; Ericson, 2001). Instead, the board raised the hospital merger in terms of reporting past events, but without explicitly discussing its future development. In a similar way, the time of publishing the organization chart occurred in retrospect. The way of not handling the conflict regarding the nursing director almost led to an explicit moment of collective sense-making, but it was redirected to a bilateral settlement. Moments of sense-making may have occurred in the privacy of bilateral conversations. But, we did not observe them on a broader scale and wonder in what ways such private sense-making could be called collective. Thirdly, temporal effects played a role in handling the cooperation between inner medicine and nursing. While nursing adapted to the practice at LaHo, inner medicine had not yet integrated creating tension between them. A second incident could have been the closing of gynecology, during which the board of directors was at stake. But since they got their way, neither their task of promoting an economic perspective, nor their position within the hospital

appeared affected. Overall, we are not satisfied with the existing explanations, and will turn to an alternative in the second part of the results to explain the fragility of the hospital merger.

A second observation regards the point of involvement of the different clinics and departments. As to our knowledge, there was no overall plan for the hospital merger that would have determined and argued causally for their order. Such, we would have expected from traditional decision theory. In comparison, the garbage can model appears more illuminating: Each of the clinics, and departments reacted in situ to a specific situation at the time. Administration became involved in the aftermath of the public dispute on closing ReHo (1998). Surgery engaged in the merger to handle its capacity challenge (2002). Nursing took part after the official starting date in response to the surgeons' critique. Inner medicine became active by grasping the opportunity of ReHo's head internist retiring, after having observed the emerging situation. Each of these actors decided on their respective involvement. They acted upon their own specific opportunities and challenges. Thus, the hospital merger was structured along temporal proximity of problems, solutions, and decision-makers.

A third observation is following the second is that the overall merger appeared more as an emerging than a planned process. The commitment to action (Mintzberg & Waters, 1990) was salient in several instances, particularly when the two CEOs agreed on the cooperation principles. The overall process, however, was not planned in terms of time, of an order which departments integrate after one another and what the envisioned hospital region would look like. Similarly, the guiding idea of integration "1 clinic – 2 sites" emerged from one actor and was later used to describe the guiding principle of the entire merger. The executive board focused on what emerged from the respective clinics, and departments.

The three observations of the data highlight that the overall hospital merger was rather an emergent than a pre-planned process, at the end of which the hospital declared its success and retrospectively described it as a process with a coherent idea of integration. In comparison to this impression, the respective actors did not follow a pre-defined order, but engaged according to the timely proximity of solutions and problems. They handled their specific challenges and opportunities at hand. How they each conducted their integration is the focus of the following section.

4.2 Four practices of decision-making and worlds within the hospital merger

In the previous section, we argued why the existing explanations for the fragility of decision-making are only partially helpful to understand the hospital merger. In this section, we turn to the four involved actors, administration, surgery, nursing, and inner medicine in more detail. In each we depict their practice of decision-making throughout the merger and relate it with their daily practice of treating patients, or of conducting interdisciplinary projects in the case of the administration.

The world of administration: Holding on to bureaucratic project management tools

Decision-making during the merger process of administrative staff appeared as attempts to balance the different interests within a hospital. This was achieved by conducting bilateral meetings and holding on to predefined procedures, which allowed an egalitarian project team to gain approval from the executive board.

Example 1: Smoking the peace pipe. The way LaHo's and ReHo's managers handled the relations between their organizations illustrates their approach to organizational issues. The relationship between LaHo and ReHo was strained: Politicians raised the idea to close down ReHo and strengthen the position of LaHo. ReHo, however, successfully fought against the closing down by reaching the public. Thereafter, the CEO of LaHo met up with the CEO of ReHo. In other words, they "smoked the peace pipe" (ReHo CEO, interview). During that particular meeting they decided to set up a project team consisting of the two hospitals' employees. Different representatives of different professional groups were part of the team and defined the rules of collaboration.

Balancing different interests. Meeting up with each other and declaring peace was the starting point of the coming merger. As major part of their efforts at handling the merger the managers tried to arrange an interdisciplinary project team. In so doing, they oriented themselves into coordinating the collaboration and integrating different interests of the various professional groups. That is, they engaged themselves in providing the ground upon which the different professionals can look after their interest and specify their collaboration. In this process, they deemed the inclusion of representatives of different professions as essential.

Example 2: Using project management tools. To coordinate the merger process the management staff made use of clearly defined project management tools. A project team

leader explained: “Based on a decision of the executive board, we use the following procedure for interdisciplinary projects, you can download from the intranet: We have a project agreement with the intended results, the structure of the project, the resource plan and the milestones. This agreement is signed by the CEO and the project owner, after my revision whether it fits with our strategy. At every Milestone, the team hands in a report to the executive board, and a final report at the end. Also, we have a main report and sub-reports the project team has to write. […] Overall, it is a systematic structure of initializing, conceptualizing, planning, implementing, and ending. That is the model."

Holding on to predefined procedures. Management employees oriented themselves toward specific management tools when dealing with the merger project. Scheduling milestones and writing interim reports were important tasks for management employees. Instead of allowing direct coordination between persons affected the project leaders within the merger process held on to the predefined decision procedures. Apparently, employing predefined procedures enabled them to gain clarity on diffuse work processes. The head of LaHo’s technical and support department explained: “We have no experience with a merger. But we do interdisciplinary projects and apply this procedure [as described above].” In particular, he highlighted the need for planning and structuring in interdisciplinary projects. On the side of those becoming integrated, we did not observe them being actively integrated in the respective integration. Instead, ReHo’s head of administration informally informed us at the time that his employment was at stake, which is why he did not want us to record the interview.

Organizational implications. Managers designed the merger project along classic project management tools. In so doing, the project was highly formalized and structured. Project team members elaborated project plans with milestones, interim reports and final reports. Many, however, perceived the project set-up as bureaucratic and tedious. Decisions took a long time and a project team member called the project management approach as “motivation killer” (Project team member; interview). Although the rules of collaboration – equal representation of the two hospitals in the project teams; respectful behavior; guarantee of securing ReHo’s existence – were clear, the content of the collaboration between LaHo and ReHo was unclear. That is, the project members of both organizations did not manage to identify outright which processes or departments they wanted to integrate or not.

Interpretation: Administrative staff attempted to conduct the merger work according to clearly defined project management tools. Correspondingly, they entered and participated in

the overall merger process of the two hospitals along pre-defined periods of time. Because they aimed to balance different interests decisions were made in interdisciplinary teams, consisting of representatives of all professional groups and both hospitals. Formal hierarchy was important and therefore, decisions made needed to be formally approved by the executive board. Overall, planning and orienting towards formal authority shaped merger work.

Daily work in the administrative department

Clearly, patient treatment comes first, and we handle the issues surrounding the clinicians' work. … But when approaching them, I need to be careful not to arouse suspicion (Administrator, interview)

Administrative work in this hospital is concerned with providing the infrastructural, information-technological conditions for clinicians' work and to handle finances. The administrative departments consider themselves as service to the medical and nursing professionals. At the same time, they struggle with the clinics' differences and autonomy. Implementing organization-wide IT-systems suffer from the often response an administrator describes as follows: "Clinics always say, we are so different from one another". Administrative work requires the clinics' consent to pursue their initiatives. This turns into a challenge, because developing hospital-wide solutions for IT or financial controlling are often perceived by clinicians as unnecessary intrusions into their domain. A financial controller explains: "Setting up the financial controlling in the clinics is tough. Instead of approaching the clinic head, I talk first to his subordinates who actually run the place. Once, I convince them, it gets easier. … But, of course it takes time." Others involve all affected clinics within interdisciplinary projects, which slows down projects because "such a group is hard to handle. They know each other well and know that they can always say: it is medically ill-advised. I cannot argue against that." An administrator argues that they therefore require a specific project management that relies strongly on reports to the executive board the approval of which enhances the administration's standing in relation to the clinical practitioners.

The world of surgery: Fast problem identification and rapid problem-solving

Decision-making of surgeons during the merger presented itself as fast and as individual. Without actively involving those on the receiving end, the surgeons intervened by transferring LaHo's standard operating procedures to ReHo. When problems aroused surgeons responded quickly on solving the situation at hand.

Merger practice of surgeons

Example 1: Imposing new guidelines. Changing the guidelines for the surgical interventions illustrates the process of how the department of surgery tried to integrate its subsidiary. LaHo's Head of Surgery perceived the subsidiary – the ReHo – as backward: "We are tightly organized. But that – of course – wasn't the case in ReHo. Well, it's just a primary care hospital. They do a good job but it's everything is a bit slower." (LaHo head surgeon, interview). LaHo's head surgeon decided to change ReHo's surgical department: „We want to have the surgical department down there exactly identical to ours [LaHo]" (LaHo head surgeon, interview). To align ReHo's clinical standards with LaHo's concepts the surgeons of LaHo introduced their guidelines in ReHo: "We revolutionized everything… We did not develop anything completely anew. We just needed to bring all our guidelines to ReHo. Various guidelines we regarded as ordinary up here just did not exist down there. We simply needed to condition the people." (LaHo head surgeon, interview). LaHo's head surgeon changed not only the guidelines of the surgical department but in addition, they sent their medical staff for a limited period to ReHo.

Enacting a tightly organized change process and personalized decision-making: When LaHo's head surgeon entered the scene he recognized instantly the slow pace of work in ReHo. That is, he identified the problem rapidly. He attributed the perceived deficits in ReHo's surgical department to guideline absences and he oriented his efforts directly to what he perceived as solution: In order to change the modus operandi at ReHo he tried to impose new regulating guidelines. In addition, he replaced the medical staff by his own people. In short, he regarded change as straightforward process in which he only needed to identify the problem and implement the solution.

Example 2: Developing more guidelines to patch problems. The way the surgeons handled subsequent problems of their change efforts highlights their approach. Imposing new guidelines proved to be insufficient: „It wasn't easy. We had to raise them out of their sleep" (LaHo head surgeon, interview). Difficulties aroused in nursing. ReHo nurses did not manage to adopt the newly imposed standards as expected. Before the change, the work rhythm of ReHo's surgical clinic was significantly slower and the new regulatory guidelines demanded a high increase of shift changes. Nurses felt "devoured" (ReHo nurse, interview). LaHo's surgeons were dissatisfied with the nurses' team leaders at ReHo and severely criticized the work of ReHo's nurses and at that, they sent out two LaHo nurses to analyze ReHo's nursing work.

Responding quickly when difficulties arise: When LaHo's surgeons encountered problems in nursing they put more resources into the change project. That is, they noticed the problems rapidly, raised them openly and promptly, they oriented their efforts to patch the problematic aspects. Not after much discussion, LaHo's surgeons decided to send out more people to analyze the problematic situation and to develop remedies. Similar to the initial change intervention they oriented their activities towards rapid problem identification and problem solving. Within their own department, the head surgeon describes how he responds quickly to arising problems at ReHo: "Just as an example, it just happened the other day: For example, last week, I was called to a surgery at ReHo sometime during the evening. They had a surgical problem, that resulted crystal clear, that the head down there, my representative there, he had done a surgery, that is just not allowed to be done there […] I have finished the surgery, got the patient up here into the intensive care unit, so that was handled. Only the consequence is that there is a new guideline, of what is allowed to be done there and what is not. Though, everybody knows that of course, but now we got it in writing. That has been the consequence of what happened" (head surgeon)

Organizational implications. Based on the analysis of LaHo nurses' the LaHo project team led by the surgeons presented their change propositions. LaHo staff compared work at ReHo along LaHo standards and raised the shortcomings at ReHo. Upon this, ReHo nurses felt "run down" (ReHo nurse, interview): "You have to change that … and that… Otherwise, you are … It was like a menace." (ReHo nurse, interview). In their analysis, LaHo staff did not explicitly address the different points of departure of the two hospitals – LaHo is a large and highly professionalized organization whereas ReHo is a small regional hospital. As a result, at ReHo, there was strong perception of unjust treatment by the mother organization and ReHo's nurses were reluctant towards the proposed changes. While ReHo staff became fully aware of the shortcomings at ReHo the change project of LaHo's surgeons didn't produce any change in the nurses' practices at ReHo. That is, although LaHo's surgeons identified the problematic issues rightly and tackled it quickly, the change process they launched created mostly negative reactions at the beginning.

Interpretation: The process of merger work resembled very much the three steps of a surgical intervention – diagnosis, operation and after-treatment. The merger process was tightly organized and enacted within a tight time window. Decision-making was highly personalized: key decisions in the merger process of the two surgical departments were made by LaHo's

head surgeon who did not involve others in the decision-making processes except his proxy, a leading surgeon in charge of the running ReHo's surgery.

Daily work of surgeons

The success of a surgical intervention is grounded on three things: the right diagnosis, the right operation and the right after-treatment. (Surgeon, interview)

Every-day work of surgeons appears as consisting of clear-cut and sequential processes. In that processes, the operation is central: "We surgeons want to operate people – and as many as possible" (Surgeon, interview). As lives hang by surgical interventions decision-making needs to be fast: "In many situations you don't have time to reflect – either I go to the operating theatre or it's all over" (Surgeon, interview). A bundle of clear guidelines enables surgeons to decide and act rapidly: "Everything is tightly organized – there are norms, guidelines and standards for everything. With clear guidelines everything is easy to handle" (Surgeon, interview). Surgical departments usually are highly hierarchical. The rigid hierarchy is justified by the fact that "at the end somebody stands with a knife and makes a cut" (Surgeon, interview). Therefore, decision-making normally is tied to one person – the chief surgeon. That is, daily practice is characterized by acting within clear hierarchical structures, fast and personalized decision-making and shaped by clear guidelines.

The world of inner medicine: Consensus-seeking understanding of emerging patterns

Decision-making of internists during the merger appeared similar to their daily work of treating patients. Observing and making sense of an emerging situation over time, they aimed for consensus and group sense-making, which included LaHo's upper hierarchy and continuously conversing with ReHo's head internist. The merger process by internists was rather tentative in comparison to the surgeons' decisive actions.

Merger practice of internists

Example 1: Getting on the merger process late. Considerably long after the surgical departments of LaHo and ReHo completed their merger process the internists of LaHo started the integration of the departments of inner medicine. The head internists from LaHo and ReHo participated in a group in which they explored cooperation options. This so-called

"structure committee" was established by the executive board so that all remaining clinics could explore their respective integration.

Waiting and understanding different options. When internists began to sound out the possibilities of collaboration between LaHo and ReHo the departments of surgery and orthopedics were already fully integrated. That is, the internists started the integration process substantially late. Apparently, they would wait and see how other medical departments organized the merger. Upon their observations they formed a group consisting of LaHo's leading internists and ReHo's head internist in which they discussed different options. They, however, did not come to a conclusion immediately. The process of decision-making was rather consensus-seeking and lengthy.

Example 2: Regular meetings without direct consequences. Several conflicts repeatedly arouse between ReHo nurses and LaHo internists. It was not clear who decides on changes in nursing practice – the internists or the head nurse. The nurses would the internists turn to the head nurse when they want changes of nursing practices at ReHo. By contrasts, the internists would ask the nurses directly. At that, the head nurse of ReHo agreed to meet up with the LaHo internists weekly to resolve this recurring conflict and to push on with the collaboration between nurses and internists. After one year, however, this meeting series did not generate a decision on the issue of power to direct changes of nursing practices. Instead, a specific pattern emerged: Each time when internists urged nurses to change a certain nursing practice nurses asked the internists to send a request to the head nurse.

Acting upon emerging patterns. The conflict around the directing power pointed at the need for regulating the relationship between LaHo internists and ReHo nurses. LaHo internists set up a meeting series to decide upon the future collaboration between nursing and inner medicine. Yet, explicit decisions were not made and internists acted upon implicit rules that emerged from the interaction between nurses and internists. That is, internists deferred a clear regulation and nurses could fill the persistent absence of clear rules in their favor. Obviously, when dealing with organizational issues internists tend to wait and act upon emerging patterns instead of being directive

Organizational implications: "Let's wait and see and how we need to position ourselves" (meeting of internists, observation). This statement was often heard during the meetings of internists when they discussed how two integrate the two departments of LaHo and ReHo. Instead of proactively shaping the integration process the internists waited for the retirement

of the ReHo's Head of Inner Medicine. Then, they installed a job rotation for internists so that those of ReHo came to work at LaHo and vice versa for several months and launched a meeting series in which ReHo and LaHo internists jointly discussed difficult patient cases. In comparison to surgery, inner medicine did hardly change any personnel at ReHo. Similar to surgery, ReHo's guidelines were replaced by LaHo's guidelines. This process, however, was less ordered and accompanied by additional actions – like the joint sense-making in the meetings on difficult patient cases.

Interpretation: When engaging in merger work internists apply similar patterns as in their daily practice of patient treatment. Merger work of internists was lengthy and the duration was not pre-defined. They tried to get collaboratively to the bottom of the problem, to make sense of the emerging situation and seeked consensus. Accordingly, they also involved the organization taken over by including ReHo's head internist in their decision-making process.

Daily work of internists

When patients come in they have many different symptoms. I examine them continuously in order to close the diagnostic gap, so to give a name to the illness. (Internist, interview)

When treating patients internists focus on closing "diagnostic gaps". Discerning the underlying root of the different symptoms is difficult task which requires monitoring the patient and her symptoms thoroughly over a longer period: "You watch the patient and always do brain-storming and ask yourself: Why is the patient here? What is she suffering? Has anything changed?" (internist, interview). Based on medical findings they construct hypotheses and when findings change they need to modify their hypotheses. Some findings allow for different interpretations and then, internists "need to wait and get a consensus" (internist, interview). That is, to make diagnoses internists need to keep an eye on patients, consult recent medical studies and include their colleagues. Daily work of internists is not action-driven but shaped by the search of the correct diagnoses. These diagnoses internists develop consensually in a tentative and iterative manner. On the whole, for internists patient treatment is a lengthy process based on close monitoring of patients, constructing tentative hypotheses based on emerging patterns and discussing ambiguous issues with colleagues.

The world of nursing: Developing personal relationships and working in collaboration

When conducting the merger work nurses tend to focus on personal and collaborative relationships besides rather tangible topics like standard operating procedures. Gaining acceptance and addressing everyday challenges were important during the merger process of the two nursing departments.

Merger practice of nurses

Example 1: Establishing the role as change agent. How a LaHo nurse established herself as change agent at ReHo illustrates the nurses' approach to the merger work. A nurse from LaHo went to ReHo with the task to adapt their nursing practices to those at LaHo. However, the ReHo staff was not familiar with the assignment of this change agent who explained: "Nobody knew that I was coming and what my job was, although we had clarified everything two months before" (LaHo nurse, interview). Although the joining of the LaHo change agent to ReHo was planned beforehand nobody seemed to have expected her presence at ReHo. After introducing herself and presenting her assignment to the different nursing wards at ReHo the LaHo change agent decided to conduct interviews with all nursing staff. These interviews enabled her to take stock of the situation at ReHo and to demonstrate that she took the needs of ReHo's nursing staff seriously. The ReHo nurses started to ring her to resolve many trivial issues: "…there were many phone calls for bagatelles. I couldn't believe it .... For example, an electric shaver was out of work and I had to say: There is a technical service, please go there." As ReHo nurses realized that the LaHo nurse took their concerns seriously, they increasingly accepted her as a superior and approached her when problems arouse. This again increased the acceptance of the LaHo nurse.

Getting acceptance and establishing a trust relationship. The ReHo nurses did not easily accepted the LaHo change agent as their superior. The LaHo nurse needed to gain their trust. She listened to the needs of the ReHo nurses and the ReHo nurses started to contact her to fix problems. These issues were not necessarily related to the original assignment but were rather of mundane nature. However, the LaHo nurse had to deal with these nuts and bolts to gain acceptance for her position and her assignment. In short, the LaHo nurse clarified her position and gained the trust by listening and by dealing with rather trivial issues.

Example 2: Setting the duty roster. The significance of improving the team scheduling highlights the nurses' general approach of dealing with organizational issues and the importance of resolving everyday problems before implementing change. When the LaHo nurse came, "…the time scheduling was wishy-washy. Everyone did what they wanted and

then, nothing was done because nobody felt responsible." (LaHo nurse, interview). Setting the duty roster was not an easy task because "it is difficult to say: -It's your private problem if your boyfriend dumped you; to say: -I expect your performance and you must do your work. This would create bad vibes." (ReHo nurse, interview). When setting the duty roster nurses had not only to consider economic concerns but personal ones as well. In our case, the nurse from LaHo realized she needed to render practical assistance in creating the team scheduling for the different wards at ReHo. Therefore, twice a day she went to each ward, demonstrated her presence and offered direct support. By applying her experience and hands-on knowledge on creating team schedules, the LaHo nurse gained respect and appreciation.

Stabilizing every-day work before implementing actual change. The LaHo nurse did not address her actual assignment directly. In collaboration with the ReHo nurses the LaHo nurse addressed issues that were not related to the original merger project but mattered to the ReHo nurses. Before the LaHo nurse could implement the actual changes she needed to demonstrate her usefulness in daily practice. First, this freed the ReHo nurses from their daily worries and released energies for the changes originally intended. Second, working together with the ReHo nurses on a tangible and urgent issue – such as team scheduling – allowed the LaHo nurse to demonstrate her way of working.

Organizational implications. The ReHo nurses experienced hands-on the problem-solving approach of LaHo. The LaHo nursed exemplified this by applying LaHo's working principles on tangible issues that mattered to the ReHo staff. Through her collaborative approach she achieves many small wins that create positive dynamics. By dealing with the daily challenges the nurses faced at ReHo the LaHo nurse seemingly made a detour but gathered momentum for change. The LaHo nurse is satisfied with the developments at ReHo – it resonates with her original ambitions: „You can only get people off the ground, they need to pave the way themselves. I am only supposed to take care of the current situation and get them off the ground. Then, I will say goodbye" (LaHo nurse, interview).

Interpretation: The length of the integration project was not pre-defined, the project was rather lengthy and focus on relational aspects was put: before the LaHo nurse could successfully change fundamental working practices of LaHo and ReHo she needed to clarify her role and gain the trust of the staff at ReHo. Accordingly, broad involvement with all affected employees was crucial. Overall, similar to their daily work merger work of nurses was shaped by the notion of developing, nurturing and empowering those who needed to change.

Daily work of nurses

When I meet a person for the first time at the hospital I am about to say: You are at our hospital now – and I am responsible for making you feel well. (Nurse, interview)

In their daily practice nurses orient themselves at the well-being of the patient. At that, they distinguish between illness and person: “It’s not about the cancer, the illness itself. We care about the person and we put the person first; not her illness” (nurse, interview). Therefore, establishing a personal relationship with the patient is important: “In nursing, it’s also about listening and letting people talk” (nurse, interview). Personal relationships are not only important in the interaction between nurses and patient but also within the nursing team: “You have to care for a good and productive climate on your ward. Do you know what would happen if you don’t? You could go into prison. No one would come” (senior nurse, interview). In addition, besides performing patient care nurses organize daily routine around patients. They negotiate and mediate between different medical professionals and social services staff. That is, they can not only focus on patient care itself but need to consider the related processes. Altogether, in the daily work of nurses making patients feel at ease, establishing personal relationships with patients and colleagues and organizing the surrounding patient processes have high priority.

5. Analysis: the fragility of decision-making in a pluralistic organization

The data displays the respective merger practices in relation to the daily work of each actor involved in the hospital merger we observed. The data leads us to three observations: first, all four decision-practices are profoundly different. Their differences let us expect that organization-wide decisions like the merger would be a highly fragile process. The second observation pursues the question of why these decision-practices prevail, thus relating them to the professional worlds of the actors. We observe them to relate as a duality in which the world of patient treatment legitimizes the decision-practice of the merger and vice versa. The third observation addresses the question of how and why the merger project came to be successful, given the different decision-practices. Here, we address the question of how the fragility of organization-wide decision making was handled in our case of the hospital merger.

5.1 Observation 1: profoundly different practices of decision-making

Our first und most salient observation is that the decision-practices of each professional actor varied significantly along our analytic focus of scope, involvement, the idea of integration and the timing.

The *scope* ranges from the very narrowly defined problem of surgeons, to the more broadly and time-sensitive definition of internists, to the relational scope of nurses. In comparison, administration defined the scope along the lines of departments, like IT, or technical support.

The *involvement of others* varies significantly as well. While surgery and administration did not include those on the receiving end of their merger practice, nursing and inner medicine did. The former two decided within a small group of officially appointed members (administration), or the head surgeon, respectively. They rather expected of their colleagues at ReHo to follow suit. Inner medicine, in comparison involved the clinic of the smaller hospital by conversing with ReHo's head of inner medicine. These conversations took place within the so-called "structure-committee" that was a regular meeting of the heads of those clinics that remained to be integrated. More broadly, nursing expanded in this dimension towards all employees of ReHo.

The notion of *how to conduct* the merger differed accordingly. Surgery followed a rather coercive strategy of LaHo's head defining the problem, the form of integrating by merely "carrying down our standard operating procedures" (leading surgeon), and rapidly handling situative challenges by settling the patient problem and by immediately explicating a new standard operating procedure. In a different, but similarly coercive manner, administration defined the departments to merge and left it to them how to conduct the integration that often did not actively involve ReHo employees. LaHo's inner medicine in comparison aimed to seek consensus with those responsible at ReHo, thus detecting over time, when to integrate ReHo's department into their own. Nursing actively involved the employees to co-develop ReHo's nursing department.

The *timing* varied accordingly. After administration began the hospital merger on the level of departments, surgery was the first medical profession grasping to handle its own challenge of capacity limits. It conducted the merger very fast, whereas nursing took about two years to call the merger completed. Nursing also faced the highest complexity because of the various relations of nursing with other clinics and departments. Its entry point was to handle the surgeon's critique even though the official date of the hospital merger had already passed.

Inner medicine was the last clinic to engage with the merger project, and took considerable time to understand the emerging pattern, while seeking for consensus between ReHo and LaHo. Like surgery, the retirement of ReHo's head internist provided the opportunity to act and adapt processes at ReHo and to install a rotation of medical doctors.

These differences in scope, in involvement of others, in how to conduct the merger and in timing exemplify that the practices of decision-making are heterogeneous. They vary along professional boundaries that manifest in clinics and departments. The following table summarizes this observation:

	Administration	**Surgery**	**Inner medicine**	**Nursing**
Entry-point & duration (when)	Several temporary and pre-defined periods in time	Handling capacity challenge in a short time period	Observing and engaging to grasp the retirement as an opportunity over a longer time period	Handling the surgeons' critique over a longer time period
Scope (what)	standard operating procedures within the departmentally separated parts	standards of operating within surgery	standard operating procedures within inner medicine, collegial consensus	standard operating procedures within nursing, relational well-being between change agent and employees while focusing on maintaining daily patient care
Involvement (who)	Project team with equal members of administration, nursing and medical representatives; approval by executive board	Head surgeon of LaHo and his delegated leading surgeon at ReHo	Group of leaders (of clinic) and head of the affected clinic through the "structure committee"	involvement of all employees, led by change agents
Idea of engagement (how)	Planning, approval, delegation to departments	"1 clinic – 2 sites"; coercive transfer of operating procedures	Observing what emerges and seeking consensus with ReHo's head of inner medicine	Developing co-development of those initiating and those on the receiving end

Table 1: differences between merger practices

These differences of decision-practices help to understand the fragility of the merger project. The moments of fragility we previously described mainly occurred, when professional boundaries were breached. This was the case when administration aimed to integrate gynecology and the emergency care unit. In both cases, resistance and open conflict accompanied the integration of these departments. On a smaller scale, nursing faced conflicts with internists, when the head nurse aimed to structure their cooperation differently than

before. Similarly, the replacement of the nursing director followed necessities to integrate nursing, but was opposed by ReHo's CEO as breaking into his domain. As long as the professional actors remained within their domain, outside critique was low, except when LaHo's surgery approached ReHo's nursing.

Organization-wide decisions, like conducting a hospital merger, are fragile decision-making processes. Here, different practices of decision-making come into play. As our results suggest, they differ significantly from each other in terms of the scope, the involvement of others, the way of integrating and the timing.

From this understanding, two questions arise: How and why do the different decision-practices prevail? And how did the merger still work, i.e. how was the fragility handled? We turn to these questions in the following two observations.

5.2 Observation 2: the duality of decision-practice and professional world

Our second observation addresses the question of how and why different decision-practices prevail within one hospital. The three actors of surgery, inner medicine and nursing extend the ways they treat patients to conducting the merger: *Surgery* almost identically followed its idea of good medical practice that they define as the right diagnosis, the right operation, and the right after treatment. In similar clarity, *inner medicine* observed in the merger case how the situation between the hospitals and between LaHo's and ReHo's inner medicine evolved before acting. Akin to their daily practice of closing the diagnostic gap, they aimed for consensus with their peers at ReHo before actively integrating this clinic into theirs. *Nursing* went a step further and included all of ReHo's employees based on their understanding of leading a ward team. Here and for the sake of good patient treatment, relationships and atmosphere are considered of great importance. These provide the basis and resonate the notion of caring they express when taking responsibility for a patient's wellbeing.

In comparison, we see the *administration* as an exception, because they do not work directly with patients. However, they approached the merger in the same way, they conduct interdisciplinary projects. These require egalitarian membership within a project team that is directly reporting to the executive board for approval. As in other projects, the rather bureaucratic procedure of reports structured each process and relied on the approval by the executive board of the hospital region.

Our following interpretation relates mainly to the two medical and the nursing professions. Transferring daily patient practice to the organizational topic of the merger served to stabilize the merger practice within each professional domain, much similar to the ways routines reproduce (Feldman & Pentland, 2003): First, the transfer provided legitimacy because the daily treatment practice is uncontested for each professional actor. It corresponds to the self-description of surgeons, internists, and nurses. As such, it reflects the world of the three professions. Second, the transfer provided guidance on to how to proceed throughout the merger project without requiring prior planning. Furthermore, the decision-practice was at least not openly contested within the clinic or department of each actor. We did not observe open resistance within ReHo's surgeons and internists at all, and in nursing first irritations subsided shortly. Third, and vice versa, the decision practice during the merger confirmed each professional world because the merger was regarded a success. Most prominently the hospital executive board approved the surgeon's merger by using their slogan of "1 clinic – 2 sites" as an overall guiding description. In this respect, the decision-practice of the merger reproduced each professional world, while each world provided the background for each merger project. In this way, the professional worlds of patient treatment and the organizational practice of decision-making in the merger formed a duality stabilizing each domain within its boundaries.

Overall, this duality of patient treatment and organizational decision-making stabilized the mergers of each professional actor. Stabilization was necessary due to the fact that neither of the four had prior experience with merging clinics or departments. In our view, the duality explains, why the different decision-practices prevail within one hospital. They reproduce the world of each profession and by their differences indicate the boundaries between them in practice. We therefore suggest that decision-making on organizational topics tends to follow routinized patterns based on the respective professionals' notion of treating their patients.

5.3 Observation 3: spatial and temporal separation to handle the fragility

The third observation relates to the overall hospital merger, thus on the level of handling heterogeneous decision-practices in organization-wide processes. In light of the different decision-practices and their stabilizing, the question arises: how and why did the hospital merger come to a successful end in the eyes of the practitioners?

As organization-wide decision processes like a hospital merger involve a wide range of professional actors, who enact their own practice of decision-making and the hospital merger in our case ended after nine years with a declared success. In our view, the main reason lies in spatial and temporal separation of the merger project of the each department. With the exception of administration, that launched the overall merger process, the medical and nursing departments were left to decide by themselves when and how they engaged in the merger project. Surgery used the merger to handle its capacity problem. Nursing involved itself to handle the surgeons' critique, and inner medicine followed once they had gained a sufficient understanding and the opportunity to act with the retirement of ReHo's head internist. Neither of the points of entrance were pre-planned or decided by others than the professional actors themselves. It turned out that they did not pursue their respective merger in parallel, but in temporal sequence and as long as was suitable to them. The sequence contributed to the spatial separation, with the mentioned exceptions of boundary breaches.

The temporal sequence and points of entry illustrates notions of the garbage can model of decision-making (Cohen, et al., 1972). Points of entry were rather defined by each actor in terms of temporal proximity than on rational causes.

A second similarity to the garbage can model is the use of ambiguity by the executive board. It took three years to publish the new organizational chart by the end of 2006. The organizational chart fixated the relationship of the two hospitals in the way of integrating ReHo into LaHo with the status of a department. Before, the executive board of the hospital region left the relationship unspecified, though ReHo's director was a member of that board. This timing may have helped to avoid moments of conflict within the board. Rather, the board appeared to wait for what emerged from the different mergers of the various clinics and departments. In our reading, ambiguity was used as a resource to reduce fragility by avoiding conflicts, similar to the view of March (1991). Doing so, resonates with the notion of Mintzberg & Waters (1985) of realized strategy, though with a strong emphasis on the emergent side. Within the executive board, the hospital merger was less discussed in a way of planning future steps, but rather in terms of reporting the past. Most prominently, taking up the surgeons' slogan of "1 clinic-2 sites" illustrates the emphasis of the executive board to observe what emerged. Its own decisions remained within the level of administration and with the initial commitment to the merger (Mintzberg & Waters, 1990).

As a summary, the temporal and spatial separation combined with the executive board's approach to adopt what emerged explains why this hospital merger came to a successful end, despite of the heterogeneity of decision-practices that would suggest a more fragile process.

6. Discussion

Organization-wide decisions are fragile processes in a hospital because they involve engaging with profoundly different practices of decision-making. Each of these practices of decision-making prevails because they reproduce the world of the respective professional actors. Handling the fragility within organization-wide decision processes like a hospital merger in our case, involve temporal and spatial separation as well as allowing for what emerges.

The heterogeneous decision-practice within a pluralistic organization provides an explanation for the fragility of organization-wide decision-making. The differences in scope, in involvement, in intervening, and in timing are significant. Misunderstanding and conflict rather appear the norm than the exception. Organization-wide decisions, like a hospital merger or developing an overall strategy, involve heterogeneous practices of decision-making. This heterogeneity of decision-making adds to the existing explanations process studies have provided so far. They have taught us that the fragility is an expression of top management in relation with its external stakeholders (Jean-Louis Denis, et al., 2001), of internal power struggles between autonomous clinical actors and hospital management (Lozeau, et al., 2002), of failed collective sense-making among these actors (Ericson, 2001), and of the fundamental tensions between medical and management (Doolin, 2001; Iedema, et al., 2003; Llewellyn, 2001; McNulty & Ferlie, 2004) as well as nursing worlds (Glouberman & Mintzberg, 2001).

Our study on the heterogeneous decision-making practice to explain the fragility of decision-making in pluralistic organizations speaks mainly to three audiences: The first are empirical process studies on hospitals to which we suggest to move beyond the dominant dichotomy of management versus medicines. The second audience is the literature that works on developing theories on pluralistic organizations. Here, we contribute heterogeneous decision-making practices as a core component of these organizations. The third audience is the process literature on decision-making itself. While their critique on the dominant traditional models is highly valuable, we suggest to further exploring decision-making in practice.

Speaking to studies on hospitals: moving beyond the management-medicine divide

Our study suggests to move beyond the traditional dichotomy of administration (or management) and medicines. Differentiating between professions leads us to more detailed understanding of hospitals as pluralistic organizations. Most organization studies on hospitals focus on the tensions, misunderstandings and conflicts between management and medicine (Doolin, 2001; Iedema, et al., 2003; Llewellyn, 2001; McNulty & Ferlie, 2004) with the exception of Glouberman & Mintzberg (2001). Our study provides a more fine-grained differentiation. We explored the different practices of decision-making of four professional actors and found them to differ significantly.

These differences in scope, in involvement of others, in how to conduct the merger and in timing point out a core challenge of managing such a pluralistic organization. The core challenge is to handle the differences of decision-making practices of otherwise autonomous actors. Each of them legitimizes their practice and rationality (or world) with their practice of treating patients. While each decision-practice becomes thus stabilized and coherent within each actor, its legitimacy in terms of patient treatment provides little space to harmonize decision-practices. Thus, organization-wide decisions and managing hospitals face the challenge of handling the differences in decision-making. The different practices complicate matters of divergent interests and dispersed power, so that organization-wide decision do not only require the consent of the led (Jean-Louis Denis, et al., 2001). But also, they require handling different practices of decision-making. As we exemplified these differences, they help us understand, why collective sense-making (Ericson, 2001) fails, even if the involved agree on similar goals. Because they practice decision-making differently, it becomes difficult if not impossible to develop a collective sense.

Speaking to the theories of pluralistic organizations: including decision-practice

Second, we suggest for pluralistic organization to including the heterogeneous practice of decision-making as a fourth component.

The literature (Jean-Louis Denis, et al., 2007; Paula Jarzabkowski & Fenton, 2006) suggest that pluralistic organizations are characterized by diverse strategic interests; diffuse power, and knowledge intensive work processes. The discussion has hardly considered the heterogeneous practice of decision-making that is embedded in pluralistic organizations and that reproduces different worlds and vice versa. Because of this duality, we suggest the

heterogeneous decision-practice of pluralistic organization as a fourth defining component. In hospitals, for example, it is defining because the decision-practice corresponds with the daily practice of the involved actors. In our case, nursing, surgery and medicine transfer the way of how they go about their daily work with patients to organizational topics, like conducting a merger. This link allows to stabilizing, legitimizing and explaining organizational practice because the daily work with patients defines the respective profession. Therefore, we expect decision-practice to be consistent and fairly uncontested within each domain. Between them, however, and as these ways of decision-making meet, they provide alternatives to each other. As alternatives, they allow for comparison, reflection, and potentially for altering them. Thus, the heterogeneity of decision-practices in organization-wide projects provides a source for their fragility.

The heterogeneous decision-practices conceptually may help to relate the three other components. Knowledge-intensive work processes – the practice of treating patients - guide and legitimize decision-making. Therefore, decision-making practices differ from each other and express the boundary between clinics and departments. Maintaining these boundaries helps to reproduce autonomy of actors and to pursue their respective interests, each in their own specific way of decision-making. For organization-wide decisions, decision-making becomes heterogeneous.

Our results show that decision-practice varies between the involved actors. For organization-wide decisions, like hospital mergers, the different ways of how to go about decision-making come together, so that different degrees of scope, of involvement and of temporal understandings meet and interact. It is this interaction of the different ways of decision-making that explains the fragility of decision-making in pluralistic organizations. In our view, this interaction lies beyond existing explanations. On the broad level of the merger as such, potentially *divergent strategic interests* did not lead to fragility of the project. Rather, the involved professionals, including the executive board and the Canton's government, shared this interest on the broad level of pursuing the merger. There was a commitment to action (Mintzberg & Waters, 1990). Like in other pluralistic organization, *power is disperse and decisions* in conducting the merger was left to the actors. The involved clinics and departments of surgery, inner medicine, nursing and administration enjoy a considerable degree of autonomy, so that power and decisions are dispersed among them. Therefore, we would have expected moments of *failed sense-making* that may have jeopardized the merger project. For the merger project as a whole, we did not observe such moments but rather

retrospectively taking up the organization chart and the slogan of one actor for the hospital merger at large.

Speaking to process views on decision-making

Our third contribution is a reflection on theories of decision-making that take a process perspective. The garbage can model (March, 1991) is one of the few approaches to decision-making that take a process perspective, besides the notion of decision patterns put forth by Mintzberg & Waters (1990), and Pettigrew's (1990) reinterpretation of decision-making as change, rather than choice. Their works provide crucial insights into understanding organizational decision-making. The garbage can model suggests that temporal proximity explains decision-making rather than a causal logic and highlights that ambiguity lies at the heart of decision-making. Mintzberg & Waters (1990) contribute to view decision-making as patterns unfolding through time, thus focusing on the traces decisions leave in an organization. Correspondingly, Pettigrew (Pettigrew, 1990) suggest to replace the idea of choice with a notion of change. As such, the specific context of the situation at a certain moment in time becomes crucial, besides the topic and the process of unfolding events in order to get a grip on decision-making.

However, their conceptualizations lose the detailed empirical insights on decision-making from which they are drawn. This loss may be inevitable, when theorizing decision-making by means of abstraction, leaving only general cues. Taking the example of the garbage can model, it points to decision styles by distinguishing between resolution, oversight, or flight (Cohen, et al., 1972, p. 8). Such cues move into the background for the sake of theoretical conceptualization. In our view, this is unfortunate as our study suggests that the actual practice of decision-making plays an important role in understanding such phenomena as decision-making in pluralistic organizations. Returning to the actual practice of decision-making may well complement the abstract concepts. Together, they show that, how, and why things like organizations are constantly in the making. The ways in which "in-the-making" unfolds is what helps us understand in more detail why such activities like decision-making are fragile, and how pluralistic organizations cope with them continuously.

7. Four limitations and one concluding remark

Our study faces a wide range of limitations which suggest future research. Four major ones are the single organizational setting, the focus on the internal side of the merger process, the limitation of the merger process as an extreme example, and the partial use of retrospective data.

First, the study is situated within a single organization. Despite the comparison between professions and with other initiatives, its insights are necessarily limited in terms of generalization for the sake of accuracy and specificity. While the latter two aspects correspond with a process perspective, it may be fruitful to know whether similar challenges of decision-making can also be found in other hospitals, or even in other pluralistic organizations, like universities or professional service firms.

Second, we focused on the inside of the hospital in our investigation while emphasizing less how the merger process was embedded in the local community ongoing. While this shift addresses the call of others (Jean-Louis Denis, et al., 2001, p. 835), it downplays the importance of the local community, and of external stakeholders in shaping the process. Future studies may consider a poly-contextual approach, by means of a practice perspective (Whittington, 2006), or by making is of the theory of social systems (Luhmann, 2000).

Third, the case of a merger process may be special in itself with regards to decision-making. We chose it because it provides a promising context to study organization-wide decision-making in practice. At the same time, such a change intervention provides an extreme case which is not a regular every-day topic of decision-making in pluralistic organizations. While it helped to gather the above insights, we suggest to studying decision-making in more routinized context. Annual budgeting may provide a promising context (P. Jarzabkowski, 2003) in which the different ways of decision-making may play out. Another setting could be the work on the organization's strategy itself. A third, but more hospital-specific setting could be the introduction of interdisciplinary forms of cooperation which become more frequent at least in hospitals. All of these may be promising for further exploring the interplay of different ways of making decisions thus providing us with more insights on how to handle this challenge.

Fourth, our data gathering involved not only direct observation (Mintzberg, 1979), but also retrospective data. Since our field phase began in 2004, we could not ourselves observe the events unfolding prior to this date. We still think our interpretations of this prior period as

valid, mainly because we could compare it with other initiatives in the case of administration and surgery.

This paper explored the fragility of decision-making in pluralistic organizations. Our focus was on the different practices of decision-making that come into play when organization-wide decisions, like a hospital merger are concerned. We aimed to highlight, first, that decision-practice differs among actors in terms of scope, involvement, idea of engagement as well as point of entry and duration. Overall, the empirical case of a hospital merger rather appeared like a garbage can process in which the overlap of decision-practices could be reduced by temporal and spatial separation. Second, we showed that the practices of decision-making draw on the daily work with patients, in the cases of nursing, inner medicine and surgery. This relation provides legitimacy and guidance for organizational decisions of merging the respective departments. Vice versa, the declared success of the merger reproduces the decision-practices of each actor. Third, and while internally coherent and stable, the different decision-practices provide an alternative explanation to why such processes are fragile in pluralistic organizations. In comparison to existing approaches, we highlight that the fragility is integral to decision-making in such settings. Therefore we contribute to the theorizing of pluralistic organizations. Decision-making in such settings is a recursive process that is both stable (within the domain of the different actors) and fragile between them. Decisions shape and are shaped by the world of a specific practice of decision-making. Whereas this world may be coherent in some organizations, it varies in pluralistic organizations. Each professional domain reproduces its practices of decision-making leading to strategic ambiguity on the organizational level. The answers to what strategy means, how to strategize and of who is a strategist differ profoundly within pluralistic organizations. This is why future work should examine more closely explore the strategic practice within pluralistic organizations without pre-conceptualizing it (Chia & MacKay, 2007).

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