

Accomplishing paradox latency with a coordinating routine

- a process perspective on accomplishing stability in a pluralistic organization

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Abstract: This paper investigates how the paradox of differentiation and integration becomes latent through a routine by which the relatively autonomous actors move forward organization wide issues. The paradox lens provides a promising perspective to explore pluralistic organizations. While it argues that paradoxes are, integral to organizations it assumes that they remain latent without addressing how paradox latency is accomplished. By using routine dynamics, this study investigates the routinely and situative enactment of the paradox of differentiation and integration. The single research setting of a qualitative longitudinal case study shows how paradox latency is accomplished within the executive board during an initiative of integrating two hospitals. Accomplishment of paradox latency reveals different patterns that are integral to a coordinating routine by which this hospital moves forward organization wide issues despite its plurality. This coordinating routine and the paradox of differentiation and integration form a duality that explains how a pluralistic organization achieves stability. The proposed duality further advances the paradox lens by attending to paradox latency. In addition, the proposed duality addresses the current interest in routine dynamics on relating groups of routines.

1 Accomplishing stability in a pluralistic organization

The paradox lens is a promising approach (Lewis & Smith, 2014; Smith, 2014; Smith & Lewis, 2011) to pluralistic organizations. It argues that paradoxes become salient in situations of multiple environmental demands (Denis, Lamothe, & Langley, 2001; Jay, 2013), the diverse interests of relative autonomous actors (Jarzabkowski & Fenton, 2006; Lozeau, Langley, & Denis, 2002), the different perspectives (Denis, Langley, & Rouleau, 2007; Kraatz & Block, 2008) that associate with a variety of knowledge-intensive work (Edmondson, Bohmer, & Pisano, 2001) and with ways of acting (Glouberman & Mintzberg, 2001; Jay, 2013). In such pluralistic settings, environmental cues, proposed changes or perceived events are interpreted within the meanings structures (Hernes, 2014) of different subsystems (Barrett, Thomas, & Hocevar, 1995; Bartunek & Moch, 1994; O'Connor, 1995; Westenholz, 1993) the resulting conflicts, misunderstandings, defensive or diluting responses express paradoxes (Bate, 2000; Edmondson et al., 2001; Ericson, 2001; Kellogg, 2011; McNulty & Ferlie, 2004; Pettigrew, 2012; Reay, Golden-Biddle, & Germann, 2006).

However, the paradox lens rather focuses on handling paradoxes once they have become salient. The literature assumes that paradoxes remain latent beforehand (Lewis & Smith, 2014; Smith, 2014; Smith & Lewis, 2011). But, by definition (Smith & Lewis, 2011: 382) paradoxical poles interrelate and persist over time through situated and local action (Clegg, Vieira da Cunha, & Pina e Cunha, 2002). These poles relate when the paradox is said to be latent. However, we still know little on paradox latency and how it is accomplished. My research question is the following: how does a pluralistic organization handle paradox and accomplishes its latency?

I address this research question by exploring the prior solution to a paradox that performs paradox latency. Routine dynamics literature provides a promising starting point because routines relate different actors (Feldman & Rafaeli, 2002) and other routines (Jarzabkowski, Le, & Feldman, 2012; Ockhuysen & Bechky, 2009). As part of process research (Hernes, 2008), routine dynamics views organizations as active accomplishments (Feldman, 2000).

Understanding paradox latency and its accomplishment is relevant for pluralistic organizations and for the development of the paradox lens. For the paradox lens, this research complements the assumption that paradoxes are integral to organizations even when considered latent. Furthermore, the previous solution that leads to paradox latency provides an essential background for envisioning and implementing alternative solutions deliberately. For pluralistic organizations, my aim is to elaborate on how such an organization accomplishes stability, given its systematic improbability.

The second *background section* elaborates on the paradox literature and argues that paradox latency and the relation between the opposing poles of a paradox received little attention. This research need invites routine dynamics as part of a process perspective.

The third *method section* depicts the research design. The fourth *result section* first, provides the narrative on a longitudinal case study of hospital integration. Second, I present the board members' discussions of undecided issues. They illustrate moments of paradox salience and their handling exemplifies the accomplishment of paradox latency. The fifth section contains the analysis. It first elaborates on the background assumption of mutually granted autonomy, which exemplifies the paradox of differentiation and integration (Jarzabkowski, Lê, & van de Ven, 2013; Lawrence & Lorsch, 1967). The paradox manifests in the perceived role of the executive board as a non-decisive body. Alternatively, the routine practitioners call "bilateralism" unfolds the paradox. Enacting this routine involves shifting conflictual issues outside the executive board, thereby accomplishing paradox latency therein. The analysis concludes with a theoretical model. The model proposes that the paradox of differentiation and integration forms a duality with the coordinating routine of bilateralism and accomplishes paradox latency.

In the sixth section, I discuss these insights with the literature. First, the coordinating routine provides a both-and solution to the paradox without being designed. Second, the insights illuminate on paradox latency by showing that latency is an active accomplishment; that latency requires a nuanced view in terms of whether it applies individually or collectively; and that the paradox and the coordinating routine form a duality that provides for stability of a specific organization.

2 Background: paradox and routines

A paradox consists of “contradictory yet interrelated elements that exist simultaneously and persist over time” (Smith & Lewis, 2011: 382). Paradox comes into play because organizations draw distinctions (Ford & Backoff, 1988) that form different subsystems which are both in- and interdependent in achieving overall success (Lewis & Smith, 2014). Each subsystem may appear coherently rational within its own specific setting, but “absurd and irrational when appearing simultaneously” (Lewis, 2000: 760). Therefore, paradoxes are integral to organizations and arise “from the interplay among complex, dynamic and ambiguous systems.” (Lewis & Smith, 2014: 6; see also Luscher et al., 2006; Rasche, 2008).

Since paradoxes are not salient all the time, they often remain latent (Lewis & Smith, 2014; Smith, 2014; Smith & Lewis, 2011). Paradox latency is thus an important underpinning of the theoretical concept of a paradox lens. The literature often mentions the latency of paradox as a starting point, and highlights the conditions under which paradox becomes salient. “Although inherent tensions may remain latent in organizations, they surface or become salient as actors emphasize differences over commonalities.” (Lewis & Smith, 2014: 7).

The literature identifies at least three circumstances for paradox salience (Smith & Lewis, 2011: 390): First, *plurality* points out to different goals and perspectives that emerge from and within subsystems and turn into juxtaposition when they adjoin. Second, deliberate *change* brings about often taken-for granted assumptions and perspectives, juxtaposing an enacted organizational understanding with a proposed one which often leads to conflict because the proposed change is interpreted according to the enacted understanding (Balogun & Johnson, 2005; Bartunek & Moch, 1994; Luescher & Lewis, 2008; O'Connor, 1995; Westenholtz, 1993). Third, the experience of *resource restriction* (funds, human resources, time) triggers the salience of paradox because such issues often call forth selective choices (Lewis & Smith, 2014). In all three circumstance differences and tensions emerge that require solutions: “...tensions will re-emerge and compromises are likely to be reopened“(Denis et al., 2001: 228).

2.1 The limited attention to paradox latency

However, studies hardly explore the initial situation prior to paradox salience. In addition, the meaning of “latent” remains vague.¹ It points to invisibility (Schoenenborn, 2011) and to laying “dormant” (Pratt & Foreman, 2000: 20, Footnote 3). The cues in the paradox literature imply the following: First, managers’ deliberate attempts to reinterpret paradoxical tensions may involve their dissolution. Abdallah et al. (2011: 335, emphasis added) suggests that handling a salient paradox makes it latent. The managers in their study promote ambiguity and quasi conflict resolution that enhances unity within difference “so that contradictions or paradoxes that were previously seen as intractable appear to be *dissolved* or overcome.” Second, Andriopoulos & Lewis (2009) provide implicit cues on paradox latency in their study on exploration and exploitation. To relate these two poles they find a pragmatically idealist vision and the handling of loose and tight customer relations as “purposeful improvisation” (ibid. 705) but without describing these insights in detail. Third, paradox latency associates with the relation between the poles of a paradox. Clegg et al. (2002: 488) note “Choosing and finding a balance between the two extremes of a paradox or replacing that tension with a synthesis helps managers to push important dynamics *out of the realm of attention*.” These scant references to paradox latency concern the deliberate attempt to handle paradoxes.

These studies do not address paradox latency as part of the relation between the poles. The locally and situatively enacted handling of the paradox renders it latent before it becomes salient. Instead, paradox latency provides a background condition, because many studies begin with paradox salience and often pursue how organizational members cope with a salient paradox. For example, Beech et al. (2004) (Beech, Burns, Caestecker, MacIntosh, & MacLean, 2004) investigates the paradox of centralization and decentralization within the British healthcare sector with a detailed account of how to handle the paradox as it becomes salient through introducing a respective change initiative. Their data points out the paradoxical poles but does not elaborate on how their relation prior to becoming salient. In the work of Luescher & Lewis (2008), the organizational members work through paradox to generate “workable solutions”. Their data starts with the perceived problem descriptions without elaborating on the previous solution in detail. Similarly, Jarzabkowski et al. (2013) takes the initiative of

¹ In everyday language the term is “used to describe something (such as a disease) that exists but is not active or cannot be seen” (Webster’s dictionary, 12.03.15; www.merriam-webster.com).

restructuring a company as a starting point through which paradoxes become salient and dynamically relate over time (ibid., 248) highlighting different response patterns without attending to how these paradoxes were handled prior to their salience. Exploring the same paradox, Smith (2014) reports the different leadership practices of differentiation and integration that accentuate the paradoxical poles as a pattern of consistently inconsistent leaders' decision-making. However, this study does not show the resulting paradox latency. These examples illustrate that paradox research starts out with the salience of paradox and not attend to paradox latency, as they tend to omit the prior relation between the poles of a paradox.

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

Overall, the cited studies illustrate the scant attention to the prior solution of paradox and to paradox latency. Paradox latency appears to be rather vague, although it is an important component to the paradox lens. Paradoxes are latent or invisible, if we assume that they are integral to organizations but not salient all the time. Further advancing the paradox lens requires attending to paradox latency and to the relationship between the poles, that marks the situative and locally enacted prior solution (Clegg et al., 2002).

2.2 Routines to explore the relation of the paradox's poles

Routine dynamics corresponds with the local and situative enactment of relating different actors and routines integral to the ongoing accomplishment of organization. *Routines as generative systems* are recognizable repetitive patterns of actions to which multiple actors contribute (Feldman & Pentland, 2003). The notion of generative system highlights the internal dynamics of a routine that leads to both change and stability (Feldman, 2000; Feldman & Pentland, 2008; Feldman & Rafaeli, 2002). Two interwoven dimensions drive this dynamic: a routine contains a performative dimension of specific actions of specific people in specific times and places. The ostensive dimension is the pattern of these actions, the routine in principle. The ostensive dimension is both explicit and implicit as well as multiple, because different actors may hold different understandings of a routine (Cohen, 2007; Dionysiou & Tsoukas, 2013).

Also, routines are means of coordination (Ockhuysen & Bechky, 2009) on two analytic levels, the second of which provides a promising starting point for my research. First, actors relate through performing a routine (Feldman & Rafaeli, 2002). Actors mutually adjust their expectations towards the routine so that these expectations become compatible (Dionysiou & Tsoukas, 2013) even if their understandings of a routine are multiple (Cohen, 2007). Routines are means of coordinating actions and communications of different actors (Ockhuysen & Bechky, 2009). Second, scholars recently embarked on exploring the relation between routines (D'Adderio, Feldman, Lazaric, & Pentland, 2012; Jarzabkowski et al., 2012). This research on coordinating routines provides a promising possibility to research the relation between poles of paradox, or between different subsystems, respectively. Jarzabkowski et al (2012) explored the emergence and establishment of coordinating mechanisms² during organizational restructuring. Such coordinating routines enable “many routines to work together to accomplish organizational goals” (Jarzabkowski et al., 2012: 921). Extending the concept of coordinating routines to a pluralistic organization helps to depict how organizations enact solutions to the paradox (Clegg et al., 2002: 488).

² Jarzabkowski et al. (2013: 921) argue that coordinating mechanisms do not pursue a task and are therefore not to be seen as routines. I do not follow this argument but follow Ockhuysen & Bechky (2009) who consider routine as coordination.

3 Methods of a longitudinal single case study design

My research applies theories to a pluralistic setting (Sandberg & Alvesson, 2011) and thereby aims to elaborate (Lee, Mitchell, & Sablinski, 1999) on a processual perspective (Abdallah et al., 2011; Andriopoulos & Lewis, 2009; Jay, 2013) within theories of organizational paradoxes by drawing on routine dynamics (Parmigiani & Howard-Grenville, 2011). Rooted in a process view I assume a world constantly in the making (Tsoukas & Chia, 2002) which fits with pluralistic organizations. They are characterized by incoherence, incompatibility, recursivity, and tensions (Denis, Dompierre, Langley, & Rouleau, 2011; Denis et al., 2001; Denis et al., 2007; Jarzabkowski & Fenton, 2006; Jay, 2013; Lozeau et al., 2002; Rerup & Feldman, 2011).

3.1 Core assumptions and analytic framework

Theorizing within a process view involves at least the two components of depicting patterns which are explained by an underlying mechanism (Langley & Tsoukas, 2010). In my case, I aim to understand the pattern that become observable throughout a process of integration to hospitals. I explain the integration process through the mechanism of self-reference because it is integral to paradox (Smith & Lewis, 2011) and to routine dynamics (Parmigiani & Howard-Grenville, 2011). Self-reference means that some "thing" refers to itself (Ortmann, 2004; von Foerster, 1994), similar to recursiveness (Feldman & Orlikowski, 2011; Tsoukas & Papoulias, 2005), duality (Farjoun, 2010) or mutual constitution. "Relations of mutual constitution produce the very system of which they are part" (Feldman & Orlikowski, 2011:1242).

The analytic framework specifies what is observed. In my study, the analytic framework includes paradox and routines: *First, paradox* contains two (or more) poles that relate to another in a mutually constitutive, albeit contradicting way. In my research, the poles of a paradox are the different clinics and departments that point out the plurality within a hospital (Jarzabkowski et al., 2013; Lawrence & Lorsch, 1967; Smith & Lewis, 2011). *Second, I use the analytical categories that describe a routine.* Routines are repetitive recognizable patterns of actions or communication that involve several actors to pursue an organizational task (Feldman & Pentland, 2003). The analytic components of a routine are the following (see Feldman & Rafaeli, 2002: 310ff.): *what* is performed

(task), *who* is involved (actors), *how* it is performed (steps), and *when* is the performance of a routines triggered (trigger). The categories of who becomes involved on what, how, and when are sufficiently intuitive to guide the data analysis. The analytic categories are abstract enough to avoid pre-conceptualizing a routine (Chia & MacKay, 2007). Finally, the analytic categories help to depict the “ways of acting” (Jay, 2013: 140) in a pluralistic organization.

3.2 The research setting of Laho, Reho, and our entrance

Pluralistic organizations provide an excellent research setting because they problematize stability (Kraatz & Block, 2008). Because paradox and routines research emphasize the significance of specific contexts, my research takes place in a single setting with the fictional name of Laho. It is a leading regional hospital located in in a state (cantonal) capital with 70.000 citizens in Eastern Switzerland. Laho is a pluralistic organization of knowledge-intensive work processes with relatively autonomous actors who pursue diverse strategic interest, resulting in ambiguous power relations (Denis et al., 2007). With its five medical departments that harbour 32 clinics, and with administrative departments and nursing, Laho combines divergent perspectives (Ericson, 2001). The executive board of this public hospital reports to the board of directors, which reports to the Canton’s health department.

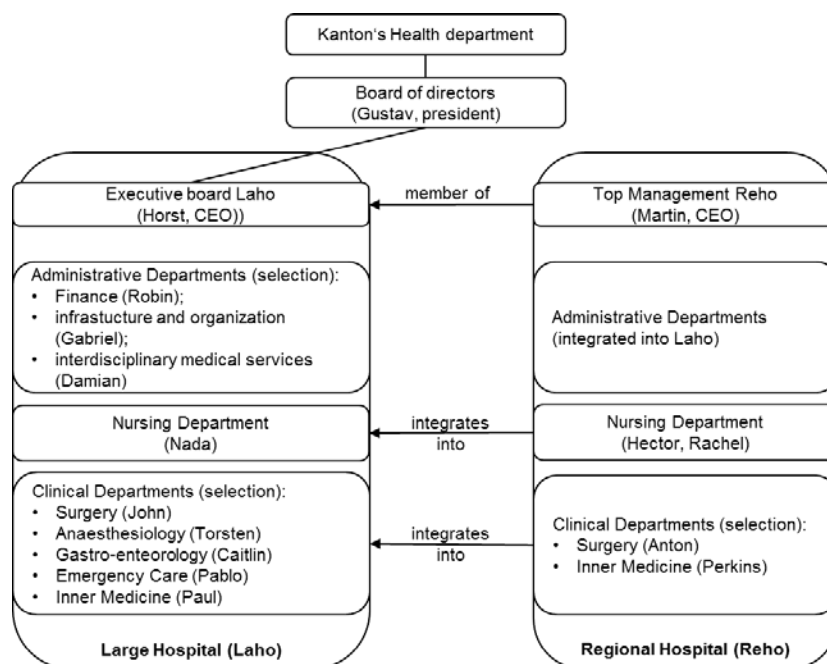


Figure 3-1: Organizational structure with names and chapters

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

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

We entered Laho through Gustav. He approached us in fall 2003 when he faced challenges with the executive board to devise an overall strategy for the hospital region that consists of Laho and a regional hospital I call Reho: "*When we [board of directors] came, we were not embraced with open arms. The clinicians had not wished our presence.*" After several preparatory meetings, we could engage with the executive board of Laho in March 2004. The executive board offered several change initiatives to accompany. One was the integration of Reho into Laho hospitals in combination with defining the hospital strategy and with a particular focus on the nursing department. A second one was the introduction of a new surgical regime by the clinic for surgery. In 2007, we could accompany the initiative to implement restricted working hours for assistant doctors throughout the clinics, and the evolving interdisciplinary centre for palliative care in 2008 (see table below).

These initiatives provided a profound and longitudinal access to the different clinics and departments in real-time and over a period of five years. They are a promising way to investigate my research interest. First, what is taken for granted often becomes contested and therefore salient for observation (Langley & Denis, 2006), which is also the case for

paradoxes (Smith & Lewis, 2011; Smith, 2014; Lewis & Smith, 2014). Second, we were able to both trace the initiatives backwards and follow them forward as they unfolded (Langley & Tsoukas, 2010), thus observing patterns of how episodic change unfolded in relation to the ongoing daily practice within the hospital (Langley & Denis, 2006). Third, the access to different clinics and departments helped us to engage with the plurality of this organization. Fourth, our engagement across the different levels of hierarchy ranging from the executive board to the shop floor of treating patients on the wards enabled us to incorporate the different perspectives of organizational members in their specific work contexts (Denis et al., 2001). In the result section, I mainly report on the integration process of Reho into Laho. This initiative involves a small regional hospital (Reho) into Laho. They form a so-called hospital region over a period of nine years.

3.3 Generating the data through accompanying change initiatives

In our research, we adopted a role of emphatic non-participant observers (Langley, 2009: 421) who offered regular feedback workshops to the different research partners within the hospital. We framed our observations as different but not better alternatives following the insight that any observation is subject to its own blind spots. We thereby addressed the expectation of our research partners to provide an outsider's view on the challenges and their conduct of the change initiatives. Due to our role, we reflected in detail on the dynamic process of field research both throughout and after the field phase (Tuckermann & Rüegg-Stürm, 2010).

Our research approach generated a generous database that draws on four different sources: observations, interviews, and archival material and feedback workshops. The following table provides an overview of these sources within the change initiatives:

Case	Topic	Involved Actors	Time	Obs.	Inter.	Doc.	FB-WS	Case Report
Hospital integration and strategy development	Integrating Reho into Laho and developing a strategy as a result of the the public owner's call to enhance efficiency	executive board of the hospital, all departments, focus: nursing, surgery and inner medicine	04-07	67	71	69	20	Tuckermann, 2007
Introducing a new surgical treatment regime (Fast Track Surgery)	Introducing a new surgical regime that enhances recovery (medically) and prepares for the coming change in the financing of the healthcare sector (economically)	surgery, nursing, anaesthesiology, executive board of the hospital	04-06	17	29	50	13	Bucher & Tuckermann, 2009; Bucher, 2011
Implementing the Labour Law	Implementing the new labour law: restricting work hours for medical doctors and aiming to enhance optimized processes in clinics	across the entire hospital, all clinics and departments	04-07	70	67	146	5	Merz, 2010
Center palliative Care	implementing palliative care as an interdisciplinary center to introduce a new hospital service	executive board, palliative care, oncology, nursing	08	5	14	--	6	Sauter, 2009
Sum			2004-2008	159	181	274	44	

Table 3-1 Data set with sources and reference to case studies

We conducted each case in a two-person team to ensure a variety of perspectives in generating and analysing data. I participated in each of the above studies directly with ongoing involvement particularly in the cases of hospital and nursing integration as well as Fast Track Surgery. Within the cases of the labour law and the Centre for Palliative Care, I served my colleagues in several field contacts, in analysing the data and in the feedback workshops. In each case study, the researchers kept a journal both during the field phase of generating data, thereby enabling to trace back emerging insights and include the diary as part of the data set. Within the field journal, we documented numerous informal conversations which occurred as part of observations or when we arrived or left for interviews.

Furthermore, we used observations, semi-structured interviews, archival material and the feedback workshops to generate the data: *Observations* are an essential means to engage with the research setting, regarding patient treatment and managerial topics. Observations also complement interviews in that they allow to generate descriptions by the researcher and therefore explore aspects that may remain dormant in interviews (Alvesson, 2003).

The data set includes 159 observations, in which I participated in 85. In the *executive board*, we were present in both regular board meetings and board away days, which lasted for two days each. Furthermore, we participated in project meetings as part of the

“labour law case” initiative, in which a group of executive board members as well as middle rank representatives of clinics and departments were present. In addition, we took part in meetings on handling issues of coordinating and advancing the central unit of emergency care with a similar membership so that we observed the professionals’ interaction frequently on different topics. *Within the clinics* our observation ranged across the hierarchy, from meetings on particular patients up to clinic leadership. Furthermore, observations of both clinics for surgery and inner medicine at both hospitals lasted for a week each summing up to four weeks of prolonged observation being present for an entire ward’s shift each day. While these prolonged stays allowed us to observe both nurses and medical doctors, we additionally followed doctors of inner medicine with three researchers for two days each in order to understand their daily work. In comparison to surgeons who are bound more to a physical location, internists move around different clinics. *Within the nursing department and besides our ethnographic visits* we observed ward meetings, and meetings of nurse leadership at Reho. In the latter, I was present regularly every fortnight during the field phase taking detailed notes of the meeting documenting the unfolding conversations. All observations were documented in detailed field notes and transformed into memos of the meeting shortly after taking place. The resulting a word-files of about 10 pages in length each included context information on the room and the sitting order, content on the topics and the unfolding conversations which were distinguished from the researcher’s interpretations. For reasons of patient and employee privacy, we did not record any meeting (Miller & Luft, 1997).

Semi structured interviews provide the possibility to engage with the perspective of our research partners on the different change initiatives and on the hospital and their work experience in general, thereby complementing our view gathered in observations. The data set includes in total 181 semi-structured interviews of one to two hour length each, of which I participated in 125. The semi-structured interviews regarded the interviewee’s understanding of the change initiative in their work and organizational context. With selected key informants of inner medicine, surgery, nursing and the executive board, we repeated interviews between two and six times to capture their evolving perceptions (Jarzabkowski et al., 2012).

The interview population was defined in reference to the change initiative guided by a contextualist framework (Pettigrew, Woodman, & Cameron, 2001) to gather data on the

content of the initiative, on the sequence of unfolding events, and on the internal and external context. Throughout this focus, we interviewed organizational members on all hierarchical levels in surgery, inner medicine, nursing, and hospital leadership as well as administration.

Each interview followed a similar structure. It began biographically, exploring important topics throughout the interviewee's career at the hospital before exploring the particular change initiative. Here, the interview partner recounted the emerging history of the change initiative, its current state and his or her future expectations. In addition, we invited the interviewee to explain how and why the course of the initiative evolved in the way it did as well as their future expectations. At the end of each interview, we posed the reflexive question of what our interview partner takes away from the interview. This question invited the interview partner to elaborate on his or her perspective on the hospital and the issues brought up during the interview. After each interview, the researchers reflected upon the interview for an initial interpretation. This initial interpretation supported to explicate the emerging insights and to generate further questions. All interviews were transcribed.

Overall, we collected 274 pieces of *archival data* ranging from internal conception papers and presentations, meeting agendas and minutes to mail and email correspondence, as well as publicly available data of annual reports and media coverage. Within each case study, we sorted the archival data to each topic first in temporal order of appearance. As to their dates, they allowed to track the sequence of events both internally and with reference to external context.

Feedback workshops provide a setting in which the researchers report their observations and interpretations while the research partners are invited to reflect on these reflections (Iedema, Degeling, White, & Braithwaite, 2004). Therefore, I include feedback workshops as a fourth data source that helps to validate and further advance the empirical insights.

We offered 44 regular feedback workshops. The feedback workshops followed an insight-out rule in that we first conversed with those immediately involved in our observations before approaching their superiors with the consent of their subordinates. The feedback workshops contained our emerging understanding of the respective case dynamic combined with our understanding of the specific context (Pettigrew et al.,

2001). Usually, three researchers took part in the feedback workshops to distinguish the facilitation from the content of the respective workshop and to enable a detailed documentation of the unfolding conversation. After presenting our insights, we engaged in conversations guided by two questions: First, “did we understand you correctly?”, and second “what do you make of these observations?” The first question geared to check the correctness of the data and to clarify comprehension in general. The second question invited the research partners to reflect on our observations. This part of the conversation not only validated our findings, but also generated additional data through the group reflecting collectively.

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

3.4 Theorizing from process data and cycles of iterations

Analysing the data involved several methods for theorizing from process data (Langley, 1999): First, each initiative resulted in a single narrative of the unfolding events in their specific context guided by a contextualist framework (Pettigrew et al., 2001). To provide further guidance of the often complex data, we employed visual mapping (Langley & Truax, 1994) in order to depict the trajectories of the change process (Stensaker & Langley, 2010). For in-case comparisons, each narrative was analytically divided into different episodes for temporal bracketing (Langley, 1999). The distinction of the episodes followed points in time, our research partners considered critical. In this phase of generating a single narrative, the respective first author coded the raw data and triangulated the different sources of interviews, observations and documents systematically (Miles & Huberman, 1989). In my case of the hospital integration, I first developed a timetable of events mainly drawing on documents. I then coded the interview data and that of my field diary to these events to capture the evolving different meanings. Third, I included the observational data to incorporate the internal context of

the organizational members' daily work. My role within the other cases at this stage was to reflect on their analysis regularly by engaging with the raw data and my colleagues' interpretations. My colleague Silke Bucher did the same in my case. Our joint interest in hospital change and the common background in social systems theory offered a common base for the continuous conversations. The different empirical cases and specific research questions helped to maintain our differences.

Second and resulting in the current text meant several iterations between literature and data. The research focus on a coordinating routine that unfolds the paradox of differentiation and integration and that performs paradox latency emerged as follows: As part of the internal context of the contextualist research to my doctoral thesis (Tuckermann, 2007), the executive board was a periphery site for observation. At the same time, the executive board members reported their understanding of this setting as a non-decision-making body. How then did organization-wide issues moved forward within this organization? In the interviews and the observations throughout the different change initiatives the research partners labelled the pattern of moving organization-wide issues "bilateralism" which they often related to "garden thinking", a label to depict the autonomy and diverse interests of different clinics and departments. Both labels allowed coding the data of the different change initiatives to extract different aspects of bilateralism as a pattern for organizational decision-making. After validating these insights with the executive board in a one-day workshop and while working on book chapter on hospital organization and management, we found a similar pattern in a Swiss university hospital. More deeply engaging with organizational decision-making (Chia, 1994; Langley, Mintzberg, Pitcher, Posada, & Saint-Macary, 1995; March, 1991; Mintzberg & Waters, 1990) this academic discourse did not appear promising because it mainly remains on the level of individuals or groups reaching decisions, without addressing the enacted collective patterns of decisions. Furthermore, the literature does not adhere to the pluralistic context of hospitals for which a paradox perspective appears more promising. Rooting the empirical insights in social systems theory I reanalysed the data along dimensions of decision premises to present bilateralism in a conference paper (Tuckermann, Lai, Mitterlechner, & Rüegg-Stürm, 2013) as a means to handle the paradox of differentiation and integration. Turning from this view to routines complemented the performative dimension that required revisiting the data. Given that bilateralism is an informal routine of private conversations renders data on its

performing difficult. At the same time and by engaging in the recent developments of paradox literature gave rise to the insight that bilateralism presents a collectively enacted paradox solution without it being designed deliberately (Clegg et al., 2002). In relating the poles of differentiation and integration, bilateralism should accomplish paradox latency, thereby helping to explain our observations on the executive board and its members' accounts. For the current text, I therefore revisited the original data of our observations on the executive board to detect the salience and latency of paradox, which are reported in the result section. Although the process involved several rounds of reanalysing and coding the data, the report only implicitly points towards the emergence of insight. After all "no analysis strategy will produce theory without an uncodifiable creative leap, however small" (Langley, 1999: 691).

4 Results: Accomplishing paradox latency during the hospital integration

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

4.1 The hospital integration process: an overview

The process of integrating Reho into Laho exemplifies how an organization-wide issue evolves. Over a period of nine years, Reho (a local primary care hospital) and Laho (a regional centre hospital) form a so-called hospital region under the name of Laho. At the end of the integration, the hospital region is called Laho, a hospital with two sites. In fall 2005, Horst, the CEO of Laho, reflects on the dynamic process in a research interview: *“I always maneuverer toward the vision I have in the back of my head. And like sailing on the lake you have to go with the wind and make detours in order to reach your destination.”* The figure provides a visual map followed by a brief description:

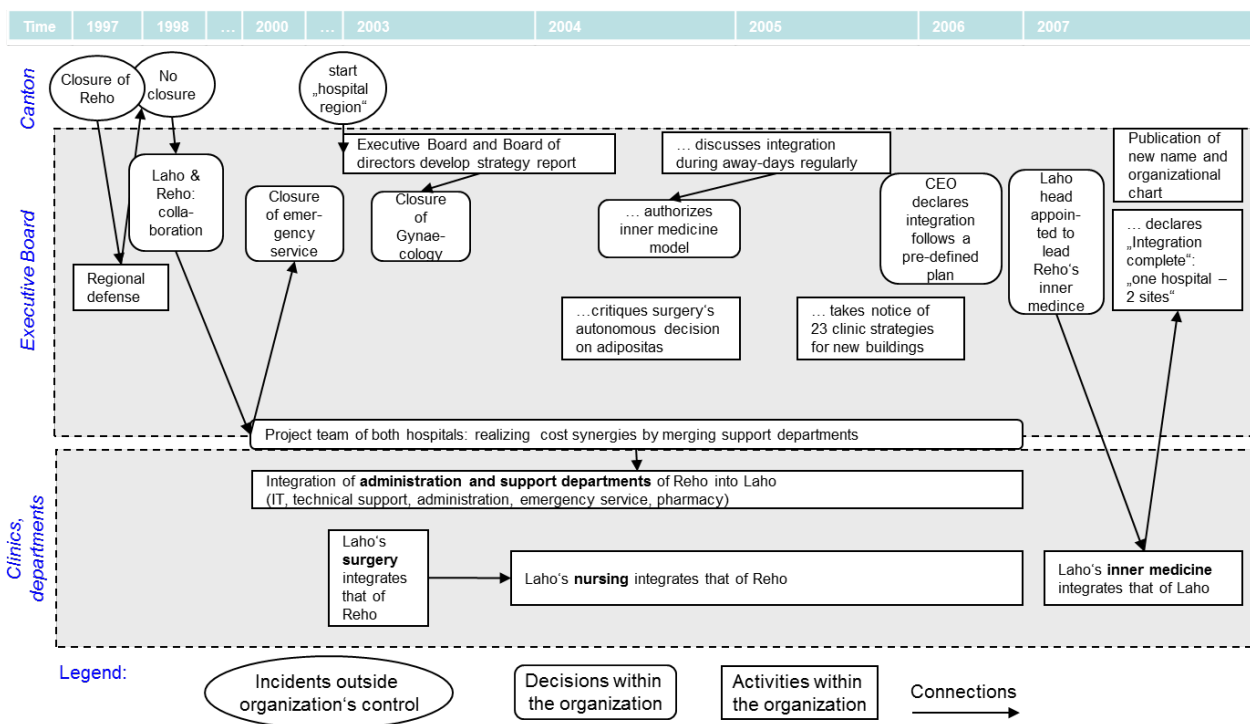


Figure 4-1: Integrating Reho into Laho

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

The surgery, the nursing and the internal medicine departments engage in the integration between 2002 and 2007 in their own ways (see result section 1). Laho's surgery clinic faces excess capacity, while that of Reho struggles with a lack of capacity. In March 2002, Laho rents operating rooms at Reho. With Reho's head surgeon departing three months later, Laho's head surgeon (John) takes over Reho's surgery clinic and declares its integration complete in the fall of 2002. In spring, 2003, John complains to Laho's nursing director (Nada) about Reho's surgical nurses. After a first attempt, Nada deploys Rachel as a change agent for Reho. In summer, 2004, Rachel is positioned along-side Reho's nursing director (Hector) and succeeds him in February 2005. Rachel initiates several changes at Reho. At the end of 2006, the integration ends. In summer, 2005, Laho's internal medicine department begins their integration initiative. After initial talks, concept developments and a waiting period, Laho's internists become active to integrate Reho once Reho's head internist retires. Internal medicine calls the integration

successful in 2007. With internal medicine integrated in 2007, the executive board of the hospital region declares “integration complete”. The yearly report (March 2008) adapts the surgeons’ slogan to “One hospital – two sites” to describe the general idea.

In line with the CEO’s observation, the unfolding events suggest that the integration is an emergent process rather than one pre-planned by the executive board. The process expresses that the executive board grants the initiative and expects it from the clinics and departments, acknowledging their respective autonomy. Each conducted the integration in its own way responding to different triggers, with different durations and ways of integrating. In retrospect, the executive board defines the organizational structure and the new name for the hospital region with declaring it a success.

4.2 Achieving paradox latency: shifting issues to private conversations, to projects, and diluting the issue

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

First, the decision of replacing the nursing director at Reho turns into a dispute between Laho’s nursing director and Reho’s CEO that shifts to a private conversation between the two. Second, the open issue of Reho’s status within Laho’s organizational structure transfers to a project, a pattern also observed in the discussion of the hospital’s strategic positioning. Third, the executive board addresses the surgeons’ Adipositas project at Reho. The project breaches the boundary of inner medicine and impacts on the integration process. It triggers the call to develop explicit rules of how to move such projects forward.

The executive board’s engagement with these issues shows that and how these issues exit the executive board without resolving them. The shift to private conversations, or to a projects, and the dilution of the issue explicate that and how the latency of paradox is accomplished within the executive board. Each incident is presented by introducing its

context, displaying the board's conversation, and analytically summarizing it by highlighting the salience of paradox and its latency within the executive board.

4.2.1 Transferring the issue of Reho's nursing director to a private talk

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

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

Table 4-1 Excerpt 1: shifting the paradox to bilateral conversation between the involved parties

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

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

Shifting conflictuous issues from a meeting to a private conversation appears to be typical at Laho. It occurs on other boundary-spanning issues. First, Pablo, the head of emergency care, describes the procedure of generating support to install the position of a clinical head for his unit. It required bilateral conversations with every clinic head: *“It took a lot talking to every single clinic head for an hour or two each. And sometimes, the clinic heads just wanted to place their wishes and worries, but without concessions on their part.”*

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

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

4.2.2 Subsuming the issue of hospital relation under emergency project

As a variation to the above transfer to private conversations, the following excerpt shows how *a conflictual issue shifts from the executive board to a project* while enlarging its scope. In the following excerpt, Robin raises the issue of clarifying the status of Reho in relation to the existing departmental structure of Laho. While Horst explains the ambiguity of this issue in terms of the external context, he appreciates Caitlin's suggestion to transfer the topic to a project with which the discussion ends.

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

Table 4-2 Excerpt 2: shifting the conflictual to a project after enlarging its scope

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

Nada, the nursing director, comments shortly after the above observation: *“It has never been clarified who is responsible for what and which hospital offers which services and what should we do jointly. Instead, we have a lot of “good-will” project groups that fiddle around with the topics but, the executive board so far has not clearly defined what the overall organization looks like and what the relation is of the departments, the clinics and all of them with the executive board.”* The status of Reho within Laho is finalized two years later, after the clinics and departments declare their integration complete.

Interview respondents depict the shifting of a boundary spanning issue to a project as a typical pattern within Laho. A first example reports Damian, the head of interdisciplinary medical services department, who explains how hospital management aimed to introduce process management along these lines (see appendix 6.1.6): *“To avoid disruptions, we subsume the process orientation under an information technology initiative and ask: how can we improve work processes through electronic devices? There, everyone thinks, ‘wow, that’s great, let’s do it!’ The idea behind it is of course a little bit different. But you have no chance if you want to sell the idea of process management directly.”* Horst, CEO of Laho repeats this pattern of subsuming the initiative under the revised labour law in 2006 (Merz, 2009). Legally required, the hospitals have to restrict the work hours of their assistant medical doctors. This resource restriction offers subsuming the process orientation under the implementation of the labour law. Horst, the CEO of Laho, comments: *“In the executive board, we knew that just telling the clinic heads to optimize their processes would not work. They just do not think in processes. At the same time, we need this thinking in the future. This is why we used the labour law initiative to place the topic of processes in the hospital.”*

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

Board member	1 st order construct	2 nd order concept	Aggregate dimension
Johannes, researching university professor	I would suggest creating an idea of the overall future hospital in which the inter-dependency of these different units becomes visible. This may help to identify important issues for decision while providing a background for the decision-criteria you want to apply.	Raising the issue of the whole by an external	Saliency of the paradox in the board
Pablo, member of the project team (head of the emergency unit)	For me these decision criteria are the number of treatments, the cost development, but also I find the implication for professional training of medical doctors relevant. ...	Responding to the issue	
Horst, CEO of	What interests me right now is the timing. When do we	Reframing the	

Board member	1 st order construct	2 nd order concept	Aggregate dimension
Laho	pursue which part in developing our hospital into the future? How do all these projects on the different parts play together on a time scale? What I would now like the group to develop is an action-oriented plan on how we proceed to make these images real.	issue on a temporal scale	
Gustav, president of the board of directors	I think we should define the future hospital image based on the patient processes. From there, we could develop alternatives and select the one that appears best to us.	Returning to the issue of the whole	
Consultant, who is hired to assist the project team	Thank you very much; we will do this in the project team.	Transferring the issue into the project team	Achieving paradox latency in the board
Horst, CEO of Laho	What I do not want is that the project team turns into some kind of closed shop, an elite group that determines the future of our hospital. I want that those affected by the future image will be included. I want an iterative process of including them and further developing the whole image with its implications for the buildings. The results need to remain open to change up to the last moment.	Enlarging the scope and calling to refrain from fixation	Garden thinking
Nada member of the project team (nursing director)	Horst, the problem is that the group then becomes too large to work with, but it remains too small to include all the viewpoints in this hospital. The current organization of our team is difficult. Just coordinating meeting times is already a daunting task.	Impracticability of enlarged scope	Achieving latency of paradox also in the project team
Caitlin, member of the project team (head of gastroenterology)	I find it important that possibly all will be included in this process. In addition, the different support departments and the second layer of leading doctors who then actually do most of the work within the clinics.	Further enlarging the scope	
Horst, CEO of Laho	We cannot overstretch it. I would involve the clinic heads, but not the others. But we really need to get started and have an action plan on how to proceed. Once the building process is under way, there will be the meat on the bones that gives as a more concise picture.	Limiting the enlargement; restating to refrain from early fixation	
End	At this point, the discussion ends and the members engage in informal conversations during the coffee break	No conclusion	
Meeting minutes	The official minutes to the meeting highlight that the executive board "took notice of 13 business concepts" of the different clinics and departments, however without referencing the above discussion regarding the relation of these parts to the whole (minutes 03.02.06, pp. 6ff)		

Table 4-3 Excerpt 3: shifting the issue into a project and enlarging its scope

These examples of shifting the undefined relation between Reho and Laho, the process optimization, or the strategic positioning to a project suggest the transfer as a typical pattern at Laho. The issue exits the executive board, which is reinforced by their omittance in the official meeting minutes. Furthermore, and by enlarging context of the issue, it risks dilution when working further on the issue. This risk is prominent in the second excerpt, while more implicit in the first one. Thereby, the potential salience of the paradox returns to paradox latency within the executive board.

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

The fourth excerpt provides a rare occasion in which the autonomy of clinics is challenged within the executive board. This time, the issue does not shift to a project or to private conversations. Rather the executive board discusses it more extensively. The excerpt also refers to the role of the executive in relation to the clinics and departments. At the end, the issue dilutes and does not enter the official minutes.

The issue is the initiative of “Adipositas” by John, the head of surgery. The “Adipositas” initiative involves a new treatment area for obese patients planned to be located at Reho. Besides surgical therapies, the Adipositas project includes a strong focus on treatment and therapeutic measures to help patients balance their weight. Thereby the project interferes both with inner medicine and with the integration process of the hospitals. The topic arises, after Martin, the CEO of Reho, finishes his presentation of the upcoming initiatives and projects at Reho to the executive board of Laho:

Board member	1 st order construct	2 nd order concept	Aggregate dimension
Caitlin, head of gastro-enterology	For me, Adipositas leans too strongly towards surgery. I suggest a more interdisciplinary approach. You need general practitioners for this kind of treatment, who are internists. In addition, they should be firmly embedded in their home discipline also to ensure their further training.	Articulating the breach in garden thinking	Paradox salience
Martin, CEO of Reho	Sure. However, my question is how do we proceed with Reho? Perkins, the head of inner medicine retires in two years. How do we continue from then on? Where are the areas of treatment that surgery, orthopaedics and inner medicine host at Laho and which ones do we have at Reho?	Enlarging the scope and raising the general issue	
Horst, CEO of Laho	This question surely is an allegation against us. But John, the head surgeon, causes this fait accompli of Adipositas. We conducted the process badly, but not with bad intentions.	Return to the issue	
Martin, CEO of Reho	Adipositas heavily depends on the clinic head. For Adipositas, we need infrastructure and equipment, because there are patients with 150 up to 300 kilos. We need different beds for them and a different infrastructure.	Questioning the location medically	Reframing
Torsten, head of anaesthesiology	I would not conduct surgeries on those patients at Reho. I would not install a centre at Reho for this kind of treatment.		Paradox salience
Martin, CEO of Reho	I have to give you a private lesson, Torsten. We are not two hospitals, but one with two sites. It is thus irrelevant where the after treatment takes place. You really have to let these larger dimensions of the hospital region enter your thinking.		
Torsten, head of anesthesiology	Still, I would not conduct such surgeries at Reho. You cannot do 200kg-surgeries there.		
Horst, CEO of Laho	In principle, I say that a clinic head develops his strategy. If the strategy requires many resources, we have to place the topic here in the board. Nevertheless, we are one hospital.	Attempt to clarify the relation between clinic and board	Garden thinking
Gustav,	Where is the instruction by the executive board or the board of	Raising the	Salience of

Board member	1 st order construct	2 nd order concept	Aggregate dimension
president of the board of directors	directors for the Adipositas project? I find it unsatisfactory that a clinic can start something and then just informs the executive board. That creates problems. Who is responsible to tell John what he can do and what not?	issue of decision-making authority	paradox
Horst, CEO of Laho	The answer to this question is clear to me. Telling him is a topic for the executive board as a whole.	Placing the issue in the board	Attempt to strengthen the whole
Gustav, president of the board of directors	We have to define explicit rules of the game here, like a clear distinction what belongs to Laho as the centre hospital and to Reho as the periphery. We need such rules of the game that also apply to clinic heads.		
Horst, CEO of Laho	Well, the whole integration is a tremendous learning process. We have to build on our successes there. With issues like Adipositas, we have to ask ourselves: how are we going to handle them?	Reframing the issue as learning, focus on success	
Sebastian, head of the HNO clinic	I appreciate this notion of the integration as a learning process, also within the executive board, and for the CEO as well. In general, I suggest having an initiative like Adipositas to be discussed here, but not decided here.	Refraining from responsibility	
Horst, CEO of Laho	I agree that also the CEO can learn here. However, there is a general tension. Handling John is not simple. In addition, I see you as clinic heads responsible because you can talk to him on a professional level whether Adipositas belongs to surgery or not. I would appreciate more support from your side in this.	Asking for board members to support the view of the whole	
Gustav, president of the board of directors	I think John cannot treat us like this, with just going for Adipositas and merely informing us once it is under way. We have to have some rules of the game here: who is doing what? In addition, if that is beneficial for the whole hospital, then we can go for it. On other topics, Reho has been also a good example.		
Martin, CEO of Reho	In my view, the general problem is the interdisciplinary collaboration. Strengthening that is the task of the executive board. Moreover, it is very hard to discipline Reho with all the parallel initiatives in different departments and clinics. In addition, we have to remember the political dimension, after we had the looming closure of Reho and the public demonstrations with the petition signed by 70000 citizens to keep Reho.	Refraining from responsibility and enlarging the context	Reframing and accepting the current situation
	End of the discussion.		
	The topic does not enter the minutes.		

Table 4-4 Excerpt 4: struggling with the paradox without further pursuing its handling

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

In discussing these issues, the executive board exchanges about its role in relation to the clinics. Sebastian refers to the general understanding of the executive board, when suggesting that such an initiative should be “*discussed here, but not decided here*” (see appendix 6.1.2). He thereby responds to the CEO’s invitation to discuss “*how to handle this issue*” of John bypassing the executive board. Insisting on the topic, Horst explicitly asks the medical board members to engage as medical professionals with the head of surgery and comments on the board’s lack of support. The board members do not respond to this comment. Rather, Martin who accepted Adipositas at his site justifies the surgical initiative by referencing the historical context of Reho and concludes that Reho is “hard to discipline”. His comment of enlarging the context to a general statement concludes the discussion. The paradox of differentiation and integration sinks back into latency and exits the board’s attention. In a later interview, Nada further explains that involving the executive board on an initiative like Adipositas would jeopardize the entire project: “*Adipositas would not go ahead if it passes through the executive board. There, you have to discuss it extensively and that can be a killer to motivation. ... Now, it is going to work. We will earn revenues and then nobody will say anything anymore.*” The clinic of surgery starts the Adipositas centre at Reho in spring 2005.

On the one hand, the Adipositas initiative is typical to Laho. Similar to the examples of revising the controlling system, introducing a centralized coordination of bed capacity, or establishing the position of the clinic head in emergency care, the Adipositas project generates commitment through a private conversation presumably between John and Martin. On the other hand, the discussion of the Adipositas project provides a rare example of the board explicitly discussing the relation among clinics and with the executive board. At this point, the paradox of differentiation and integration becomes salient. Often, such conflictual issues remain hard to communicate because of the “desire for harmony” reported above. Board members state, like Robin, the head of finance: “*It would be really – underlined three times- really helpful to genuinely engage in an open discursive struggle, and put the truth on the table within the executive board. But instead you have to watch out all the time, what you say.*” Likewise, the board members do not seem eager to move the issue of Adipositas forward in a way that explicates the relation between clinics and with the executive board.

4.3 Analysis: paradox latency as an active accomplishment

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

The following sections elaborate on the background of the illustrated excerpts and the hospital integration. First, I explicate the mutually held assumption of the clinics' and departments' autonomy at Laho. It fosters and impedes the hospital integration. This mutually held expectation points out the paradox of differentiation and integration. Second, this paradox mirrors how the members consider the executive board as hot podge of partial interests, but not as the space to move boundary-spanning issues forward. Third, I explicate the informal routine of "bilateralism". It serves as the enacted solution to the paradox of differentiation and integration alternative to the executive board. Fourth, the enactment of paradox latency associates with the role of the executive board. The paradox becomes latent therein while salient to its members. I summarize the analysis by concluding that bilateralism and the granted autonomy form a duality that stabilizes this hospital.

4.3.1 Mutually granted autonomy: enables initiatives but impedes integration and the executive board

At Laho, the clinics and departments mutually expect autonomy. Gustav, the president of the directors' board summarizes: "*the clinics run themselves*". Likewise, the CEO among others (see appendix 6.1.4) explains, "*The issues must originate from the units. You cannot just tell clinics top-down or from outside: 'You have to do it!'*"

Granting autonomy to clinics and departments adheres to the specialized expertise of each clinic and their knowledge-intensive work (Denis et al., 2007; Jarzabkowski & Fenton, 2006). Gabriel, the head of organization and infrastructure, explains: "*They [the*

clinic heads] have to develop their specialty so that they continue to be successful.” Accordingly, the executive board calls for and allows the clinics and departments to pursue their respective integration in their own way.

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

4.3.2 The executive board as a non-decisive hot podge of partial interests

In line with the mutual expectation of autonomy, the executive board members do not consider it as the space for deciding on issues of the overall hospital, despite its official role: *“The official version is that the executive board bundles all these different partial interests”* (Robin, the head of finance). In practice, the executive board appears to its members more of a hodgepodge of particular interests (see appendix 6.1.2).

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

Acknowledging the double role of its members, Horst, the CEO of Laho takes the executive board as a “sounding board”: *“In my view, it is a sounding board. When we try*

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

Across the executive board, its members do not consider it the space to move boundary-spanning issues forward. The four excerpts illustrate that and how conflictual boundary-spanning issues exit the executive board. Within the board, its members refrain from interfering with someone else's domain.

4.3.3 Bilateralism as a routine and a both-and approach to handle the paradox of differentiation and integration

As an alternative to the executive board, boundary-spanning issues are moved forward by an informal routine. The organizational members call it "bilateralism" (appendix 6.1.3). It provides the way through which they move an issue forward that spans the clinics' and departments' boundaries: *"The bilateralism is very formative here. Everybody looks with whom he can push something."*(Nada, nursing director)

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

Bilateralism is a means to generate support by involving the clinic or department heads through private conversations. The given examples are the establishment of the position as head of emergency, the revision of the controlling system at Laho, and the centralization of handling bed capacity. These issues span the boundaries of clinics and departments, and the actors pursue by private conversations first. *“Only after this preparatory work do we have a joint meeting”*, notes Horst in his story of bed capacity.

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

Bilateralism provides an alternative for handling those issues that are not considered resolvable within the executive board due to the mutual expectation of autonomy. Therefore, bilateralism serves as an enacted solution to the paradox of differentiation and integration. Bilateralism works on the premise that the different clinics and departments act relatively autonomous. Bilateralism allows pursuing issues that span the boundaries between the clinics by bilateral involvements of actors selected by the actor pursuing the issues. Nada, the nursing director, summarizes the underlying idea that relates bilateralism to garden thinking by elaborating on an image of neighbours: *“Well, you steal your neighbour’s apples (laughs). No, no, it is also like this: you would also borrow the lawn mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well.”* The notion of *“neighbour”* highlights the autonomy of different departments and the potential for cooperation, but rather on a one-to-one level in specific circumstances.

Bilateralism leaves the poles of differentiation and integration intact, thus representing a both-and solution to the paradox (see Lewis, 2000; Clegg et al., 2002; Smith & Lewis, 2011). At the same time and integral to bilateralism, handling the paradox involves

accomplishing its latency within the executive board. The latency is accomplished by shifting conflictual issues to private conversations, to projects or to let them dilute. In light of the paradox literature, bilateralism explicitly marks that the paradox is accepted within this organization as the underlying assumption of granting mutual autonomy due to the differentiation of the clinical and departmental knowledge-intensive work. The data presented here shows that the organizational members are aware of the paradox of differentiation and integration. However, bilateralism does not lead to confront the paradox. Such confrontation may occur in private conversation, but the interview respondents note this to be difficult (see appendix 6.1.5). Furthermore, and as the reported excerpts of the board's discussion suggest, confrontation is avoided within the executive board. Therefore, one could view bilateralism as a defensive response to the paradox (see Jarzabkowski et al., 2013; Smith, 2014). However, bilateralism does not evoke a vicious circle as these studies suggest. Leaving issues unresolved and ambiguous did also not become problematic neither to the hospital integration nor to the involved managers as may be suggested (see Abdallah et al., 2013; Denis et al., 2011).

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

- "*Who becomes involved* is up to the respective clinic or the department. Likewise, the CEO and non-medical departments approach others in a bilateral way, particularly on boundary spanning issues prone to be controversial – like the ones mentioned.
- *Topics (what)* mainly emerge from the respective actors, and their interests. To enter the organizational agenda more broadly, the executive board or meetings of clinic heads serve as a first resonance for "*sounding*" an issue. Alternatively, topics are subsumed under existing projects or attention with clinics is raised with the subordinates of a clinic head first.

- *Reaching support and commitment (how) occurs* in private conversations on a one-to-one basis before entering into a formal setting like the executive board. Addressing the diverse interests often takes a lengthy cascade of bilateral conversations and may require zigzagging towards the envisioned decision.
- *In terms of time (when)*, issues are triggered situatively and ad hoc by those actors with the concern, be that clinics, departments or hospital management. The period of generating commitment varies as actors reach agreements with their various counterparts.

4.3.4 Paradox latency in the board and salience with its members

Bilateralism describes the relation between the poles of the paradox of differentiation and integration. It thus depicts the enacted solution that also accomplishes the latency of the paradox. This accomplishment occurs in the group setting of the executive board. At the same time, the paradox is salient to the individual members of the executive board. They are quite aware of the tension between differentiation and integration. However, this individual awareness is clear in bilateral conversations like research interviews, but hardly in the group setting of the executive board (see appendix 6.1.5). As part of bilateralism, the “desire for harmony” limits the possibility to address conflictual issues openly (see excerpt 1). Accordingly, members and non-members of the executive board point out the incommunicability of potential conflicts or differences. Robin, the head of finances, states: *“It would be really – underlined three times- really helpful to genuinely engage in an open discursive struggle, and put the truth on the table within the executive board. But instead you have to watch out all the time, what you say in that setting.”* Instead and as part of bilateralism, such issues are transferred to private conversations. Even there, it is not always possible to raise them openly, as Pablo, the head of emergency care states: *“Sometimes, I really would like to tell my colleague clinic heads: ‘Come on. Let us put our cards on the table and tell each other what is really at stake.’”*

4.3.5 Theoretical summary: the duality of paradox and coordinating routine

The analysis shows that bilateralism is a routine that coordinates the actors who represent different clinics and departments. These share the mutual expectation to grant autonomy to one another. As a result, the executive board does not appear the space of

moving boundary-spanning issues forward directly. Alternatively, bilateralism compensates for this challenge of the executive board and handles the paradox of differentiation and integration in such a way that the paradox becomes latent. Boundary spanning issues like the hospital integration or other similar issues move forward within this organization by means of handling conflictual issues in private conversations, shifting them into projects or by leaving them unresolved.

The paradox of differentiation and integration therefore requires bilateralism as a routine and both-and solution that leaves the poles intact. At the same time, actors draw on the assumption of clinical and departmental autonomy to explain the coordinating routine of bilateralism (Feldman & Orlikowski, 2011). As both require one another they form a duality, with duality defined as two components that are complementary albeit potentially contradictory (Farjoun, 2010). The paradox requires the routine, and the routine reproduces the paradox by handling it. Like the paradox of differentiation and integration, the coordinating routine resonates with the clinics and departments it relates through the assumption of mutually granted autonomy. Bilateralism accomplishes the latency of paradox through shifting arising tensions to private conversations, into projects or by diluting them. It maintains ambiguity leaving conflictual issues unresolved at the time of their salience (Abdallah et al., 2011; Smith, 2014). The following figure depicts graphically the relationship between founding paradox and coordinating routines with the effect of the paradox's latency:

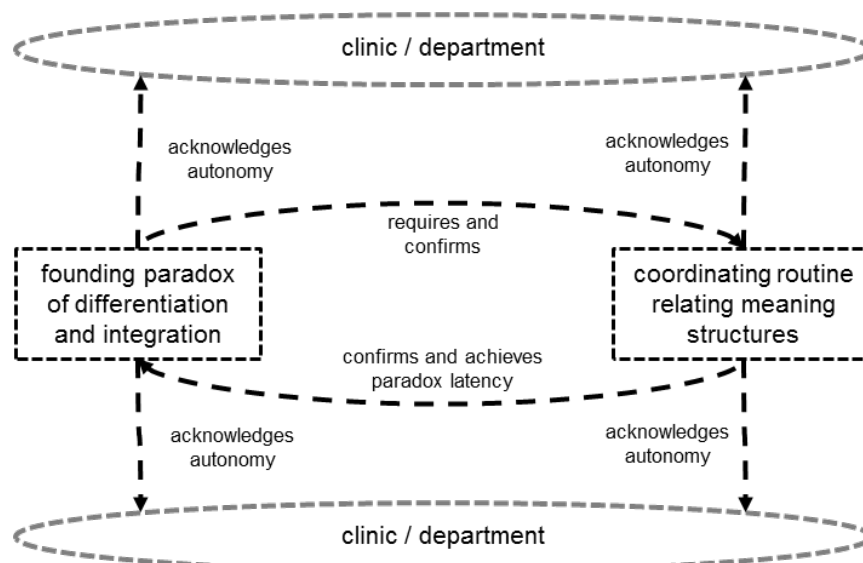


Figure 4-2: Paradox and coordinating routine in a pluralistic setting

The duality of the paradox and the coordinating routine illuminates on how this pluralistic organization achieves stability. The stability results from at least five reasons: First, accomplishing a boundary spanning issue reaffirms that bilateralism works. Nada, the nursing director summarizes: *“But for the time being it works It works with some pains we can handle.”* Such pains occurred in the Adipositas initiative for example without jeopardizing the initiative (see excerpt 3). In addition, the hospital integration proved the benefits of bilateralism. Horst says: *“the politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted and I need this support to really do something.”*

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

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

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

Fifth, bilateralism stays in place even when there is a call for explicit rules to coordinate clinics and departments with one another and with the executive board. Besides the benefits for the involved and its informality, there is the following catch: Explicit rules would have to be developed within and through bilateralism. Doing so would be a contradiction in terms (Barrett et al., 1995). Developing more explicit rules would imply to enact the informal private conversations to generate commitment in order to change this very routine. Attempting to change bilateralism by enacting it would demonstrate that bilateralism works.

For these reasons, I consider the duality of the paradox and its coordinating routine as a theoretical mechanism to explain the stability of pluralistic organizations as an active accomplishment (Denis et al., 2001). My findings therefore provide an insight into how pluralistic organizations “hang together” (Kraatz & Block, 2008: 257), despite unsuccessful sensemaking (Ericson, 2001), divergent interests (Jarzabkowski & Fenton, 2006), escalating perpetuating conflicts (Bate, 2000), escalating in-decision (Denis et al., 2011), diluting change initiatives in various ways (Lozeau et al., 2002), resistance (Kellogg, 2011); or difficulties to learn from failures (Edmondson et al., 2001), or undermining effects of previous decisions on current ones (Denis et al., 2001). The duality of the paradox and the coordinating routine creates stability. The duality serves as a bootstrap (Barnes, 1983) by which the studied organization pulls itself out of the mud that it re-creates through its founding paradox (Putnam, 1986). This continuous pulling is achieved with a coordinating routine like that of bilateralism. Bilateralism thereby adds to the insight of Denis et al. (2001) that the leaders require the consent of the led in that it shows how this is accomplished.

5 Discussion: the coordinating routine and the paradox as a duality that accomplishes latency

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

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

These insights imply three contributions to the paradox lens: First, the coordinating routine of “bilateralism” handles the paradox of differentiation and integration, in a both-and way. It serves to move boundary-spanning issues (integration) forward while leaving the different clinics and departments (differentiation) intact. As a routine, it emerged from the situative practice and prior to managers’ attempts of deliberately handling paradox.

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

Third, the coordinating routine and the paradox form a duality that helps to explain their persistence within the organization, supported by the informality of the routine and its resonance with the different clinics and departments by acknowledging the respective autonomy.

Extending *routine dynamics* to pluralistic organizations, this study also contributes to the emerging interest of relating routines by identifying a coordinating routine that relates routines (Parmigiani & Howard-Grenville, 2011). Furthermore, the empirical insights underscore the theoretical argument within routine dynamics of mutually held

expectations as a condition for recognizing a routine, thus specifying what a shared understanding means (Dionysiou & Tsoukas, 2013; Feldman & Rafaeli, 2002).

5.1 Contribution 1: the coordinating routine as an un-designed solution

The first contribution is that the coordinating routine of “bilateralism” handles “garden thinking”, the paradox of differentiation and integration, in a both-and way. As a routine, bilateralism emerged from the situative enactment prior to managers’ attempts of deliberately handling the paradox. Rather the routine draws on the mutually held expectation that knowledge-intensive work associates with mutual autonomy.

In comparison, the paradox literature hardly explores the prior and situatively enacted solution of a paradox. Empirical studies rather focus on deliberately handling paradoxes once they have become salient and invite acting upon them (Beech et al., 2004; Luescher & Lewis, 2008; Jarzabkowski et al., 2013; Jay, 2013). Their and others’ conceptualizations (Smith, 2000; Smith & Lewis, 2011; Lewis & Smith, 2014) hardly incorporate the prior solution of the paradox under study. As an exception, and investigating the paradox of exploration and exploitation, Andriopoulos & Lewis (2009) mention the prior solution of handling the contradictory relationship of the two poles on the level of “personal drivers” (ibid., 705f.), in loose and tight coupling with customers and on the company’s strategic intent to combine exploration and exploitation. The data reveals the contradiction between the poles, but lacks detail on how the contradiction was handled within the organization. For instance, handling loose and tight customer relations is mentioned to involve “purposeful improvisation” (ibid. 705) without providing a detailed account of how it occurred. Likewise (ibid, 703) a ‘pragmatically idealist vision’ is found to help combine both exploration and exploitation as the strategic intent. In light of my findings, such a vision would be sufficiently broad and ambiguous to allow the actors to handle issues of tension in situ.

As a starting point, the relational view of paradox argues that the opposing poles of a paradox relate in a mutually constitutive way, which is enacted situatively, and locally (Clegg et al., 2002). These authors elaborate on individual actors relating structure and action through improvisation. Coordinating routines help to extend from the individual

level because routines coordinate and relate different actors (Feldman & Rafaeli, 2002; Ockhuysen & Bechty, 2009) and different routines (Jarzabkowski et al., 2012).

In my case, bilateralism exemplifies such a coordinating routine. It relates the opposing poles of differentiation and integration. This routine serves to move boundary-spanning issues forward. It expresses the emerged solution to the paradox that has hardly been considered in the paradox literature. My insight therefore complements the existing literature by illuminating on the solution to the paradox that is enacted prior to its salience and deliberate change.

Attending to the solution that an organization or its members collectively enact provides important insights for those who aim to design and to embed proposed solutions to paradox (Smith, 2014; Luescher & Lewis, 2008; Jay, 2013; Jarzabkowski, et al., 2013). Such a proposed solution differs from the enacted one. At the same time, the proposed solution enters the organization through the enacted solution. In my case, the proposal to change from bilateralism to rules implies to move this issue forward bilaterally. This is the case because the enacted solution continues to relate the opposing poles situatively and locally (Clegg et al., 2002), while proposing its own change. Proposing a solution to a paradox is therefore self-contradictory. A proposed solution means to alter an enacted one, and attending to the latter helps to explain why embedding paradox solutions is a current open issue in the literature (Smith, 2014; Luescher & Lewis, 2008).

5.2 Contribution 2: the coordinating routine achieves paradox latency

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

Within the paradox lens, paradox latency is central to the general assumption that paradoxes are integral to organizations. So far, we have learned of the conditions for paradox salience such as plurality, change, and resource restriction (Smith & Lewis, 2011; Smith, 2014). Prior to such circumstances, a paradox is said to “remain latent” (Lewis & Smith, 2014: 7), outside the attention (Clegg et al., 2002: 488), and dormant

until an issue triggers its awakening (Pratt & Foreman, 2000: 20, Footnote 3). However, the literature assumes latency, but hardly explores empirically what it means, to whom it applies and how it is achieved. Paradox latency remains latent in recent theoretical models. These include latency mainly as their starting point (Smith & Lewis, 2011; Jarzabkowski et al., 2013; Jay, 2013; Luescher & Lewis, 2008).

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

These insights of paradox latency as an active accomplishment help to advance the paradox lens in three ways: First, and conceptually, showing paradox latency as an active accomplishment strengthens the central assumption that paradoxes are integral to organizations. So far, we assumed paradoxes to remain latent, but without illuminating on how to accomplish latency.

Second, accomplishing latency is more nuanced than the literature broadly assumes. So far, some literature suggests that latency implies organizational members to be unaware of paradoxes (Luescher & Lewis, 2008; O'Connor, 1995; Westenholz, 1993). My insights show that the organizational members may be well aware of the paradox, but collectively enact its latency as part of their routinized collective performance to handle the paradox.

Third, accomplishing latency as integral to the enacted paradox solution implies that paradox latency influences proposed solutions. Recent empirical studies and theoretical models tend to suggest that paradox remains salient once organizational actors engage in handling it (Smith & Lewis, 2011; Lewis & Smith, 2014; Jay, 2013; Jarzabkowski et al., 2013). However, responses to paradox and their dynamics hardly address this point explicitly and do not explore whether proposed solutions also contribute to paradox

latency. Only Clegg et al. (2002: 488) note that “choosing and finding a balance between the two extremes of a paradox or replacing that tension with a synthesis helps managers to push important dynamics *out of the realm of attention*.” Abdallah et al. (2011) contains a similar hint as they explore how managers use “quasi resolution to conflict” (ibid, 340) and “strategic ambiguity” (ibid, 342) “so that contradictions or paradoxes that were previously seen as intractable *appear to be dissolved* or overcome.” (ibid, 335, emphasis added).

In sum, I suggest to consider paradox latency as an active accomplishment that is performed collectively (see Beech et al., 2004; Luescher et al., 2006) even if the paradox is salient to individual members. If paradoxes are integral to organization, so is paradox latency. The organization is “driven by the continuous need to handle this paradox and thus tends to oscillate between visibilizing and invisibilizing [it]” (Schoenenborn, 2011: 674) as it moves organizational issues forward that span the boundaries of the differentiated subsystems. Thus, paradox latency not only serves as a starting point of theoretical models. In addition, paradox latency is integral to the enacted solution of a paradox and suggests that it plays an important role also in proposed solutions to paradox.

5.3 Contribution 3: the duality of paradox and coordinating routine

The third contribution is that the coordinating routine and the paradox form a duality. This mutually constitutive relationship helps to explain their persistence. The informality of the routine and the acknowledgement of the mutual autonomy forsters the persistence. At a minimal level, the paradox and its enacted routine solution provide core components to understand a pluralistic organization as a paradoxical one.

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

integration (Andriopoulos & Lewis, 2009), or consistently inconsistent decision-making (Smith, 2014) as temporal or so-called workable solutions (Luescher & Lewis, 2008).

As a meta-theoretical framework (Lewis & Smith, 2014:8) the paradox lens argues, “paradoxical tensions reflect polarities that are interrelated aspects of a *greater whole*”. (Lewis & Smith, 2014: 8, emphasis added). To picture the greater whole, Lewis (2000: 762f) employs the Yin and Yang metaphor, and explicates that the polarities “obscure the interrelatedness of contradictions” (ibid, 762). Thus, shifting to one pole of the paradox will eventually lead to a reverse development to the other pole (ibid, 763). In correspondence with the empirical studies, the greater whole indicates the paradox, although many studies emphasize the tension and less the complementarity of the different poles (Jay, 2013; Jarzabkowski et al., 2013). There are few works that specify the relationship between these poles comprehensively (see Clegg et al., 2002).

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

The routine of bilateralism reveals the patterned relationship between the poles of the paradox of differentiation and integration in the studied organization. The routine itself is enacted locally. It emerged from the ways of acting without being deliberately designed (Clegg et al., 2002: 488). At the same time, the coordinating routine refers to the paradox thus providing the reason for its persistence. I therefore suggest that the paradox and the coordinating routine identified form a duality.

The proposed duality of the paradox and the coordinating routine provides a means to depict a pluralistic organization in terms of paradox. Pluralistic organizations involve the characteristics of knowledge-intensive work processes, ambiguous power relations and diverse strategic interests (Denis et al., 2001; Denis et al., 2007, Jarzabkowski & Fenton, 2006). Pluralistic organizations thereby relate different worldviews (Glouberman & Mintzberg, 2001; Jay, 2013). This is why I argue for a paradox lens to approach pluralistic organization and am interests in the one on differentiation and integration. Within the paradox literature, however, precedence is given to the tension between the pluralistic components, or subsystems, thus underscoring the importance of their complementarity and leaving their ability to hang together under researched (Kraatz &

Block, 2008). The identified coordinating routine of bilateralism helps to address this open issue. It provides a means to move boundary-spanning issues forward and draws on the expectation of the different subsystems to acknowledge autonomy. Since the identified coordinating routine relates with the paradox in a mutually constitutive way, this duality provides mechanism to theorize a pluralistic organizations, which includes the descriptive characteristics known to the literature.

The duality of a paradox and a coordinating routine to depict a pluralistic organization implies the following to the paradox literature: First, the duality strengthens the paradox lens. Paradox is not only integral to organizations (Smith & Lewis, 2011), but also a pluralistic organization can be viewed as an expression of the paradox and its handling. With the duality, we gain a view of organization as paradoxical (Schoenenborn, 2011) that complements the existing one on paradoxes in the context of an organization.

Second, the duality implies to reconsider the role of leaders and managers. Among others (Ford & Backhoff, 1988; Luescher & Lewis, 2008), Lewis & Smith (2014: 5) argue to place “substantial responsibility on senior leaders to enable the interplay between differentiated efforts and see more holistic synergies...”. Considering the organization as paradoxical, these senior leaders already act within the duality of a paradox and its enacted solution. Without considering this prior solution, we miss that their efforts respond to the enacted solution. This is why leaders’ attempts of handling of paradoxes may undermine their very aim: “action aimed at resolving issues creates new dilemmas that seem to undermine this resolution” (Abdallah et al., 2011: 334).

Third, viewing the organization as paradoxical shifts our attention on problematizing stability and invites researchers to explore how stability is accomplished before we engage in investigating attempts to change such a temporally fixated arrangement. This path corresponds, first, with pluralistic organizations. They problematize stability by definition and thereby call for exploring how they avoid disintegration (Kraatz & Block, 2008). Second, this path expresses a processual perspective that emphasizes organizations as temporal social orders that emerge from fleeting events as active accomplishments (Feldman, 2000; Hernes, 2008). Furthermore, my study shares the dynamic view called for by Jarzabkowski et al. (2013). These authors show the dynamic relation between paradoxes. They relate paradoxes found on the individual, the group and the organizational level in a mutually reinforcing way. Complementarily, my

findings and insights reside with one paradox and its enacted solution. The duality they form emphasizes how stability is accomplished. In addition, my study complements Jay (2013) who shows how the top management team works through paradox by re-inventing their organizational understanding. My study shows the other side of this coin, patterns of how to avoid such a process.

In conclusion, the organization would not exist without a situatively and locally enacted solution to the foundational paradox (Clegg et al., 2002). The empirical investigation elaborates on this situative performance of the solution to the paradox within the top management team attuned to the accomplishment of paradox latency.

5.4 Concluding reflections

This text explores the stability of a pluralistic organization. I build on the paradox literature that emphasizes a dynamic (Jarzabkowski et al., 2013), processual (Jay, 2013; Abdallah et al., 2011), and relational view (Clegg et al., 2002) of the mutually constituting poles. These works broaden the common focus on the tensions between the poles to include their complementarity. Furthermore, the relation between the poles emerges generically in situative and local action without design (Clegg et al., 2002).

Routine dynamics helps to elaborate on the relation between the poles. Routines coordinate different actors (Feldman & Rafaeli, 2002; Dionysiou & Tsoukas, 2013) and routines with organizational understandings (Rerup & Feldman, 2011). As enacted coordination, routine dynamics complements the paradox literature that focuses on handling paradoxes once they have become salient (Luescher & Lewis, 2008; Andriopoulos & Lewis, 2009; Beech et al., 2004). Routine as coordination attends to the enacted solution when the paradox is assumed to remain latent (Smith & Lewis, 2011; Lewis & Smith, 2014; Smith, 2014). Although paradox latency is a core component to the paradox lens, it remains vague in what it means, where it occurs and how it works. Thus, I pursue the *research question*: how does a pluralistic organization handle paradox and accomplishes its latency?

The empirical results show a coordinating routine. It handles the paradox of differentiation and integration while accomplishing paradox latency within the executive board, despite the paradox's salience to its individual members. The coordinating routine

of “bilateralism” is a means of moving a boundary spanning issue forward without interfering with the clinic’s and departments’ autonomy. My analysis shows that bilateralism is a routine that handles the paradox of differentiation and integration. This routine draws on the paradox and reproduces it at the same time. Both form a duality.

These insights offer three contributions the paradox lens. First, the coordinating routine provides a both-and way of handling the paradox. It relates the poles of differentiation and integration, and it emerged not as a deliberately designed solution but as one that is enacted situatively (Clegg et al., 2002; Jarzabkowski et al., 2012). Second, the coordinating routine accomplishes latency by transferring conflictual issues into a project or to a bilateral conversation or by diluting the conflictual issue. Paradox latency is not only a conceptual assumption, but also a collective accomplishment, even if the paradox is salient to the individual members. Furthermore, paradox latency gains importance in deliberate attempts of handling paradoxes because it shields the enacted solution from deliberate change attempts. Third, the duality of the coordinating routine and the paradox suggests considering a pluralistic organization as paradoxical. I thereby offer a specification of the pervasive Yin and Yang metaphor that considers the poles of a paradox as forming a greater whole. This greater whole is the organization composed (at least) of the paradox and the coordinating routine. Further building on a processual view within the paradox lens (Jarzabkowski et al., 2013; Jay, 2013; Abdallah et al., 2011), this text expands from viewing opposing poles in tension towards their enacted solution as actively accomplished and made latent.

Reflecting on this research reveals several limitations, three of which are the following: First, the study is on a single organization. Thus, generalizing is limited (Langley, 1999), despite engaging in several initiatives and analysing them systematically which yields specificity and accuracy. It therefore invites future research on pluralistic organizations to depict their coordinating routines to handle plurality, thus enriching our understanding both of handling paradoxes, accomplishing latency to further illuminate on what holds these organizations together.

Second, my results mainly focus on the ostensive dimension of the coordinating routine. The reported incidences show the mutual constitutive relationship between the founding paradox and the coordinating routine. My results demonstrate the pervasive use of the coordinating routine by drawing on examples and illustrations from other topics.

However, the case is limited as to their recursive relationship for which one would display over time, how the paradox and the coordinating routine reproduce each other repeatedly. This was difficult due to the informal character of bilateralism. The label bilateralism indicates that agreements and commitment evolve in private conversations. They render it difficult to observe the routine's performance. Gustave, the directors' board's president states: "*With their high degree of inter-relations and with their continued high autonomy, a lot of issues go through the informal networks of personal relations between the clinics*". Nevertheless, bilateralism qualifies as a routine for three reasons: First, interviews that are rather private conversational settings themselves reveal that the coordinating routine is known across the organization. Respondents of different clinics and departments openly reported on its enactment within this organization. Accordingly and second, the comparison with our other case studies revealed the enactment of bilateralism. Third, we validated bilateralism and its relation with the paradox of differentiation and integration by conducting a one-day workshop with the executive board. Its members confirmed: "*These are the rules of the game around here*" (Torsten, the head of anaesthesiology). Likewise, Nada, the nursing director states: "*Yes, it works like that. It works, with some pains and all, but we can handle that*". Therefore, and for this hospital, the specific coordinating routine presents the way in which this hospital pursues organization wide topics. Future research could address this direction and thereby enrich our insights on how a founding paradox becomes latent over time.

Third, the focus is on how a pluralistic organization achieves stability given the autonomous and different actors, clinics and departments by means of an informal coordinating routine. In the research, I followed the practitioners' emphasis on such a pattern, than on more formalized ones. Future research could extend on their relationship in more detail and enrich the accomplishment of stabilizing a pluralistic organization, while incorporating the use and role of artefacts in such a process.

This research is but a starting point to understand today's challenges as organizations tend to become increasingly pluralistic (Kraatz & Block, 2008; Denis et al., 2007). Therefore, Putnam's (1988: 166) call still holds: "*With continued research, perhaps we can discover how organizations pull themselves out of the self-made quagmires by their own bootstraps.*"

6 Appendix: data tables and vignettes

The appendix contains additional data and vignettes in the order of their reference in the text. The following sections follow the previous chapters

6.1 The perceived role of the executive board

Interview Partner	1 st order construct	2 nd order concept	Aggregate dimension
Nada, nursing director	All members wear two hats, if you want to say it that way. They have to look after their own department; and at the same time, we are responsible for the entire hospital	Double role of members	separate interests within the hospital but hardly the decision-making body
Caitlin, head of gastroenterology	We are all wearing two hats, and everyone knows this. It becomes a bit difficult then.	Double role of members	
Gabriel, head of organization and infrastructure	The challenge for the members of the board is the following: 'do I think now for the whole hospital or do I think for myself and my clinic? Is it better to push my pet project or do I pursue the overall benefit?'	Oscillating between the part and the whole	
Torsten, head of anaesthesiology	Reflects on the away-day in which we validated bilateralism: „I think, in the board, everyone talks strategically with his own agenda in mind.“	Double role of members	
Robin, head of finances	The official version is that the executive board bundles all these different partial interests. Everyone will tell you that.	bundling the separate interests	
Gabriel, head of organization and infrastructure	I believe that it is important for the executive board to draw on a broad base of preferably all the different views and interests. If we had a single person at the top it would not work. The air up there is very thin, and he would be very lonely. Thus, the broad support is essential, but it does not mean that someone needs to take decisions.	Representation of interests	
John, head surgeon	In the end, the executive board represents individual interests.	Pursuing „Particular intercession“	
Horst, CEO of Laho	<i>In my view, it is a sounding board. When we try to do something for the hospital as a whole, I can sense here how the different clinics and departments may react and whether the time is right for an initiative or not.</i>	Body to sound ideas with the separate interests	
John, head surgeon	<i>A decision-making body with ten people cannot decide. And therefore it does not decide anything. Because everyone looks after his own garden</i>	No decisions in the board made	
Sebastian, head of HNO (throat, nose, ears)	The board meetings are supposed to serve the legitimization of issues and projects, but not the place of defining strategies.	A body to legitimize decisions officially	
Robin, head of finances	But, you cannot compare this executive board with one you find in private companies, the one I was a member before coming here. Where I was before, the board had the right to coercively define what was to be done. Such a right does not exist here, not even slightly. You cannot tell the clinics or departments what to do. That does not work.	You cannot tell the clinics what to do	

6.2 Bilateralism

Interview partner	1 st order construct	2 nd order concept	Aggregate dimension
Nada, nursing director	The bilateralism is very formative here. Everybody looks with whom he can push something	Bilateralism, informal networks	Ubiquity of bilateralism
Nada, nursing director	Many issues are handled bilaterally. If you have to incorporate all the different opinions you lose momentum. When I think of some clinic heads, they act like lightning. 'I want it, and I want it right away'. Then they are active and really do a lot. But placing their topic in the public so that everybody else contributes his opinion may kill the motivation."	Topics emerge from the clinics Moving topics forward with bilateralism	Who, and how of the routine
Nada, nursing director	The surgical Adipositas center – if this project had taken the way over the hospital management, it would have been killed. But it has been initiated and introduced via bilateral discussions and agreements. And now it works and nobody will say anything." (NM, 585, 599)	Moving topics forward with bilateralism	How of the routine
Nada, nursing director	We will need some time until biological solutions kick in ... but then, I think, we clearly have to address this change. But for the time being it works. After all, we are not a turnaround case. It works with some pains we can handle	Bilateralism works	Legitimacy of the routine
Nada, nursing director	"Well, you steal your neighbor's apples (laughs). No, no, it is also like this: you would also borrow the lawn-mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well."	Collaboration on one-on-one	How of the routine
Pablo, head of emergency care	It took a lot talking to every single clinic head for an hour or two each. And sometimes, the clinic head just wanted to place their wishes and worries, but without concessions on their part.	Separate clarification takes time and invites wish-lists	How / Who of the routine
Pablo, head of emergency care	You have to be tough but also diplomatic. You must know that the shortest path between two points is not a straight line. You need to keep your goal in your own view and then look how to reach it, without losing too much along the way. But if you are just tough and tell the others: 'That's it, that is what I want and that is what I do not want' You do not get anywhere. In principle, you have to be like a gas. I mean you have to bend, but a gas does not break.	Reaching agreements	How of the routine
Horst, CEO of the hospital region	The issues must originate from the units. You cannot just tell clinics top-down or from outside: 'You have to do it!' Instead, a topic must originate bottom-up. It needs to address the clinics' demands. And with some incentives for enhancing collaboration you can move it forward, and coordinate it from the top. But in essence, topics need to grow from the bottom.	Topics require to be driven by the clinics	Who / What of the routine
Horst, CEO	Horst, Laho's CEO, develops the issue of establishing a centralized handling of patient bed capacity across the clinics: "Bed capacity is a hot issue. You only have a change with it, when talking to every clinic head in private first. If you approach them jointly, you get a collective 'no'. I talk with them one-by-one about the possibilities, their worries and how to handle them. I thus sense where the resistance may come from and where I might have support. Only after this preparatory work do we have a joint meeting where I will discuss the give-and-take for every clinic that comes along with coordinating our bed capacity centrally."	Reaching individual agreements before entering a collective setting	How / Who of the routine
Robin, head of finances	Here, I have to sell the clinics a revision of our financial controlling system which they generally refuse. It is really	Reaching agreement	Who of the routine

Interview partner	1 st order construct	2 nd order concept	Aggregate dimension
	difficult to get the surgeons and the internists into this single boat. You have to circle around and around so that it fits, and that takes a lot of time ... I get the senior physicians (Oberärzte) and leading doctors into a working group because they run the wards on the shop floor. After they understand the benefits for their own work in the clinics, I approach their superior.	with those with a concern	
Gustav, president of the board of directors	The clinics run themselves. With their high degree of inter-relations and with their continued high autonomy, a lot of issues go through the informal networks of personal relations between the clinic.	Informal networks	Who / How of the routine
Horst, CEO	With the integration, Johannes and you criticized that we lacked a clear concept and transparent plan. Looking at it from the organizational view, I agree. But, I always manoeuvred toward the vision I have in the back of my head. And like sailing on a lake you have to go with the wind and make detours at times in order to reach your destination. Look, Harald, the politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted and I need this support to really do something	Achieving accepted results	Success of the routine

6.3 Mutual autonomy as Differentiation

Interview Partner	Data excerpts	2 nd order concept	Aggregate dimension
Nada, nursing Director	„Everyone cultivates their own garden, the surgeons, the internists and the administration. ... Ultimately the members in the executive board represent particular interests.”	<i>Partial interests, Garden thinkin</i>	Differentiation
Nada, nursing director	When I think of some clinic heads, they act like lightning. ‘I want it, and I want it right away’. Then they are active and really do a lot.	Clinic heads’ initiative	
John, head of Surgery	Everyone looks after their own garden, the internists, the surgeons, and the administration	Attention to one’s own interests	
Damian, head of interdisciplinary medical services	This is how the medicines have developed, with increasing specialization and this specialization manifests in the different clinics with their respective associations and titles	Specialization	
Robin, head of Finances	You have to let the clinics have their individuality. It is essential to ensure their professional work of treating patients so that they can obtain the most also for the entire hospital	Individuality of the clinics	
Robin, the head of finances	“Where I was before, the board had the right to coercively define what was to be done. Such a right does not exist here, not even slightly. You cannot tell the clinics or departments what to do. That does not work”	Board lacks hierarchical power	
Pablo, head emergency doctor	There are clinics that put their own interests first and not that of the whole hospital. It becomes difficult then because you cannot throw this truth to their heads directly.	Incommunicability of partial interests	
Gabriel, head of organization and infrastructure	Of course in the board we first have to think in terms of the entire hospital. But that is not so often the case for the clinic heads. They have to develop their specialty so that they continue to be successful.	Clinics can think of their own best	
Horst, CEO of the hospital region	The clinics run themselves. With their high degree of inter-relations and with their continued high autonomy, a lot of	Independence of clinics	

Interview Partner	Data excerpts	2 nd order concept	Aggregate dimension
	issues go through the informal networks of personal relations between the clinic heads.		
Gustav, president of Board of Directors	Personally, I believe that the clinics discuss the topics among themselves, and that is done in private one-on-one conversations. ... And you cannot really see how that works in detail. We just have a very strong autonomy of the clinics at Laho. Damned a lot is done informally here.	Bilateral agreements	

Table 1: garden thinking of autonomous differentiated clinics in relation to the executive board

Interview Partner	1 st order construct	2 nd order concept	Aggregate dimension
Sarah, project manager for developing the hospital strategy	It is clear that tearing down the walls between the clinics and opening ab the view to the whole organization becomes essential. But it still is a learning process.	Necessity for collaboration between the clinics	Integration
Nada, nursing Director	"Well, you steal your neighbor's apples (laughs). No, no, it is also like this: you would also borrow the lawn-mower, and you would water the other's plants and trim his roses. Well, garden means: you need someone to take care when you are away. And that happens as well." „	Collaboration possible	
John, head of Surgery	Many clinic heads cannot yet imagine, that we would be better of collectively, more efficient, faster, and more profitable.	Challenge of interdisciplinary collaboration	
Damian, head of interdisciplinary medical services	At the same time, there must be a close contact relation between the clinic and the overall organization. How that works needs to be clarified with the different clinics in detail. If we do not do that, we will end up with a mere collection of specialized clinics ... This is the daily challenge of leading a hospital to ensure this relation between the part and the whole.	Necessity for the embedding into the whole organization	
Robin, head of Finances	The challenging goal is to develop a different relationship between the clinics and my finance department ... The medicines and the administration have to work as partners	Needed collaboration between clinics and administrative departments	
Gabriel, head of organization and infrastructure	To cover yourself the patient benefit always works if you have nothing left as an argument. But I ask myself, who represents their genuine interests here. I doubt that we are really organized to the patients' needs. But of course there are ways to enhance that like with the interdisciplinary treatment centers we are setting up right now. But then, we encounter the next challenge internally: do we position these centers independently, or subsume them under a certain clinic? And how do we decide on that question?	Enhancing interdisciplinary collaboration through creating centers	
Horst, CEO of the hospital region	Look, Harald, the politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted."		
Gustav, president of Board of Directors	We have it in our strategy report to Kanton's government that we need to enhance the interdisciplinary cooperation. But I am unsure how that really works. There is quite some way ahead of us.	Need for more collaboration between the clinics	

Table 2: Integration on hospital-wide issues

6.4 Incommunicability of (potentially) conflictuous issues

Interview Partner	Data /description	2 nd order concept	Aggregate dimension
Torsten, head of anaesthesiology	There is a strong desire for harmony here at Laho. That is a big difference to, let us say, a private company. Here at Laho, you try to avoid interfering with someone else's domain, and rather try to stay in harmony with one another.	Avoiding interference with the domain of others	
Horst, CEO Laho	The politicians praise us for the integration, because there was no public uprising, the doctors remained quiet and are satisfied now. The integration is widely accepted and I need this support to really do something	Success means a calm initiative	
Robin, head of Finances	It would be really – underlined three times- really helpful to genuinely engage in an open discursive struggle, and put the truth on the table within the executive board. But instead you have to watch out all the time, what you say.	Incommunicability of differences	
Nada, nursing director	I can be straight and emotional in my office. But if someone makes me angry it does not belong to anywhere outside this door.	Certain things do not belong to the outside	
Pablo, head emergency doctor	Sometimes, I really would like to tell my colleague clinic heads: 'Come on. Let us put our cards on the table and tell each other what is really at stake.	Incommunicability of differences	
Sam (Observation in palliative care center)	Observation Palliative Care Centre (Steffen): The leading oncologist and the head of the palliative care centre continuously engage in heated discussions on whose patient it is	Shifting conflicts down the hierarchy	
Clinic Head Symposium (Observation)	During the workshop on sounding the topic of "process orientation" in Fall, 2005 with the heads of clinic, their discussion turns to the risk of fragmentation as a result of specialized medical disciplines. The discussion circled around what good patient treatment was about until Hans, the head of cardiology, asks the question: "What do we, as a hospital, as the group of clinics, mean by 'success'?" Nobody answers the question, until one clinic head suggests to move over to the next point of their agenda.	Remaining ambiguous	

6.5 Vignette: launching "process optimization" at Laho

The following anecdote of launching "process management" at Laho provides an example of how to move an issue forward that lies outside the clinics' attention and transcends their boundaries. The anecdote conveys several components of bilateralism: raising attention by introducing a concept, subsuming the initiative under other developments, enhancing clinic-driven pilots and supporting the diffusion of a process orientation with these pilots.

Strengthening a process orientation has been on the CEO's agenda for the hospital: "*In our board meeting in 2004, we realized that the work hours were too high, ... And then, we*

thought about the consequences. If we raised the number of employees, as usual, that would have been 40 to 50 new assistant doctor positions. Doing that was impossible. ... We had to approach the topic differently. The only solution was to enhance our processes.” (Horst, CEO of Laho)

First, hospital management tries to raise the attention for process orientation by introducing it as a concept to the heads of clinics and the nursing director. The CEO initiates a workshop in Fall 2005, to discuss the concept of process management with the heads of clinics and the nursing department. He invites a university professor to a one-day workshop to provide a first input and foster discussion among the clinic heads. During the workshop, we observe the topic received positively but are unsure about its concrete impact. Horst, the CEO of Laho, summarizes: *“I think we have started something into this direction”*.

Second, hospital management subsumes process orientation under two other initiatives. They include it into the project of enhancing the hospital’s information technology infrastructure, says Damian, the department head of interdisciplinary medical services: *“To avoid disruptions, we subsume the process orientation under the IT project and ask: how can we improve work processes through electronic devices? There, everyone thinks, ‘wow, that’s great, let’s do it!’ The idea behind it is of course a little bit different. But you have no chance if you want to sell the idea directly.”* With the year of 2006, the new labour law had to provide another possibility (see in detail, Merz, 2009). Legally required, the hospitals have to restrict the work hours of their assistant medical doctors. This resource restriction offers subsuming the process orientation under the implementation of the labour law. Horst, the CEO of Laho, comments: *“In the executive board, we knew that just telling the clinic heads to optimize their processes would not work. They just do not think in processes. At the same time, we need this thinking in the future. This is why we used the labour law initiative to place the topic of processes in the hospital.”*

Third, hospital management supports pilot initiatives of clinics to review their processes. To motivate the clinics, Laho’s management restricts hiring and provides financial and conceptual support that motivates clinics to analyse and optimize their treatment and administrative processes. Between 2006 and 2007 six clinics begin initiatives to adapt

their treatment and administrative processes as a way to solve their restricted man-power resources (Merz, 2009). These pilot projects are reported to be successful in clarifying tasks and responsibilities, reducing over time for clinicians, and improving the planning of patients flows (Merz, 2007).

Fourth, and in order to foster diffusion among the clinics, the hospital management helps to make the results of the clinics' process initiatives available to a wider internal audience. With successful pilot examples, the CEO launches an afternoon workshop open to all clinics in which the respective clinics presented their initiatives. Showing the success and challenges of pursuing a process orientation they make their experience accessible to a wider audience. In retrospect, the CEO considers his approach successful: *"I think the willingness has increased both in favour of process thinking and to learn from one another"*.

The anecdote illustrates a typical way of moving an integrating issue forward. In the following sections, I will complement the four components and add the one of enhancing commitment to a topic, which lies at the core of bilateralism.

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