Paradox as invitation to act

in problematic change situations

Beech, N.[1], Burns, H.[2], de Caestecker, L.[2], MacIntosh, R.[1] & MacLean, D.[3]

1 University of Strathclyde, Graduate School of Business 199 Cathedral Street

Glasgow, G4 OQU

2 NHS Greater Glasgow, Dalian House, Charing Cross, Glasgow

3 University of Glasgow, Dept of Business and Management, West Quadrangle,

Gilbert Scott Building, Glasgow, G12 8QQ

Tel: 0141 553 6004 E-Mail: beech@gsb.strath.ac.uk

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Abstract

It has been argued that organisational life typically contains paradoxical situations such as efforts to manage change which nonetheless seem to reinforce inertia. Four logical options for coping with paradox have been explicated, three of which seek resolution and one of which 'keeps the paradox open'. The purpose of this paper is to explore the potential for managerial action where the paradox is held open through the use of theory on 'serious playfulness'. Our argument is that paradoxes, as intrinsic features in organisational life, cannot always be resolved through cognitive processes. What may be possible, however, is that such paradoxes are transformed, or 'moved on' through action and as a result the overall change effort need not be stalled by the existence of embedded paradoxes.

Key Words

Paradox, Serious Playfulness, Action Research, Mode 2

Introduction

Organisational life contains paradoxical situations. Such situations demand both individuality and coordination, and organisations need systems to support both control and autonomy in their employees (Bouchikhi, 1998). The practice of management in such situations entails dealing with the simultaneous presence of opposites (Clegg, et. al., 2002). Managers may need to get hidden agendas out onto the table so that action can be agreed as well as meeting the need to keep personal agendas private since otherwise agreement to act would be impossible (Huxham and Beech, 2003). Although apparent solutions may be found to organisational and managerial paradoxes, such solutions are often temporary in that they either displace the problem to some other organisational location (Eden, 1987) or are part of a 'problematic situation' (Checkland and Scholes, 1990) in which solutions generate new problems. The aim of this paper is to explore possibilities for acting within paradoxical situations where traditional approaches to 'solving the problem' are not satisfactory. We wish to explore the experience and consequences of holding paradox open and 'working with or through it,' rather than following the more traditional route of resolving, removing, or simply denying the existence of paradox.

In line with Poole and Van de Ven (1989), we define paradoxes in the 'lay sense' of interesting tensions, oppositions and contradictions that occur in practice. Poole and Van de Van identify four options for addressing paradoxes (where A and B are two opposing propositions): first, accepting the paradox and maintaining and appreciating the contrasts between A and B; second, situating A and B at different spatial locations (e.g. macro and micro, or different settings within the organisation); third, situating A and B at different temporal locations (e.g. periods of incremental change punctuated

by periods of radical change); and fourth, finding a new perspective that eliminates the opposition between A and B. Table 1 represents Pool and Van de Ven's four options alongside our own depiction of each in terms of the managerial stance which might be adopted.

[Table 1 about here]

In both practice and theory, options 2, 3 and 4 tend to dominate as they offer apparent solutions (Lewis, 2000; Nooteboom, 1989). However, increasingly there have been calls to explore option 1 where paradoxes are held open. For example, Clegg et al. (2002) advocate holding the opposing poles of paradoxes apart whilst simultaneously seeking synthesis. Rothenberg (1979) has argued for 'Janusian thinking' in which contradictory propositions can be held to be simultaneously true. Lewis and Keleman (2002) have argued that multi-paradigm approaches which entertain 'conflicting knowledges' will enhance reflexivity in theory generation. In this paper we seek to engage with these calls by examining a theoretical addition to Poole and Van de Ven's option 1 together with a practical exploration of working with paradox. We suggest some ideas for an approach to management that acknowledges and engages with the messy, paradoxical and incomplete reality of everyday organisational experience.

Option 1, keeping the paradox open, whilst being an intriguing idea, could be viewed as different from the other three options in a fundamental sense. In rejecting the intellectually structured drives towards harmonious unity implicit in the other three options it rejects end-driven rational action and the tendency to reduce complex

dynamics to simple “either-or” choices and “both-and” syntheses (Stacey et. al., 2001). As such, the modernist tendency to try to disentangle experience into familiar dichotomies such as subject-object, thinking-acting and individual-social, is replaced by a view in which the paradoxical dimensions of experience are created and recreated in different patterns of interacting. In keeping paradox open, action can be seen as an essentially creative or transformative phenomenon in which individuals interact to contribute and respond to shifting and unpredictable patterns of private intention and embodied expression (Joas, 1996).

This description of action calls to mind the experience of taking part in a game. In games, experience is intentional but unpredictable in detail. Games are highly social in the sense that most are inherently interactive and governed by agreed rules, and they involve the expressive contributions of individuals who play to their own embodied attributes and emotional drives in a spontaneous manner.

One way of conceptualising action in option 1, ‘keeping the paradox open’, is to develop the concept of ‘serious play’ (Gergen, 1992), which in turn relates to prior theory on games. The theorizing of games in organisations identifies the rational engagement for gain, the structuring of conformity to rules (Crozier, 1985) and the power, either overt or disguised, in the structure of the games (Frost, 1987). However, there is another side to games as they contain contradictions (Crozier and Friedberg, 1980). For example, players remain free, but also must adopt strategies that conform to the nature and rules of the game if they are to win.

Games entail qualities that are potentially useful in those paradoxical situations encountered in organisational settings. First, they are not purely rational but also incorporate desire and emotion (e.g. the desire to belong or the desire to win). There is a sense in which, whilst playing, concepts, emotions and bodily movements become merged in such a way as to subvert the Cartesian hierarchy in which action is controlled by and follows from thought (Joas, 1996). Secondly, as Gergen (1992) points out, games incorporate not only conformity to rules but also creativity (e.g. in the novel application of rules to gain advantage). In gaming, minor changes to the structure of rules can create unstable conditions from which new adaptive forms of connection or system can emerge (Coveney and Highfield, 1995; MacIntosh and MacLean, 1999). Thirdly, playfulness introduces jokes, puns and postures, many of which rely on words and gestures having multiple meanings, and these may be of use in engaging with multiple realities embedded in some paradoxes. Multiple meanings can be revealed as unexpected connections and disconnections between divergent but co-present versions of the organisational story (Boje, 1995). Fourthly, games enable participants to challenge the normal boundaries of behaviour, for example, they may allow for touching, verbal expression, and competitiveness that may not be permitted in the normality of everyday life.

Using serious play as a framework for keeping the paradox open whilst acting is intended to introduce an alternative to 'solving' the paradox. Rather than focusing in on 'one best way', our contention is that there is a need for a 'shifting stock' of experimental practices which can be used as the basis for elaboration and improvisation (Gabriel, 2002).

[Insert Figure 1 about here]

In summary, the concept of serious playfulness entails purposeful action, but action which is:

- driven by emotion and the body, not simply rationality
- notable in its creativity in terms of both adherence to, and disruption of, rules
- involves play between multiple meanings
- challenges normal boundaries through experimentation.

This conceptualisation aids the process of keeping paradoxes open since it provides some potential lines of exploration.

The paper will examine an empirical example in which the four options are worked through. We pay particular attention to option 1, where we attempt to operationalize the concept of serious playfulness. Following this, we proceed to offer some reflections drawing on the empirical and theoretical material.

Method

Our research process was one of action research (Eden and Huxham, 1996) and was highly engaged with practice, seeking as it did, to produce knowledge in mode 2 (Gibbons et. al., 1994, MacLean et. al., 2002). As action researchers, we had developed a basic theoretical framework (serious playfulness) to underpin a practical exploration of option 1, holding paradox open, but we were seeking a more detailed understanding and enrichment of our framework through an experimental engagement

in some practical issue or problem. As such, we envisaged embarking on an iterative process whereby the framework would be used to inform novel approaches to paradox in practice, and the experience of such endeavours would provide material for reflection, theory-building and subsequent actions.

The authors formed a multidisciplinary team comprising healthcare professionals and management researchers, seeking both to develop new forms of organisation in healthcare and to deepen our understanding of alternatives to traditional modes of healthcare management. The team brought different perspectives to the problem which enabled a flow, not only between action in the situation, theorizing events, and subsequent action, but also between conceptual stances with areas of both agreement and disagreement (Lewis and Grimes, 1999).

The aim of such research is not to present a case study of the organisation, nor to provide proof of generalisable conclusions. Rather, the purpose is to extract from a broad and rich experience of organisational processes over time, lessons which reflect emergent theorizing (Eisenhardt, 1989), and which may be applicable/adaptable by other researchers and practitioners. In this sense, the concept of paradox as invitation to act is a 'generative mechanism' (Tsoukas, 1989) for both action, and theorizing on the basis of data which are particular to a local context (Eisenhardt, 1989; Alvesson and Karreman, 2000).

Empirical Context: policy dimensions

The empirical illustrations are drawn from a project in the UK's National Health Service. The setting relates to the development and introduction of a new approach to

cancer treatment services on a national scale. Adverse comment in a number of media about figures suggesting that patients in the UK had a poor survival after being diagnosed with cancer led to political dissatisfaction with the effectiveness of the NHS in treating cancer. In 1995, a policy document, known as the Calman-Hine Report, was published which represented the government's thinking on how the situation could be improved (Chief Medical Officers of England and Wales, 1995). The main thrust of the Calman-Hine Report, as perceived by the clinicians involved in providing cancer treatment, was to reorganise cancer services into those provided in "Cancer Centres" and those provided in "Cancer Units." Cancer Centres were seen as those hospitals which could provide care for complex problems. They had an extensive range of services on site and, by centralising care of complex cancers on fewer sites, it was hoped that survival rates would improve. Cancer Centres would mainly be designated in University teaching hospitals. Cancer units, on the other hand, were likely to be based in District General Hospitals (DGHs). They would offer a simpler range of services and would be expected to refer complex or difficult patients to a Cancer Centre for treatment. This polarization of treatment on the basis of institutional size and complexity caused considerable concern amongst clinicians who felt that it did not give due recognition to clinical competence. "Just because you work in a teaching hospital doesn't make you a good surgeon and working in a DGH doesn't make you a bad surgeon" [Cancer Surgeon].

Initial discussion of this issue also took place at a time when the NHS was being organised as an internal market for health care. A central directive to refer patients to certain hospitals caused concern that resources would flow away from institutions that had been treating cancer successfully and towards cancer centres whose success in

treating cancer was, at least in some cases, felt to be unproven. In the light of these concerns, many clinicians decided not to engage in the process of centralisation of services.

Empirical Context: clinical dimensions

From the description above, it is clear that policymakers found themselves confronted with a problematic change situation. They had approved a plan which they thought would improve treatment outcomes for patients. However, doctors who felt that the new arrangements for care would have exactly the opposite effect were resisting implementation of this plan. Moving forward in this problematic situation was not straightforward. Doctors deliver care within the NHS according to ethical standards laid down by their regulatory body (the General Medical Council). Managers of hospitals in the NHS cannot and do not prescribe the clinical decisions taken by doctors, so the conventional arrangements by which managers control the activity of production staff in many other organisational settings are ineffective. Also, managers in the health service have a prime interest in the organisational unit which they manage, whilst doctors are largely focused on the wellbeing of individual patients.

Hence, there were tensions between three groups: policy makers who advocated centralisation, managers who, largely, saw themselves as agents of government but who might feel their organisations liable to lose revenue if they were not designated cancer centres and doctors who often felt their patients liable to suffer if proposals to centralise care were implemented.

Following an initial failed attempt to implement the Calman-Hine report, policymakers invited Jack, a clinician with extensive experience in treatment of

cancer, into this situation to advise on and implement a 'more robust' programme to improve the outcomes of cancer treatment.

The Paradox:

the need for services which are simultaneously centralised yet decentralised

On starting the project, Jack had "no clear view what the eventual outcome would be." It was however, clear that any changes he might recommend needed to deliver clinical outcomes which were demonstrably better than those achieved by the existing arrangements. To be acceptable, the eventual system had to incorporate a process of continuous quality improvement based on peer-reviewed audit of clinical practice.

With this prior condition, Jack embarked on a series of visits to the management teams of almost thirty hospitals and the clinicians working in them who treated cancer. A number of themes emerged from these encounters.

(i) *Management assumptions*.

Hospital managers were generally supportive of the Calman-Hine plan. It based cancer care around institutions of different sizes and, while some managers were unhappy at the suggestion that their institution would not be considered a cancer centre, the institutional basis of service organisation was something they assumed would be part of any solution.

(ii) *Clinical cooperation across institutional boundaries*.

Throughout the discussions, clinicians emphasised the importance of multidisciplinary care for cancer patients. Not all clinical disciplines are represented in all hospitals. Clinicians expressed concern that they should continue to have access to experts in other hospitals if they were to provide the best possible care for their patients. An institutional configuration was not acceptable to many clinicians.

(iii) *Hospital care vs. Prevention as ways to control cancer*.

Since its creation, the NHS has been split in the way in which care is provided. General practitioners deal with most initial contact with patients while hospital doctors provide more specialist care. The NHS has not traditionally had much interest in prevention of ill health, yet much is known about prevention of cancer. It is often argued that it is more efficient for any population to invest in prevention rather than treatment of cancer. Some public health experts argued that an organisational solution for cancer should be based on a geographically defined population rather than be based on the "customers" referred to a hospital. Adopting such units of organisation would allow clinicians – and particularly primary care clinicians - to take a stronger interest in prevention.

(iv) *Habit in clinical practice.*

A common response among clinicians when visited was: "why do we need to change? We have good results and our patients like what we do." Usually these assertions were made without any objective data to support either the contention that patients were satisfied with their treatment or that treatment was of an acceptable standard. Discussion in these circumstances occasionally became acrimonious and difficult as

Jack made it plain to those clinicians who were reluctant to change that objective evidence of excellence was necessary if the status quo was to be supported.

(v) *Incompatible aspirations: of managers for control of clinical practice, and of clinicians for freedom in how they practiced.*

Ultimately, it was clear to Jack that managers had insufficient insight into the nuances of complex, multidisciplinary cancer treatment to allow them to manage services in the way they felt was needed. Similarly, clinicians in individual institutions needed to participate in an audit of practice that was transparent to their peers. Where peers were unhappy with the results of an audit, reluctant clinicians would have to agree to change their practices. Failure to adopt best practice would constitute clear breach of clinical standards and ethics and lead to sanctions. Exchanges of this nature were rare but when they occurred, they were associated with much bluff and bluster on the part of defensive clinicians. What was being proposed was no more than what was required by professional organisations such as the Royal Colleges. Clinicians were clearly the only people who could persuade other clinicians to change.

The Paradox Transformed?

Having set out the problematic change situation in some detail, we now turn to consider ways to engage or resolve the centralised-decentralised paradox. In examining this situation we consider all four of Poole and Van de Ven's responses to paradox and we use serious playfulness to structure a more detailed exposition of option 1. In so doing, we hope to offer some insight into our theorizing process and to illustrate the way in which a paradoxical situation was maintained yet transformed through action. At this stage, we note that Jack's experience of the paradox was

undergoing a subtle shift through his engagement with it. Rather than a simple cognitive distinction between centralised and decentralised services, Jack's initial interactions revealed the poles of the paradox as embodied in opposing groups: clinicians (decentralised services) and managers (centralised services). The paradox as experienced by Jack was thus possibly transforming into that of clinically-led organisation yet managerially-led organisation, each of which was incompatible with the other, as will be described in detail in the next section. First though, we will look at this problematic change situation in relation to options 2, 3 and 4 from Poole and Van de Ven's schema.

Option 2 requires a spatial separation of the conflicting elements. 'Space' in the sense that it is used here may be organisational space. So, for example, it could be decided that there was a single hierarchy with managerial positions above clinical ones, and once a clinician moved upwards into a managerial position, he or she would become a manager not a clinician. This would privilege the managerial side of the paradox and would not be a seriously acceptable 'solution' for those on the other side. Alternatively, the clinical side could be privileged by, for example, having a committee of practising clinicians who made the strategic and budgetary decisions that would subsequently be implemented by managers. Both these solutions carry new problems with them. For example, they assume a separation between strategy and enactment, whereas it can be argued that enactment has implications for, and changes, strategy as it occurs, and that incrementalism is a more realistic understanding of the strategy-implementation interaction (Pettigrew, 1992).

Option 3 would be a temporal separation between clinical and managerial tasks. So, for example, clinical managers could undertake clinical duties for some of the time and managerial duties at other times. This is a pattern of work which is adopted in various parts of the health service. In practice this may privilege one side or the other, depending on where the quality and quantity of time is focused. As with option 2, this temporal option also produces new problems. For example, there could be problems with a person being perceived as developing and maintaining the requisite skill and knowledge levels if they are spending half their time and energy on other activities. It would be possible for full-time members of the clinical and managerial groups finding ways of undermining the views of someone working with dual roles which were temporalized in this way.

Option 4 would seek a synthesis between the two sides. This may entail arguing that solutions in health care cannot be either clinical or managerial alone, rather they must involve a synthesis of the views of both sides. A possibility would be to incorporate management training as part of the clinical education in order to produce a hybrid clinician-manager. Some medical degree programmes have moved to introduce management training in the form of optional modules or the ability to intercalate the medical degree with a one-year MBA or MSc qualification in management. As with the other solutions, option four could produce new problems. For example, if a new breed of hybrid professional were produced, there would be the potential for conflict between graduates of the new and the old systems. Even if a hybrid were produced, it is unlikely that it would be an equal match. It is far more likely that the clinical education and requirements for excellence would predominate over the managerial ones, or vice versa. If there were an equal division between managerial and clinical

education and training, there would be a danger that the hybrids would be regarded as not sufficiently specialist in either side, and that they were 'jacks of all trades' rather than full professionals.

It can be seen that whilst each of the above options deals with the appearance of paradox in its own particular fashion, collectively they seek to reduce, collapse or displace paradox. In so doing, they often introduce other problems, perhaps associated with what are tantamount to attempts to fillet everyday organisational life of its paradoxical backbone. In the area of cancer care, policy driven change required "managing" either by people whose expertise and credibility in cancer care required them to distance themselves from the practices of management, or whose expertise in management deprived them of the necessary knowledge of, and influence in, cancer care. Paradoxically, integration of these perspectives seems like an obvious solution, and yet the perspectives rely on differentiation for their existence.

Treating Paradox as an Invitation to Act

The alternative to the three options discussed above is to explore Poole and Van de Ven's option 1, in which the paradox is held open. By "held open" we mean that one actively resists the temptation to achieve intellectually driven closure (as in options 2-4) and instead pursues the kind of practically driven action that characterises the behaviours which occur during game play. By adopting this stance, the existence of paradox in problematic change situations can be viewed as an invitation to take part in a game in which serious playfulness encourages the actor to engage fully with the sensory, emotional and intellectual dimensions of paradoxical experience. Hence, we now turn to ideas concerning serious playfulness in order to work with paradox as an

invitation to act, rather than an intellectual puzzle to be thought through. From Gergen's initial concept of serious play, we have elaborated four dimensions of a framework for action (see figure 1) and will now go through each of these in turn.

a. Expressing Emotion

Clinicians who felt that their clinical freedom was being curtailed unfairly by the Calman-Hine proposals expressed considerable anxiety and anger. "I am supposed to refer all my cancer patients to Mr X in the University Hospital. He worked with me as a trainee. He was useless when he came here, and not much better when he left," [experienced consultant working in a DGH]. "We're supposed to refer our patients to hospital A," said a group of consultants in a rural hospital. "Our patients prefer to go to hospital B," they said, naming a hospital in another town which was more centrally located and was noted for its shopping facilities. The apparently arbitrary nature of the decisions made by management caused irritation and unwillingness to collaborate in the new system.

Such expressions could engender resistance to change. However, in this setting, emotional conflict, which would not normally be acceptable, was accepted by Jack. By empathising with these expressions of anger and frustration Jack helped clinicians recognise the need for change. This in turn made clinicians more interested in developing alternative ways forward.

b. Challenging Rules

Since the one unambiguous objective of any new emergent system was to ensure that care was of a higher standard than the system preceding it, new rules relating

to peer review, implementation of agreed pathways of care and opportunities for new patterns of resource allocation for cancer care suggested new approaches to managing care. Prior to this point, some clinicians saw audit as an optional activity and most clinicians regarded it as something to be done in private, without management interference. Similarly, most managers felt that allocation of resources was their responsibility and clinicians were encouraged to challenge this assumption in their efforts to improve outcome of care.

c. Exploiting Ambiguity

In dealing with those involved in the exercise, Jack employed *multiple meanings*, for example, of the term 'management'. He was sometimes scornful about management as a group when in the presence of clinicians (although he did not always perceive himself in this way). However, in relation to management as a process, he appeared more favourably disposed, albeit to a new formulation of management. This ambiguity helped retain the creative tension of paradox: centralisation is bad, centralisation is good. This tension enabled novel action rather than stasis in oppositional groups of management and clinicians. To clarify matters, by adopting either centralisation or decentralisation, would have engendered resistance by the 'losers' and would have generated new problems in itself.

d. Experimenting with Boundaries

The behaviour of the project leader helped to *challenge the boundaries of behaviour* and facilitate the emergence of new practices and new forms of organisation. In particular, managers required a degree of openness and

auditability from clinicians. Clinicians were often resistant to the notion that data on their clinical practice could be made available to mangers in anything other than anonymised form. Jack was able to point out to the clinicians that poor outcome might not necessarily be due to incompetence but might also be due to lack of resources to allow adequate treatment. In the latter case, the responsibility would lie with the manager. Jack helped redefine the boundary of what was acceptable to clinicians and this redefinition helped create a climate which allowed the clinicians to engage with possible alternative ways of working. There was a traditional boundary to creating transparency. At points during which the traditional conception was challenged, greater transparency was achieved. Having said this, in clinical circles the knowledge was not new as 'everyone knew' where the standards of practiced varied. But, under normal circumstances, such knowledge remained unobtainable for managers and, in practice, clinical judgement as to who produced best outcomes was often shown to be inaccurate once audit data was collected. Other forms of experimentation involved encouraging transcendence of traditional boundaries which existed between primary and secondary care provision in order to ensure better continuity of care for patients.

The Paradox Transformed

Using concepts from serious playfulness, a range of different types of action and intervention formed the basis of experimentation. The challenge facing Jack was to create a system that improved prospects for prevention and cure of cancer. Managers wanted control of a system for which they felt accountable. Government policy supported a classical top-down arrangement which reduced options for clinicians in

how and where patients were treated and so seemed, to angry clinicians, to give managers unacceptable levels of control over their clinical practice. Clinicians, on the other hand, argued that the multidisciplinary nature of cancer medicine required cross institutional links. They produced evidence that outcome was more dependent on the integrity of multidisciplinary teams than on the number of patients treated by individual clinicians. In return for recognition of these concerns, clinicians seemed prepared to contribute to transparent audit of their practice.

Jack's recommendation was to accept that health service managers remained accountable for costs and outcomes of treatment in the hospitals they managed while supporting the clinicians desire to work across institutional boundaries. He recommended the creation of "Managed Cancer Networks" in which clinicians in each region dealing with individual cancers would work in a networked way to peer review each other's practice. For example, all the clinicians involved in treating lung cancer in a region would participate in a lung cancer network. They would be provided with some management support to facilitate the activity of the network but they would individually remain employees of, and accountable to, their hospitals. The network would report to hospital managers on the results obtained by clinicians employed by them but would also raise issues of resource scarcity that the network felt impaired the ability of clinicians to practice effective cancer medicine. Health service managers agreed an allocation of money to permit the creation of teleconferencing links to facilitate clinical contact across the network.

Rather than attempt to close down or resolve the paradoxical need for cancer services which were centralised yet decentralised, we have provided an account of an attempt

to hold the paradox open. In so doing however, the paradox itself was transformed. The original tension between centralisation and decentralisation changed through the early stages of developing a network approach to service provision. The paradox became manifest as a tension between managers and clinicians.

Three years after the publication of this plan (NHS Scotland, 2001), networks are publishing audit results. Investment plans are agreed annually between networks and health authorities. Frustration still exists on the part of managers who feel that their ability to control clinical care is impaired by the existence of the networks. Clinicians remain frustrated by their feeling that networks are not taken seriously by hospital managers. In fact, managers have more insight into standards of clinical care because they are getting more audit data than they would have under the previous system and doctors have benefited from having a higher level of input into investment decisions.

The paradox has been held open in that managers continue to have responsibility for care while clinicians have been given permission to work outside conventional institutional boundaries. Clinical processes have demonstrably changed as a result of the organisational 'solution' which emerged into the gap between management and clinician aspiration.

The framework for action presents four dimensions of serious play, and we have attempted to highlight aspects of the way in which the inherent paradox is maintained, treated as an invitation to act and transformed through that action. By considering management as a process, and by describing this process of management in terms of the negotiation and application of rules governing the operation of the new cancer

network, and embodied in the decision maker (whether they be clinician or manager) the paradox is both maintained and transformed. Thus, those concerned have in some senses moved beyond the need for, and impossibility of, having managers who are doctors by focusing on a self-management process. Nevertheless, underlying tensions between clinicians and managers still exist, and these paradoxical tensions are beginning to centre on the nature of the network's rules, who conceives them, and how they are policed.

Serious Play as a Way of Keeping the Paradox Open

Our aim has been to explore the possibility of 'keeping paradoxes open' through serious play. When Jack was originally commissioned to develop a new system of cancer care it was assumed that some kind of resolution or accommodation would be found that would bring the managerial and clinical views together. Such an outcome was unlikely since the objectives of managers centre around the efficient running of their institutions whilst clinicians - even those clinicians who also fulfil a management role - are judged on how effectively they treat individual patients. Creating a cadre of clinicians trained in management would not have resolved this paradox since the basic skills required for the two roles are far from complementary. Attempts to resolve the paradox by a synthesis of views would have been doomed to failure for this reason.

The illustrative paradoxical situation was 'moved on' through the use of emotional expression and personal contact in the place of purely rational arguments where professionals were supported through processes that were not presented as neatly resolvable. Indeed, frustrations still exist, but through changing the typical

boundaries of emotional expression they now exist as part of a changed situation rather than fuelling resistance and 'stand off' between the parties. We have illustrated how rules were challenged and recast, introducing some instability and maintaining the fluidity of an interactive 'game'. The cancer care network experimented with organisational boundaries, building new links between clinical disciplines, institutions and individuals. The normal boundaries of behaviour were challenged, as clinicians did "what doctors do not do," and the normal forms of control were subverted within the network. The multiplicity of meaning and exploitation of ambiguity was important - enabling the co-present conceptualisation of management as both good and bad. Without this neither clinicians nor managers would have been able agree to movement.

The four dimensions of serious play presented in this paper can act as a stimulus for alternative or complementary forms of action. On reflection, a number of points can be made about serious play as a way of acting through paradoxical situations. First, it is not the case that all the four elements of play identified in theory are necessarily equally present in practice. In this case, it was not clear how much of each element would be present in advance, and there was a need for those engaged in practice to make judgements about how to proceed once the activity was already underway.

Secondly, as with other games, it is not necessarily the case that radically different actions are undertaken, rather it is the setting and subtle reversals that constitute the actions as play. For example, in play sword-fighting, the players enact a fight, but in a way that parodies an actual fight, using non-harmful weapons. And if the play fight ends with one person being hurt, it is typically the person who did the hurting who is

in trouble - a reversal of the rules in genuine combat. In the illustration presented, some of the actions such as seeking ways of altering the rules of engagement are not in themselves revolutionary, but the ways in which the setting is managed and the nature of outcomes make the impact and meaning of such actions different. Hence, playful actions can be simulacra of mundane actions in which there is a transformation of meaning that enables a transformation of taken-for-granted boundaries of behaviour.

Thirdly, notwithstanding its name, serious play is not necessarily fun. It can entail pain and conflict when people are challenged to act outside their normal behavioural repertoires, and to challenge their normal assumptions. Even when, from an external perspective, it would appear that the new state of affairs would be preferable for the actors in the situation, they may perceive things differently. For example, one might think that removing the impression of a group of professionals that "the managers are bad and incompetent" would result in greater happiness. However, this is not necessarily the case where the "bad managers" conception had been fulfilling some other function for the professional group such as a scapegoat function (Douglas, 1995).

Fourthly, although we are interpreting serious play positively, it is possible for actors in the situation to interpret it negatively, for example as incompetence, prevarication or as a political tactic. These different 'readings' can result in conflictual social outcomes. Such outcomes are undesirable because they increase the likelihood of dichotomising perceptions in the paradoxical situation, and right/wrong dichotomised representations of paradoxes may militate against action. For those who believe

themselves to be in the right and their oppositional group to be wrong, the obvious conclusion is more of the same behaviour.

Fifthly, in adopting serious play as a tactic, actors must be aware that their intentions may be subverted through the play. Serious play entails planning, and yet it may also entail the abandonment of plans. In this sense it may represent an alternative to cognitivist approaches to problem solving. It requires a mind-set accepting of experimentation and positive support for outcomes even if they deviate from original intentions.

Conclusions

In problematic management situations (Checkland and Scholes, 1990) contradictions, tensions and paradoxes can, and frequently do, arise (Bouchikhi, 1998; Lewis, 2000; Clegg et. al., 2002). It may be possible to resolve such paradoxes through the separation of the contradictory elements over time or space or through synthesis (Poole and Van de Ven, 1989), but sometimes resolution may not be possible or desirable. We would argue that the common propensity towards resolution of paradoxes through options 2 – 4 should be challenged, and that 'living with paradox' should not be regarded as necessarily the worst option. We would argue that options 2, 3 and 4 often hold the promise of solving problematic situations, but that in practice such 'solutions' may not deliver progress. Our exploration of paradox as an invitation to act might indicate that the pursuit of option 1 is a viable option.

Furthermore, we suggest that a positive way of confronting problematic change situations is to regard paradox as an invitation to act rather than seeking to 'think oneself out of the problem'. Seeking cognitive solutions could lead to inertia, whilst acting in the situation, acknowledging the messiness entailed by this, can help to transform, rather than remove, the paradox. We believe that the dimensions of serious play offer a framework for action in such situations. We have suggested that adopting the dimensions of serious play (focusing on desire and emotion; being creative in the application and recreation of rules; exploiting the multiplicity of meanings; and challenging the normal boundaries of behaviour), can offer a helpful guide to productive action.

We acknowledge that there is an ethical dimension to such game playing. Questions can be raised about how acceptable it is for some actors to be indulging in experimentation and play when others are earnest in their actions. This is particularly the case where one group of actors is subject to the experiment by others who have greater power.

We should also emphasise that it is not our proposal that serious play is a panacea. We have specifically conceived it in paradoxical settings where other options for resolving the paradoxes are problematic. We accept that there may be situations where Poole and Van de Ven's options 2, 3 or 4 may be both feasible and preferable. In this paper we have sought to offer a means of operationalizing option 1, to move beyond the somewhat passive connotation of the term "holding it open", and in so doing, we have argued against an inherent and perhaps inappropriate tendency to default to other options which resolve, close down or deny the existence of paradox.

We would suggest that in such situations where action would otherwise be stifled by trying to find resolution through cognition as a precursor to action, regarding paradox as an invitation to act might offer a way of 'moving-on'. We might add that managers, who, consciously or otherwise, overlook the possibility of transformative action in paradoxical situations and focus exclusively on problem-solving approaches may be denying to their organisations a basic stimulus to creative action.

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Option	Poole and Van de Ven's Description	Managerial Response
1.	Accept the paradox of A and B	Engage (to transform)
2.	Resolve A and B by arranging them at different spatial locations	Spatialize (to eliminate)
3.	Situate A and B at different temporal locations	Temporalize (to avoid)
4.	Find a new perspective which eliminates the opposition between A and B	Synthesize (to transcend)

Table 1: Managerial stances in relation to Poole and Van de Ven's Four options

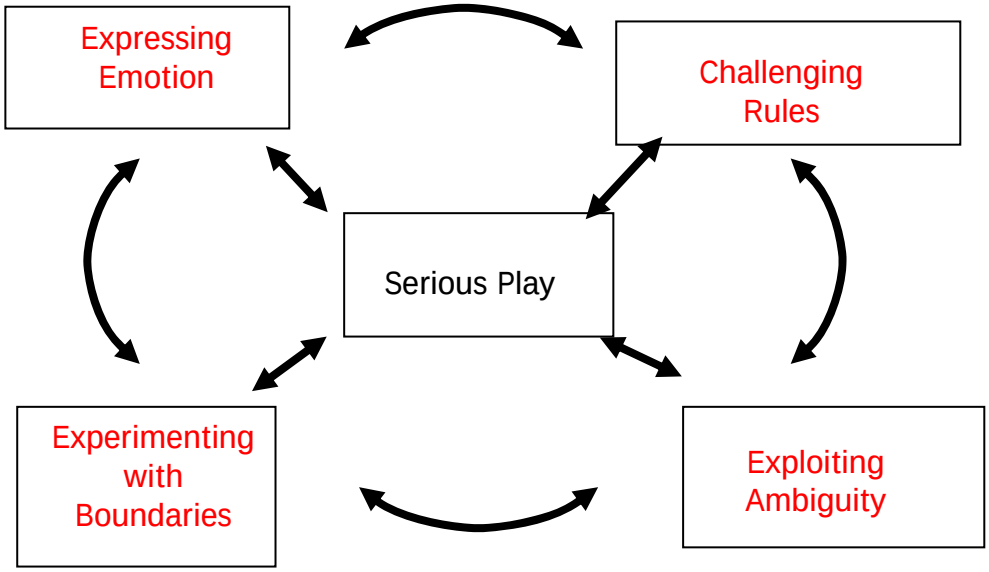

Figure 1. Serious Play in Practice