Paradox management delegation: inter and intra-individual variability

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Introduction

While paradox is increasingly presented in organisational literature as a normal, even advisable element, it is still seen as a problem by individuals who are confronted with it on a daily basis. Thus there is a clear gap between researchers' conclusions and real-life situations experienced by practitioners, or maybe a tension between two levels of analysis, organisational and individual levels. We have found that this tension has seldom been studied. In a nutshell, existing literature tends to be divided into two groups. The first studies the manner in which organisations deal with these paradoxes, notably through proposal of typologies (for example, Pool and Van de Ven, 1989). They contain reflexions exploring the potential of managerial action where the paradox is held open to use it constructively (Beech, et al., 2004 ; Clegg, et al., 2002). The second group is centred on individuals. The emphasis is laid either on the negative effects of paradoxical injunctions (Bateson, 1972; Festinger, 1957; Schneider, 1990) or on the different attitudes provoked by paradoxes (Lewis, 2000; Vince and Broussine, 1996). There is a common assumption that individuals generate defence mechanisms. Some papers however are an exception. Some authors - who are interested in the actors' capacity for action rather than cognitive and psychic processes - on the contrary underline the fact that the paradoxes of the environment are an opportunity for agency (Crozier and Friedberg, 1977). They are considered as a resource for change (Jepperson, 1991; Seo and Creed, 2002). Whatever their point of view, these different papers tend to study the individual and organisational levels of paradox management separately. Nevertheless, the manner in which individuals react when faced with paradoxes goes hand in hand with the choices made by the organisation, and conversely an organisation's capacity to manage paradox is closely related to the choices made by individuals. Hence, our work seeks to contribute to reflections linking organisational paradox management and individual reaction to paradoxical situations. More specifically, we aim to highlight the consequences for the organisation of a certain choice of paradox management: its delegation to individuals. We lay

down the hypothesis that the organisation's capacity to manage organisational paradoxes depends on how individuals cope with contradictions that are delegated to them.

Our work is focused on the French health sector, and more specifically on public hospitals. This sector, as is the case in many OECD countries, is subject to increasing tensions that are expressed as follows: an ageing population, technological and medicinal innovation, an increasing demand for lower levels of risk and higher levels of quality combined with a lack of medical and paramedical resources, policies aimed at limiting health expenses. The system is therefore faced with the following paradox: offering more and more treatment, with increasing levels of quality, while limiting the consumption of medical and budgetary resources. This is the root paradox of public hospitals.

Management methods applied to date have proven ineffective in this respect. French public hospitals have recently appointed physician-managers to head transversal care units (which can include from 50 to 600 employees). We interpret this shift as a measure of delegation to individuals of management of the root paradox of medical institutions. Physicians are being held accountable (responsible) for their capacity to correctly meet the demand for medical treatment as well as their ability to limit the consumption of resources. It alters the previous - pluralistic - paradox management method (Denis and al., 2001; Westenholz, 1993). By delegating paradox management to physician-managers, it is assumed that as they possess a particular set of characteristics (knowledge, skills, legitimacy) and specific management tools, they will be capable of paradoxical thinking (Westenholz, 1993), i.e. moving beyond contradiction and transcending paradoxes to invent new solutions that would not have been possible with the previous regulation method. To us, this organisational solution is not disconnected from individual attitudes when faced with paradoxical situations, and their capacity to deal with them. It shifts the focus of the analysis to the level of the individual, the true black box of this reform.

Our research work therefore aims to study the positions of health sector professionals with respect to the paradox management that has been delegated to them, to analyse the extent to which this delegation might alter the pluralistic organisational management of paradoxes. To this end, we conducted semi-structured interviews with 14 of 16 new physician-managers working in a large teaching hospital where the reform was initiated.

Our results show that individuals adopt four types of positions when faced with paradox: rejection, detachment, absorption, and transcendence. These four individual positions lead to four consequences for the organisation: unchanged paradox management, illusory care,

blocked management, and in the last case, effective and innovative individualisation of their management. We underline that not only is there an inter-individual differentiation of paradox management, but also an intra-individual variation according to the types of paradox to be dealt with. Thereby our research highlights the weight of middle management on the form taken by organisational change.

1. The issue of individual and organizational paradox management

Clarification on paradoxes and paradoxical thinking

Paradoxes have become an increasing managerial cliché of our time to describe "conflicting demands, opposing perspectives or seemingly illogical findings". Yet its study suffers from under specification, lack of in depth research (Lewis, 2000). Indeed, its long history and use in various disciplines - from philosophers to organization theorists not forgetting psychologists - may explain that it has become a useful umbrella (Lewis, 2000). In organization theory, approaches are heterogeneous, schematically divided between the study of paradox management at organizational or individual levels. However, there seems to be some agreement on the need to clarify what a paradox is and what paradoxical thinking encompasses.

Definition of paradox

Poole & Van de Ven (1989) detail three meanings for paradoxes, from the more general to the more restricted. In general parlance, paradox is used loosely to express thought-provoking contradictions, something which grabs our attention, and can be compared to a puzzle needing to be solved. In rhetorical studies, paradox designates a trope that presents an opposition between two accepted theses. Thus, it causes the audience to reconsider taken-for-granted assumptions or opinions. It is in logic that paradox has the narrowest sense. It means two contrary or even contradictory propositions taken separately are incontestable but taken together seen inconsistent or incompatible (see the famous Liar's paradox). This type of paradox is close to what Putnam (1986, cited par Lewis 2000) calls "self-referential loops", that he differentiates from "mixed messages" (inconsistencies between responses) that aggregated in the long run lead to "system contradictions" (for example demand for decentralization in a centralized system of control).

Smith and Berg (1988, cited by Westenholz, 1993) characterize paradoxes by referring to similar concepts notably dilemmas, irony, dialectics, and ambivalence. A *dilemma* is defined as an either-or situation; an *irony* exists when an unexpected outcome arises from a single alternative; a *dialectic* is a pattern that always begins with a thesis followed by an antithesis, resolved by a synthesis. *Ambivalence* is uncertainty of which of two alternatives should be chosen, the consequences of which are unknown. In paradoxes, no choice need be made if possible between the contradictions constituting the paradox. The contradictory elements are present simultaneously and are accepted as such.

Paradoxical thinking and frames of references

Paradoxes are cognitively and socially constructed to give a meaning to our environment. They denote an underlying frame of reference that structures our relationship to the world. Frames correspond to logics, points of view that refer to the underlying assumptions, deeply held, often unexamined, which form a framework within which reasoning takes place and feeling occurs (Ford & Ford, 1994). According to Westenholz, paradoxical thinking calls for "divergent thinking" that invites to go beyond the traditional "convergent thinking" where problems appear as distinct, precise, quantifiable and logical (Westenholz, 1993). Convergent thinking often derives from the formal logic of traditional scientific thinking, a rational perspective expressed in terms of "either-or". Reality is perceived as things opposing contradictory polarities, between which no choice is possible. Figures are understood by differentiation from one another: artificial brackets and boundaries are placed around them, masking their relatedness. Problems, often expressed in terms of contradictory bipolarities, thus have to be solved. According to Vince and Broussine (1996), such models often overemphasize the rational, and consequently do not take into account the complexity, ambiguity and paradoxical aspect of organizations. In the case of divergent thinking, problems are more difficult to delimit or quantify and no simple, predictable solutions seem to exist. Here wholeness is seen as composed of contradictions. For example in Eastern philosophies, the well known "yin and yang" figure illustrates the relatedness of each pole of a tension; when one force escalates to the other state, it retains elements of its opposition, as summarized by Lewis (2000). If convergent thinking leads thus to autopoesis, that is when individuals stay within their existing frame of reference through a self-referential process, it is a way to protect themselves from a chaotic world. Thus convergent thinking opens a safe place that is also a prison that does not allow them to see the world in a fresh way – under for

example the process of deframing then reframing. This latter point reveals the role of individuals in managing organizational paradoxes - and the connectedness of the two levels of paradox management.

Management of paradoxes at organizational and/or individual levels

Separate study at organizational or individual levels

Despite this connectedness, most research focuses a single level. One of the most popular analyses at an organizational level is probably that of Poole and Van de Ven (1989). The authors identify four ways to manage contradictions: acceptance (A&B, the two opposing theses are kept separate and contrasts appreciated), spatial clarification (A&B are situated at two different levels or locations in the social world), temporal separation (A&B are temporally separated in the same location), or resolution (new perspectives are brought which eliminate the opposition between A&B).

An increasing number of authors support the first of these options, being to "accept the paradox and to use it constructively", thereby engaging to transform. This manner of keeping the paradox open (Beech and al., 2004) calls for divergent thinking and thus may cause troubles at individual levels.

Indeed, in the literature that deals with the individual level of paradox management, only a few approaches propose that individuals can find personal benefit in paradoxical contexts. For example, helping individuals initiate in-depth organizational changes as put forth by the theory of institutional entrepreneurship (Seo et Creed, 2002). Here individuals are regarded as free actors. But the most classic approaches consider that paradoxical contexts can generate suffering and stress for individuals (Bateson, 1972; Schneider, 1990), because they often imply a major paradigm shift (Swanberg, 1995). To help people prevent themselves from doing so, different defence mechanisms will arise. While they are very common and useful in everyday life, as boundaries around the self, they protect the ego, it is their degree and frequency of usage that transform them either in assets or liabilities. Again, we may differentiate their study at organizational or individual levels. Organizational defense mechanisms are for example organizational cultures (Menzies-Lyth, 1990, cited by Vince & Broussine, 1996), organizational reasoning, since, as pointed out by Vince and Broussine, logical thinking for example overemphasizing technical approaches to problem-solving may be in itself an expression of defence. At individual levels, Vince and Broussine (1996) identify the five defence mechanisms commonly analyzed by authors. They are repression

(blocking unpleasant experiences from memory), regression (resorting to actions that have provided some security previously), projection (transferring personal shortcomings to others), reaction formation (excessively manifesting the feeling opposite to the threatening one) and denial (refusing to accept an unpleasant reality).

The way people will manage this defensive reaction may determine their ability to act paradoxically. Through approaches to deal with model ambiguity, Westenholz (1993) offers a typology that can prove helpful in understanding individual paradox management. Westenholz identifies three logics: logical, pluralistic and schizophrenic. The logical approach refers to the convergent thinking above described in terms of "either-or thinking" and the individual does not experience contradictions at his/her level. In the pluralistic approach, people subscribe to only one side but tolerate differences in the organization. The individual management of paradoxes is according to "either-or" thinking (people do not experience contradictions at individual level) but the organizational management of paradoxes is "both-and". Finally some people, who are engaged in several contradictory camps, cannot choose a best side. They still view the world according to categories of "either-or", but they want "both-and", well knowing that it is hardly possible. For Westenholz, these people have created inadequate defence mechanisms against the complexity of the environments, which have led them to view the environments with uncertainty. As a consequence, they find it difficult to define problems or solutions unambiguously. They articulate "either-or" and "both-and" approaches at individual and organizational levels. Finally, in her review on paradox management, Lewis interestingly summarizes three main means: acceptance, confrontation and transcendence. Acceptance means to learn to live with paradoxes, while confronting implies discussing tensions to socially construct a more accommodating understanding of practice. Transcendence implies the capacity to think paradoxically, that is when tensions are viewed as complementary and interwoven.

Despite the fact that organizational literature on paradoxes shares a common concern for specifying what paradox and paradoxical thinking cover, and even if the study of their management is treated at separate levels - individual or organizational - we would like to point out the lack of precision regarding the situation in which paradox management is studied. Indeed the study of paradox management is unclear whether it is restricted to situations where people demonstrate the ability to think paradoxically - that is according to divergent thinking - or whether it is extended to the study of the way people cope with situations that can appear as paradoxical when seen from outside? This latter remark calls for

another: are paradoxes subjective or objective (they may exist by themselves in a situation that is analyzed as paradoxical)?

Articulation of the individual and organizational levels

In this literature on paradoxes, individual and organisational levels are most of the time approached separately. However, some research tries to articulate the two levels more systematically and links are different.

In their study on management of strategic contradictions, (Smith and Tushman, 2005) develop a top management model that notably associates paradoxical cognition and organization outcomes. They argue that sustained performance occurs through attending to and dealing with strategic contradictions and that balanced strategic decision making in the context of contradictions is rooted in paradoxical cognition – cognitive frames and processes that allow teams to effectively embrace, rather than avoid, contradictions.

Westenholz (1993) in her study of mental frames of references that enable employees to process information, identify problems/solutions and act accordingly, assumes the connectedness between individual actions and actions in the organization. She concludes on the weakness of the link between change in frame of references and organizational change because in most situations individual relapses into the old frame of reference. The process of deframing and reframing has thus partly failed.

Our study is inscribed in the same design of articulation of the individual and organizational levels.

2. Research method

Research context

In 2007, faced with the hospital's inability to solve the cost- treatment quality root paradox, the French hospital sector implemented a series of changes. We interpret these changes as an attempt to transform the organisational management of paradoxes.

The initial situation can be characterised by a pluralistic type of organisation (Denis, and al., 2001; Denis, et al., 2007; Westenholz, 1993). Each actor strives to complete their own tasks. These tasks coexist and are contradictory. Faced with an incompleteness (Brunsson and Sahlin-Andersson, 2000) of rationalities, of hierarchy and of information systems, decisions

are of a highly political nature consisting of negotiations that are highly dependent on power struggles. In these situations, changes bear little innovation, consume high volumes of resources and are degraded in their implementation (Denis, and al., 2007).

Reforms aim to move away from an "arena" type organisation (Brunsson and Sahlin-Andersson, 2000), to individualise paradox resolution while diminishing the role of power struggles. To quote one of the instigators of the reform on a national level:

> *It was as if there were two separate worlds. Hospital directors with their budgetary, legal and public-health based culture, and practitioners as bearers of their medical knowledge, set in a patient to doctor relationship. When hardship befell on the hospital sector, everyone realised that this schizophrenia had to end (instigator of the reform).*

There are two parts to the reform. The first has to do with budget management. Hospitals have shifted from overall budget funding to patient level costing. Until 2007, budgets were allotted ex ante for a period of one year. The year's activity was therefore subject to the budget negotiated, while public hospitals are obliged to provide medical care to all patients, to offer uninterrupted service, to carry out research and innovation. As of 2007, the Ministry opted for patient level costing. The budget is allotted to the hospital ex post according to the volume and price of the diagnoses it carried out. Overall budgets seem to place institutions under more severe paradoxical injunctions than patient level costing. In practice, budget extensions or deficit authorisations were always granted to avoid limiting the offer of treatments, thereby reducing tension. Today, hospitals deem that the levels of patient level costs are not sufficient to cover their expenses. At the same time, the Ministry's tolerance level for deficits has dropped as the new budgetary technique is seen as more reliable and efficient than the former method. The trust in the new budgetary instrument therefore enhances the "paradoxical pressure" hospitals are faced with. On top of price pressure, the lack of nursing and medical skills - a common challenge to all European countries - increases the resource constraints. As a consequence of this change, all actors - administrations, practitioners, nurses - have become aware of the idea whereby the quality of care offered should be developed and resources kept under control.

The second change concerns the overall organisation of the hospital sector. Until 2007, administrative staff was in charge of budget management while doctors were responsible for the quality of the care offered and service obligation. To be efficient, the new budgetary technology requires that resource control and medical decisions be taken concomitantly. The reform calls for the creation of a mixed executive council made up of doctors and directors as

well as “medium-sized management units” encompassing existing services. These new management units are designed as places where organisational decisions are made. They are headed by practitioners appointed for 4 years, who thereby become physician-managers responsible for clinics as well as for their own budget.

> *By appointing physicians at the head of the unit, the idea is to aim for controlling expenses from a medical perspective as opposed to an accounting perspective (instigator of the reform).*

The notion of “control from a medical perspective” can be seen as the mechanism making it possible to transcend paradox, to provide new solutions and break away from the “arena” organisation by dealing with the issues of expenses and medical activity concomitantly. Individuals are responsible for making resource allotment decisions based on their medical knowledge and values. As can be observed in literature, this individualisation of paradox management is not self evident. We therefore focus on the perception and position of these individuals in front of paradox management delegation.

Research design and data analysis.

Our research is based on a case study concerning a teaching hospital with 9,000 employees. We conducted semi-structured interviews with the physician-managers working there. Out of the 16, two refused to meet us and one had left. Thus we interviewed 14 physician-managers. We also conducted 6 interviews with management staff and 4 with people at the Ministry or having played an influential part in the reform. The research is still ongoing. This collected data, basis of our article, is completed with material not directly used here - interviews with people working with these doctors and observations made at meetings to witness how these practitioners express paradox and their positions with respect to with paradoxes in decision making situations.

The interviews focused on broad topics related to the creation of the position of physician-manager, the challenges and opportunities facing it and possible evolutions. Therefore the interviews were not explicitly dedicated to paradox. The latter emerged from what was discussed. The interviews lasted between 1h30 and 2 hours. They were recorded and transcribed into writing. Our goal was to discover the perception of paradoxes by individuals as well as their positioning in front of these paradoxes.

Perception of paradoxes. It is our assumption that the quality - resource control root paradox can take different shapes, when the point of view is shifted from the level of the health system or the institution to that of the individual. We have observed that, just like any other innovation, paradox management is subject to translation operations (Callon, 1986) according to the actors and the context of action in which they express themselves. As it "moves through" the organisation, it is inscribed within a set of injunctions/expectations, management instruments, information systems, specific organisational patterns... As it is disseminated, it is transformed.

We then went through every interview and compiled all paradox related comments. We are interested in situations in which paradox is experienced subjectively. We discarded, after an analysis by two of the authors, those which seemed unrelated to the root paradox (for example related to the requirements of one's professional and private lives). Rather than paradoxes, we in fact compiled paradoxes and contradictions as soon as they were expressed in the form of two notions connected by an "or" or an "and" and that the interviewee positioned him/herself according to these notions. We carried out an inductive analysis of paradox related topics that could be found in 4 different interviews. The frame of reference suggested by Lüscher and Lewis (2008), which was then completed appeared as an adequate tool to organise the paradoxes. We then used it on the remaining interviews.

Positioning. Concerning individual positioning with regard to paradox, we constructed our own typology which can be considered as a confrontation and an adaptation of two grids that can be found in literature, by Westenholz (1993) and by Lewis (2000).

Characteristics of the interviewees. We interviewed 14 physician-managers, 12 men and 2 women, aged between 55 and 65 years old. Many of them are nearing the end of their career. They were appointed by the director in close consultation with the president of the medical commission, following the design work on the management units. None of these physician-managers were hired outside the hospital, or even outside the departments making up the new units. The method of appointment was rather "consensual". The appointment was made on the basis of criteria of legitimacy and acceptance by co-workers. Criteria such as skills and knowledge were considered in a more marginal manner. These physicians do not receive any complementary wages. They were not given any specific training for this new role.

3. Results

13 out of the 14 physician-managers interviewed expressed that they were confronted with one or several paradoxical situations. Only one made no mention of paradox whatsoever. This does not mean that he is not in a paradoxical context, but in his interview he gave no indication that he felt that was the case.

From "root paradox" to paradoxes perceived by individuals

Paradoxes formulated by physician-managers take on a variety of different forms. Our analysis reveals four types of paradoxes and we wish to convey this variety.

The typopology of Lüscher and Lewis (2008) composed of three types of paradoxes is relevant to analyse some of our data. Indeed, we found paradoxes of *performing* (competing views of managerial success leading to conflicting demands), of *belonging* (loyalty towards different groups bearing potentially divergent objectives and behaviours), and of *organising* (difficultly compatible organisations of resources). The distinction between these categories can sometimes have more to do with formulation than with content. For example, two expectations can be perceived as contradictory (performing) and stem from two types of actors with whom the individual feels a conflict of belonging. We refer to *performing* when the comments made in the interview refer explicitly to an external expectation and to *belonging* when the person refers to what they are.

The interviews revealed a fourth type of paradox: paradoxes of value. Practice leads to values that can be perceived as being incompatible. The fact that some interviewees spontaneously referred to their activities as unfolding among conflicts of values can be explained by the nature of medical activities in which ethics play a major role.

Paradoxes of performing. They have to do mainly with the dual expectation of activity development and resource control. They are the most predictable type, but not the most frequent. They can be expressed as follows:

> *You are being asked to run a 100-metre dash with your feet bound and a bag over your head … (Unit Manager 1)*
>
> or

I was very upset that we had spent the nurse replacement budget, but at the same time we did so because we needed to. So, there you go, it's really... (Unit Manager 5))

Paradoxes of belonging. They are very common in middle management situations. They express the obligation to be loyal towards management and doctors.

We cannot prescribe freely. We offer services (biological analyses) to our colleagues, who in turn prescribe. We cannot say no to them. It's normal. Doctors are opposed to the notion of budget. It is necessary to perform a diagnosis, and therefore treat patients. At the same time, the director says: you must cut your activities, you are too expensive. It's true that it makes no sense to perform unnecessary biological analyses. Some make more of an effort than others. We are caught in a crossfire (Unit Manager 7).

These paradoxes of belonging can translate into the need to play a double role, both a management agent and a spokesperson for the doctors. As these individuals are being asked to achieve management objectives which have little to do with their original profession, identity can play a leading part in the way they express the need or the unwillingness to be both a manager and a doctor.

I am caught between my colleagues and the administration. My colleagues say we need this and that. You didn't get it, you're a loser. I'm exaggerating but it's not far from the truth. So I say I'm a doctor, I´m not a manager.

So you end up losing your soul as a doctor, you hardly practice any more. I visit the ICU once a week. I come and see how things are doing every morning… No, I'm still a doctor. But my administrative colleagues and the nurses tell me "you have to start thinking differently, you're not a doctor anymore!" (Unit manager 14)

Sometimes the contradictory discourse of the interviewees informs us of the contradiction of roles that they think they have to play. As suggested by (El-Sawad, and al., 2004), the paradoxical sequences in discourse can be analysed as a staging of these different roles.

To me, what counts are the patients. Period. Our job is to offer high quality treatment, the rest is not my problem…

Later on in the interview, showing the need to meet management requirements:

It is frustrating, we aren't given what we need to offer good management. We know how much we cost but not how much we bring in. (Unit manager 11)

Paradoxes of organising. They are expressed mainly around difficulties in allotting time, and the need to dedicate limited periods of time to either activity.

> *We have to work as a doctor, teacher, researcher, in the clinic and on top of that manage the unit, which takes a lot of time… I don't want to leave the clinic. Can you imagine having worked in the department for a month and not having met the boss? No, he's got no time, he's managing the unit. It's a job for the paranoid or the schizophrenic… (Unit manager 6)*

Some organising paradoxes are directly linked to the recently implemented budgetary tools, financing an increase in activity ex post for which resources must be found ex ante.

> *We're having to close beds because of staff shortages, there's less work and we don't have the budget. We can't let this happen. (Unit manager 12)*

Paradoxes of values. Some doctors see the management-medicine tension in the light of values.

> *I have a set of political values, and public service is essential, health is not a commodity. But I know there are strong budgetary constraints, both present and to come. I think that in our field, it is possible to defend these values, or keep them alive without too much compromise. (Unit manager 5*)

The physician-managers express one or several of these levels of paradox.

Unit Manager	**Types of paradoxes**			
1	Performing			
2	Performing		Belonging	
3		Organising	Belonging	
4	Performing			Value
5		Organising		Value
6		Organising		
7			Belonging	
8		Organising	Belonging	
9	No paradox mentioned			
10				Value
11	Performing		Belonging	
12		Organising		
13		Organising	Belonging	
14		Organising	Belonging	

Table 1: Types of paradoxes expressed by the 14 physician-managers

4 positions of the actors regarding paradoxes

We then looked at the position of these actors regarding paradox. As mentioned above, we combined two frames of reference, one suggested by Lewis (2000) and the other by Westenholz (1993). The former deals with attitudes of acceptance, confrontation and transcendence with respect to paradox. The latter looks at logical, pluralistic or schizophrenic approaches to paradox. Our analysis grid is made up of four standard positions: rejection (or pluralistic), detachment (Acceptance), absorption (or schizophrenic), transcendence, which gives an account of the individual attitudes towards organisational paradoxes.

Rejection. The individual keeps one facet of the paradox, rejecting the other. He/she does not question the paradox, but feels it should be dealt with elsewhere, or differently. The choice is justified by competence or identity. The usual phrase is *"I am a doctor, not a manager"*. It resembles the pluralistic attitude pointed out by Westenholz (1993).

> *I'm being asked to manage a small institution, but I have no idea how to go about it, I'm a doctor. Some people have it in their blood, but it's not my case. So there you go. (Unit Manager 13)*

Detachment. The individual recognises the paradox but keeps it at a distance, moves away from it or minimises it. This corresponds to what Lewis (2000) called "action though paradox".

This detachment expresses a refusal of direct confrontation of the resolution of the paradox.

> *You know, we've all met one, a person who's good at saving money, a father who wants his daughter to get the best treatment. I understand reorganisations, I meet my responsibilities as a doctor but I want projects to advance… further… It just makes me want to scream Leave me alone! (Unit manager 1)*

This sometimes goes hand in hand with a form of minimisation, showing that there is paradox but solving it is not at the heart of people's concerns. Individuals learn to live with it.

> *I can't make money on health care. What can you do, it's no big deal. (Unit manager 10)*

Absorption. Individuals recognise the organisational paradox and make it their own individually. However, they are unable to keep it at bay or to solve it by transcending it. The term schizophrenia used by Westenholz (1993) is mobilized on several occasions by the

actors. Individuals express suffering, some are even considering changing positions. Whatever the paradox presented, it often boils down to conflicting roles.

> *It's a job for the paranoid or the schizophrenic… I'd be glad to hand over my position at the head of the unit. If you want it, it's all yours… I'm cut in 2 and I'm not necessarily competent. The fact that I was appointed doesn't mean I know everything. (Unit manager 6)*

> *They'd like to see us as managers exclusively, to be hard liners… I try to do it by saying "be careful, we need to save money …" But at the end of the day, we are still in contact with the base, with the doctors below. But the doctors, the medical staff, they don't understand these extreme savings, this push to break even… So managing a unit is like being schizophrenic. It's a heavy load; long working hours, it wears you out. (Unit Manager 14)*

One of the managers mentions how a third party (here, the press) can be called on to resolve what was considered a deadlock.

> *We have a very high rate of absenteeism. We've got no staff but we still have to guarantee service. Children need to be treated. We have had to close beds in the paediatrics unit. We're heading for big trouble. We are preparing a press release to inform people of our difficulties (Unit manager 12).*

Transcendence. Individuals recognise the paradox. Their comments show that not only are they able to cope with it, but also find conciliatory solutions that transcend opposition. They are those in particular who control and value medical resource arbitration systems.

> *We are really caught in a crossfire. We tried to talk to our colleague, not to try to limit their demands but rather to make them more coherent. So we try to build frameworks, and prescription plans (Unit manager 7)*

Some see the paradox as a resource for action.

> *I don't mind going from one activity in the unit to another in record time, from the clinic to teaching, research, unit management. On the contrary, it allows me to refocus my attention each time I move from one goal to another (Unit manager 3).*

Others highlight the personal characteristics that allow them to achieve this transcendence.

I'm being asked to be a manager. OK, I'll be a manager. But I am a surgeon above all, and the hospital's reputation also depends on me. So my management style is that of a surgeon. On the field. I do alright because I have intuition, flair…(Unit manager 2)

We suggested that the paradoxes mentioned were of a variable nature, according to the individuals. The same can be said of attitudes. Barring a few exceptions (Unit manager 14), who has a constant discourse of personal suffering with respect to the resolution of the paradoxes in which she is heavily involved; unit managers 1 and 2 who seem to be coping without any trouble), the others seem to adopt a variety of attitudes, according to the paradox mentioned.

	Performing	**Organising**	**Belonging**	**Value**
1	Minimisation			
2	Rejection Transcendence		Rejection Rejection	
3		Transcendence	Rejection	
4	Transcendence			Transcendence
5		Minimisation		Transcendence
6		Absorption		
7			Transcendence	
8		Absorption	Transcendence	
9				
10				Minimisation
11	Rejection		Absorption	
12		Absorption		
13		Absorption	Rejection	
14		Absorption – Absorption	Absorption – Absorption	

Table 2: Individual attitudes of physician clinicians toward paradoxes, by types and occurrences

4. Analysis and discussion

We studied discourses of 14 people with both medical and economic responsibilities. This situation is analysed as an attempt to delegate the management of an organisational root paradox, resource consumption control and the increase in treatment quality and volume. The types of paradoxes mentioned in the interviews and individual positions with respect to these paradoxes vary from one person to the other. We have drawn several conclusions from this.

We have identified four individual positions. They bear different consequences on the organisation's capacity to alter its methods of paradox management.

In the first case, that of rejection, the individuals recognise their responsibility only under one of the terms of the paradox. If they admit that all missions are legitimate, they think that different actors should perform them, or at least that they should not be responsible for them. The organisation returns to the previous situation, that of pluralistic management. Paradoxes are still solved through negotiation and power struggle. The shift towards individualised delegation is not applied. However, costs are implied due to implementation and temporary interruption of the system.

In the second case, that of detachment, individuals recognise the fact that they are in charge of paradox management. There are no hints of accusation or particular difficulties in their comments, but paradoxes are held at a distance. The individual minimises them, and protects him/herself against their implications. By resorting to individualised delegation, paradoxes appear to be concealed. From the organisation's point of view, paradoxes seem to be dealt with by individuals, with no guarantee of the fact that behaviours and mindsets might indeed be altered. While this situation might appear favourable from an individual perspective, one could wonder if it is not risky from an organisational standpoint. Change is merely apparent, illusory.

In the third case, that of absorption, paradoxes are indeed dealt with on an individual basis, but are blocked by an individual who has neither the internal nor the external resources to confront them. By resorting to individual delegation, paradox is shifted without any clear positive effects. On the contrary, it can lead to individual suffering and make the reform appear as violent, and therefore illegitimate.

Finally, only in the last case - that of transcendence - can the individual cope with paradox and invent new solutions. In this case, resorting to individualised delegation leads to a change

in paradox management which can be expected to prove positive for the organisation. This is only this latter case that can be considered as a vindication of the implementation of the reform. However, the transcendence position only appears 7 times out of 25 occurrences in our grid. As things stand, there is no indication of any major change in paradox management.

Thus our conclusions highlighting the relative underrepresentation of successful individual paradox management match those made by Westenholz (1993): “paradoxical thinking is the exception rather than the rule”. Besides, our results show that the capacity to transcend paradox certainly depends on the type of paradoxes individuals are faced with. Rather surprisingly, the people we interviewed seem more capable of developing personal values that transcend the economic and the clinical (by favouring such values as respect, kindness, honesty) than inventing new organisational methods. The latter are also dependant on individuals themselves, their behavioural complexity (Denison, and al., 1995), paradoxical capabilities (Lüscher and Lewis, 2008) or “divergent thinking”. As things stand, while the hospital sector was able to develop this divergent thinking, it is more challenging to do so at an individual level. Peng and Nisbett (1999) highlight that paradoxical thinking and acting are not taken for granted in Western culture. Medical practice is certainly an archetype of these cultures. However, personal experience and guidance can facilitate this learning process. In the studied situation, the support of the reform was not designed in this way.

Our results show that not only do individuals vary from one to another with respect to paradox recognition, but there is also an inter-individual variability according to the nature of the paradoxes. This study belongs to the research work looking at the manner in which middle management interpretation practices shape change (Balogun and Johnson, 2004.) The simultaneous consideration of the economic and of the clinic unfolds, according to the interpretations of these unit managers, over various layers (performing, organising, belonging, values), which will be subject to different treatments from a single individual. We also reassert what was stated by Westenholz (1993) “a change in frame of references brought about by paradoxically thinking cannot per se be expected to result in organisational change”. She underlined the temporal instability of individual transformation, we highlight intra-individual variety.

We were surprised not to find a higher number of comments regarding the strategic opportunity offered by paradoxical situations. They are held at a distance or transcended, but there is no indication of the fact that they might allow individuals to implement individual strategic projects, as suggested by the approaches of institutional entrepreneurship. This might

be due to the relatively recent nature of this change since implementing strategic action supposes that the individual be highly familiar with the system it belongs to. Furthermore, in this medical sector, individual games are hard to admit: it seems easier to express difficulties and suffering than an ability to bend rules for personal gain.

Individual attitudes toward the paradox	**Rejection**	**Detachment**	**Absorption**	**Transcendence**
Organizational paradox management	Back to pluralistic management of paradoxes	Illusionary delegation	Blocked management	Successful delegation on individual

Table 3: Individual paradox management and resulting organizational paradox management

Conclusion

In this work, we studied the attempts made by French hospitals to change the management of the root paradox- increasing the volume and quality of medical services and controlling resources. Starting from a political, pluralistic management of this paradox, they are seeking to delegate it to individuals to stimulate new, more effective solutions. This research aims to show the dependency links between the organisational management of paradoxes and the individual situations of the paradoxes, which, according to us, had not been adequately studied in existing literature. To do so, we turned towards these individuals to look into how they coped with such delegation. The results of our case study are the following:

The root paradox, stemming from the requirements of the hospital environment, translates into different types of paradoxes covered by the typology suggested by Lüscher and Lewis (2008) - performing, organising, belonging - to which we added the paradox of values. Here lies a first effort of interpretation by unit managers according to their local framework of action. Individuals then adopt different positions with respect to paradox. We have identified four - rejection, detachment, absorption and transcendence. Each of these individual positions has specific consequences on the organisation, which can be listed as follows: unchanged paradox management, illusory management, blocked management, and in the last case, an effective and innovative individualisation of their management, which then appears just as a case among others. We point out that there is an inter-individual differentiation of paradox

management but also an intra-individual variation depending on the types of paradoxes studied. Our research therefore underlines the weight of middle management on the form taken by operational change. Not only do unit managers translate the organisation's paradox according to their specific framework of action, but they also alter their treatment according to the type of paradox in question.

There are however some limitations to the scope of this research. The most significant one is the fact that it is based on comments made at a specific moment, in an interview situation. It needs to be confirmed by positions taken in decision-making situations. It also needs to be prolonged in time in order to observe the stability of positions - or lack thereof.

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