

Original citation:

Huq, Jo-Louise, Reay, Trish and Chreim, Samia. (2017) Protecting the paradox of interprofessional collaboration. *Organization Studies*, 38 (3-4). pp. 513-538.

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Published version: <http://dx.doi.org/10.1177/0170840616640847>

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PROTECTING THE PARADOX OF INTERPROFESSIONAL COLLABORATION

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Forthcoming in *Organization Studies*

PROTECTING THE PARADOX OF INTERPROFESSIONAL COLLABORATION

ABSTRACT

We studied an interprofessional collaboration (IPC) to understand how professionals engaged with paradox in collective decision-making. At the beginning of our study, we observed vicious cycles in which conflict led to negative tension, professionals were holding tightly to a particular pole of the paradox, and the higher status pole being consistently over-represented in collective decision-making. By the end of our study we observed the presence of virtuous cycles, where conflict led to more positive tension, and where professionals engaged in collective decision-making with more equal representation of conflicting approaches. We call this change process *protecting the paradox* and we identify three strategies that support this process: (1) promoting equality of both poles, (2) strengthening the weaker pole, and (3) looking beyond the paradox by focusing on desired outcomes. We contribute to the paradox literature by showing how vicious cycles can be shifted to virtuous cycles, how professionals and managers can work together to protect a paradox, and how status differences between poles can be redistributed.

The team leader introduced the next client for discussion. She started off by commenting, “We all know Mary (pseudonym) well. She is 13 years old, came into the unit last week. We had trouble deciding whether to admit her or not. Her diagnosis is “bipolar,” and the community counsellors said that they feared she was heading into a lifestyle of drugs. The social worker said she has pulled her out of crack shacks and whore houses a couple of times, and was worried about keeping her alive. I know that a number of people on the team didn’t think we should admit her, but we ultimately agreed it was the right decision. And now we’ve got her, and we have to decide what to do.”

The psychiatrist spoke next: “I really want to get her on the right meds. I’m pretty sure it’s medical, but I want to hear what others think.”

A nurse spoke up quickly, “She is tough to manage here. She pushes all the boundaries. It’s been a whole week. I know we wanted to clear the street drugs from her system before making a decision, but I agree – she needs something (meds) to manage these symptoms.”

The social worker spoke next, “Well, I wonder if we are pushing this too fast. It’s only been a week. I thought we were starting to see some progress with her. She’s following some of the rules. We had a good session yesterday, and I’d like to wait until next week to decide.”

Suddenly everyone at the table seemed to have something to say. The team leader had to remind people to talk one at a time. Everyone who spoke (in turn) spoke with a lot of energy. The conversation went on for about 25 minutes – the counsellors and social workers wanted to work more with behavior modification programs. The nurses and psychiatrist were focused on quicker treatment (medications). The professionals talked together about the importance of both the behavior modification approach and medications, and several people spoke passionately about the value in having such a long conversation because the client was so volatile.

Eventually the team decided that moving ahead with medications on a trial basis was the right way to proceed. The team leader ended the discussion by thanking everyone for their engagement and energy, and said, “This is how we come to much better decisions for clients. We have to really listen to the different points of view.” [Meeting notes, Team meeting: Mental Health & Addictions for Youth]

[from Interviewer notes later the same day] I met with a counsellor who was still unhappy about a couple of decisions made at the meeting today. He told me they should have waited longer to decide about Mary. He was worried that the “counsellor view” wasn’t getting enough attention; he thought his view wasn’t heard.

The above vignette from our study of interprofessional collaboration (IPC) illustrates how professionals can engage with paradox — “contradictory yet interrelated elements that exist

simultaneously and persist over time” (Smith & Lewis, 2011: 382; Schad, Lewis, Raisch, & Smith, forthcoming) as part of their professional work. In the vignette we see that professionals proposed clearly contradictory approaches to dealing with a complex problem — the psychiatrist and nurses proposed treatment guided by a medical approach, social workers and counsellors proposed treatment guided by a psycho-social-behavioural (PSB) approach. And yet, these approaches are also interdependent because their simultaneous use for one client is expected to improve treatment effectiveness (McGaffin, Deane, Kelly, & Ciarrochi, 2015). The recognition that somehow these poles were interdependent is what motivated the professionals to collaborate.

We highlight this situation of paradox as one of many that we heard about in our study of IPC in mental health and addictions. This example illustrates how professionals working in an IPC and making collective decisions can be stretched between contradictory positions — in our case, contradictory treatment approaches underpinned by specialized expertise. What we learned from observing this meeting and others, and from follow up interviews with many of the professionals, was that although they believed that the IPC resulted in better treatments for clients, a number of the professionals felt anxious, discouraged, and even angry about some of the decisions made. They worried about high levels of disagreement and experienced anxiety about bringing together contradictory approaches; PSB professionals, in particular, were concerned that their engagement in debate might not have much value because the medical treatment approach tended to dominate.

The meeting described above was at the beginning of our study. A researcher’s summary comment at the end of the first days of observations and interviews was, “IPC decision-making seems to be time-consuming, energy intensive and likely to lead to angry exchanges or hurt feelings.” As we examined the interview data, it became clear that these negative anxieties could

lead to a situation where professionals dissociated themselves from the group decision and found ways to provide treatment from their own approach (either medical or PSB treatment) within the privacy of their own professional practice. However, over the three-year duration of our study, we observed that professionals became more committed to the group decisions, even if they were initially opposed. By the end of our study, we continued to see professionals argue from either a medical or PSB perspective but, instead of anxiety and negativity, the result of heated debate was usually a collective decision that everyone supported. How did these changes happen? This was our empirical puzzle, and we addressed it by grounding our investigation in the literature on paradox.

Paradox and associated tensions are becoming more salient and persistent in organizations (Lewis, 2000; Smith, 2014; Smith & Lewis, 2011). Successful organizations increasingly find ways to engage with paradox and its inherent tensions (Beech, Burns, de Caestecker, MacIntosh & MacLean, 2004; Fiol, 2002; Smith, 2014). In attempting to understand how managers engage with paradox, scholars have focused on cognitive and organizational strategies through which managers bring together polarized perceptions of distinct occupational groups, customers and employees, or alliance members (Andriopoulos & Lewis, 2009; Jay, 2013; Lewis, 2000; Smith, 2014; Smith & Tushman, 2005).

In particular, the role of managers in avoiding vicious cycles has been highlighted (Smith & Lewis, 2011). Vicious cycles arise when decision-making overemphasizes one side of a paradox leading to counter-demands to attend to the other pole (Lewis, 2000; Lüscher & Lewis, 2008). They are characterized by emotional anxiety and defensiveness - negative tensions - that prevent ongoing engagement with paradox (Lewis, 2000; Lüscher & Lewis, 2008). In contrast, successful managerial action spurs virtuous cycles – positive tensions that encourage attention to

both poles (Andriopoulos & Lewis, 2009; Smith, 2014; Smith & Tushman, 2005). These studies collectively suggest that managerial actions are critical to setting up virtuous cycles, and protecting others from experiencing negative tensions. Yet, as our example shows, others, particularly professionals, may be required to directly engage with paradox. To foreshadow our findings, our study shows that instead of managers setting up virtuous cycles, managers and professionals collectively work together to protect the paradox (shift vicious cycles to virtuous cycles and maintain the tension experienced when stretched between the contradictory poles) in order to gain the benefits of engaging with paradox.

Scholars have recently recognized that paradox arises and becomes salient at different levels in organizations requiring responses from people other than managers (e.g. Jarzabkowski, Lê & van de Ven, 2013). However, we know little about how professionals collectively engage with paradox as part of their everyday work. This is a particularly important gap to fill because professionals are critical members of many contemporary organizations (Noordegraaf, 2011). In these organizations, professionals enjoy high levels of autonomy regarding the nature and quality of work with the result that managerial influence over professional work is limited, at best (e.g. Abbott, 1988; Denis, Langley, & Rouleau, 2007; Freidson, 2001; Noordegraaf, 2011). More often, professionals themselves develop solutions related to issues concerning their own work (Leicht & Fennell, 2008). When professionals engage with paradox it is incumbent upon them to develop ways to engage with contradictory tensions, and while their ways may be connected to managerial strategies, how this potentially more collective engagement with paradox plays out remains unknown (Schad et al., forthcoming).

Focusing on professionals also requires attention to the hierarchy of professional work (Abbott, 1988) and how hierarchy affects professionals' engagement with contradictory

positions. Power and status imbalance between the poles of paradox has been identified as a factor influencing managerial engagement with paradox (Jay, 2013; Smith, 2014). When considering professionals, hierarchy can be important in decision-making. This is particularly so in health care where medical (physician) opinion is accorded the highest status, with established levels of influence among other health professionals (Abbott, 1988; Freidson, 1986; Nembhard & Edmondson, 2006). In understanding how professionals engage with paradox, it is critical to consider status distinctions because these tend to prevent equal engagement with both poles of a paradox. In our study, we pay attention to how status differences play out, examining the question: how do professionals and managers engage with paradox to accomplish interprofessional work?

As shown in the opening vignette, we conducted our study in a health care IPC (D'Amour, Ferrada-Videla, San Martin Rodriguez & Beaulieu, 2005; Petri, 2010). This IPC brought together professionals with medical expertise (psychiatrists and nurses) and professionals with psycho-social-behavioral (PSB) expertise (psychologists, social workers, counsellors) to collectively provide services for clients with complex health problems. Combining these interrelated approaches is expected to improve client outcomes (McGaffin et al., 2015), yet the two approaches are contradictory (Roberts, 1989). The medical approach is aggressive, short term, and heavily dependent on medications, while the PSB approach is conservative, long term, client oriented, and focused on incremental behavioral change. The structure of the IPC was implemented relatively easily; however, after start-up, professionals found it difficult to make collective decisions that drew on medical and PSB treatment approaches equally. This led to vicious cycles in which PSB professionals (in particular), who felt their expertise and treatment approach was undervalued, pulled away and refrained from fully participating in group

discussions and decision-making. Over the three year period of our study, we observed that professionals and managers together developed strategies that helped them protect the paradox, enabling them to keep contradictory approaches central in collective decision-making and sustaining the tension between these approaches. In this paper we focus on these strategies and show how they helped shift vicious cycles to virtuous cycles.

THEORETICAL BACKGROUND

Paradoxes in organizations occur when decision-makers face contradictory yet interrelated elements (poles) that bring with them tensions that persist over time (Lewis, 2000; Smith, 2014; Smith & Lewis, 2011). Paradox consists of two components: first, the underlying tension between “elements that seem logical individually but inconsistent and even absurd when juxtaposed,” and second, decision-makers’ responses to the contradictory elements (Smith & Lewis, 2011: 382). In responding to situations of paradox, decision-makers are stretched between the contradictory interrelated poles.

A classic example is March’s (1991) paradox of exploration or exploitation where organizational decision-makers were advised to choose to explore or exploit rather than trying to cope with the seemingly unresolvable tensions of doing both (Leonard-Barton, 1992; Levinthal & March, 1993; Tushman & Anderson, 1986). In contrast, the contemporary paradox literature suggests that organizational decision-makers can simultaneously engage opposing poles of a paradox in ways that improve organizational outcomes (Smith, 2014; Smith & Tushman, 2005). This approach has been linked to creative and transformative responses, such as supporting and enabling change efforts (Beech et al., 2004; Jay, 2013; Lüscher & Lewis, 2008), transforming organizational identity (Fiol, 2002), and developing creative product designs (Smith, 2014).

However other studies point to potential difficulties in simultaneously engaging

contradictory poles. Overemphasis on one pole can lead to “vicious cycles” characterized by emotional anxiety and defensiveness - negative tensions - that interfere with organizational objectives (Lewis, 2000; Lüscher & Lewis, 2008; Smith & Lewis, 2011). To avoid vicious cycles and encourage “virtuous cycles,” research suggests that managers “openly and critically examine polarized perceptions (e.g., of distinct occupational groups, demands of customers versus employees)” (Lewis, 2000: 764). This managerial approach protects employees from experiencing “confusion, anxiety, and stress that impede and paralyze decision making” (Lüscher & Lewis, 2011: 221). By protecting employees, managers encourage “dramatic changes in ... understandings and behaviors” (Lewis, 2000: 764) instead of allowing employees to flounder in vicious cycles fueled by uncertainty and angst.

The literature points to two general managerial strategies for engaging with paradox in ways that encourage virtuous cycles. First, managers can cognitively accept paradoxical tensions and explore implications for their work (Lewis, 2000; Smith & Tushman, 2005) by engaging in “paradoxical inquiry” that “accommodates, rather than eliminates, persistent tensions” and that helps develop “workable certainties” (Lüscher & Lewis, 2008). The second strategy is to engage with contradictory tensions through the simultaneous adoption of differentiating and integrating tactics (Tushman & O’Reilly, 1996; Andriopoulos & Lewis, 2009; Jarzabkowski, Le, & van de Ven, 2013). These tactics can be combined in organizations because differentiation (separate attention to each pole of the paradox) occurs through organizational design, and integration (interwoven attention to the paradox poles) occurs through organizational visioning and the enhancement of processes and practices (Andriopoulos & Lewis, 2009; Tushman & O’Reilly, 1996). Andriopoulos and Lewis (2009) showed that managers used differentiating strategies to build diversified portfolios, separate project demands, and divide work temporally and spatially;

simultaneously, managers used integrating tactics to develop paradoxical vision, identify integrative practices, and gain support from subordinates. Recent work suggests that these two managerial strategies can be combined. Smith (2014) brought the managerial cognition and the differentiation-integration literatures together, showing how managers cognitively accept paradox and use differentiation and integration tactics in their dynamic decision-making.

Although most studies of paradox have focused on managers and managerial strategies, a few studies have considered the involvement of other organizational members (Andriopoulos & Lewis, 2009; Jarzabkowski, et al., 2013; Raisch & Birkinshaw, 2008). Raisch and Birkinshaw (2008) suggested that choices about how to resolve tensions at one level (i.e. management) could impact decisions made at lower organizational levels. Empirically, Andriopoulos and Lewis found that managing contradictory tensions “becomes a shared responsibility, not only of top management, but across organizational levels” (2009: 708). Similarly, Jarzabkowski et al. (2013) showed that paradox can reside at different levels in organizations impacting individuals, groups, and the overall organization, although their study did not identify strategies to engage paradox at each level. In addition, Smith (2014) noted that managers gathered valuable input from others in the organization (leaders from other units, subordinates and clients) when making dynamic decisions in the face of paradox. All of these studies show that engaging with paradox can involve or have implications for more than managers, but thus far there has been little attention to examining how other organizational members engage with paradox.

Paradox studies show how managers can engage with paradox in ways that spur virtuous cycles and avoid vicious cycles. However, it is less clear how vicious cycles can be changed to virtuous cycles. In addition, we have little knowledge about how professionals engage with paradox. These gaps and questions are particularly important in today’s world where many

organizations employ professionals who hold significant control over decisions about their work.

Professionals, Professional Work and Paradox

Professional work is based on applying specialized expertise gained through lengthy education and focused experiential learning. Professionals in organizations tend to work relatively independently, applying their specialized expertise to parts of complex problems, relying on managers to develop systems for combining the work of different professionals (Abbott, 1988; Freidson, 2001). Latent tensions that exist between contradictory approaches to problem-solving are managed by structurally separating professionals in organizations.

However, with the increasing trend in organizations to combine the services of multiple professionals, new challenges arise (Noordegraaf, 2011). Today, organizational strategies call for interprofessional collaboration (IPC), an attempt to resolve complex problems by combining professionals' different problem-solving approaches. These different professional approaches are interrelated because each addresses a particular aspect of the same complex problem. However, the approaches can also be contradictory, proposing very different answers to the problem at hand. In IPCs, when contradictions become visible and latent tensions become salient, professionals experience paradox in their work.

The literature on professions and professional work suggests that in IPCs vicious cycles are more likely to arise than virtuous cycles. Within health care, but also in other professionalized settings, there is an established and well-accepted status hierarchy that affects decision-making (Abbott, 1988; Freidson, 2001). For example, medical professionals (physicians) hold the highest status in comparison to other health professionals; they hold the exclusive right to practice medicine, and they are allowed by law to engage in 'restricted acts' that no other professionals are allowed to undertake (Abbott, 1988; Freidson, 1986). Nurses are subordinate to doctors;

physicians delegate tasks to nurses and oversee this delegated work (Abbott, 1988; Freidson, 1986). PSB professionals (social workers and counselors) are located lower than physicians and nurses (Abbott, 1988). Within health care organizations such as hospitals, nurses are commonly ‘in charge’ and are given organizational authority over health professionals lower in the hierarchy (Krugman & Smith, 2003). These hierarchical differences translate into challenging dynamics and are likely to spur vicious cycles because decisions are likely to over-emphasize the pole linked to higher status professions (Adler et al., 2008).

Managerial action to protect professionals from paradoxical tensions is also likely to spur vicious cycles. Studies show that professionals hold sufficient power to sustain traditional ways of working even when pressured to change (e.g. Currie et al., 2012; Reay & Hinings, 2005). Power dynamics resulting from clashes between professionals and managers can lead to ongoing conflict that negatively impacts organizational outcomes (Fiol, et al. 2009). Thus, managerial action designed to change professional work in ways that engage with paradox could easily lead to ongoing conflict between managers and professionals, entrenching professionals at opposing poles and further encouraging decision-making that emphasizes the pole connected with higher status professions.

The effect of status and influence imbalances in engaging with paradox is only recently receiving attention in the paradox literature. Smith (2014) suggested that tensions in the explore-exploit paradox exist in part because of a power imbalance between organizations and clients. Somewhat similarly, Jay (2013) suggested that managerial action could avoid power struggles that arise when groups adhere to opposing poles of a paradox. However, additional research is needed to understand the ways that status imbalances affect engagement with paradox, and in particular how these are implicated in vicious and virtuous cycles.

Interprofessional Collaboration

Interprofessional collaborations (IPCs) are an example of organizational arrangements designed to engage with paradox. In IPCs, professionals with diverse, specialized expertise are brought together to engage in collective decision-making to find solutions for complex problems (Abele, 2011; Adler et al., 2008; D'Amour et al., 2005; Petri, 2010). Because they are expected to engage with contradictory positions, professionals tend to find it challenging to work in IPCs, often experiencing conflict, emotional distress and anxiety (Caldwell & Atwal, 2003; Brown; Lewis; Ellis; Stewart, Freeman, & Kasperski, 2011). Conflict can arise because different professionals may take contrary positions, and because hierarchy and status tends to privilege certain professionals over others (Atwal & Caldwell, 2005; Brown, 2011; Hall, 2005).

Although healthcare IPCs have not typically been characterized as paradoxical, professionals are stretched to combine contradictory yet interrelated approaches, as is indicative of paradox (Andriopoulos & Lewis, 2009; Smith, 2014; Smith & Tushman, 2005). Similar contradictions also exist in other IPCs where professionals approach a problem differently but where different approaches are needed to resolve the problem, for example between engineering and architecture where problems involve developing a design solution, (Chrisp, Wilson, & Cairns, 2003; Cuff, 1992). In IPCs tension arises because different types of expertise provide contradictory approaches to problem-solving, reasoning and decision-making (Abbott, 1988; Hall, 2005). Each approach is self-referential, providing its own tools and practices to resolve a particular problem; these tools and practices are typically not compatible (Smith, 2014). Negative tensions arise and persist because each time professionals make collective decisions, the contradictory, self-referential nature of different approaches becomes salient. And, because hierarchy is important, higher status approaches tend to be over-emphasized.

To sum, the current literature shows that virtuous cycles are critical to successful engagement with paradox; however, when professionals engage with paradox vicious (rather than virtuous) cycles are likely to arise. It is unclear how such vicious cycles could be changed to virtuous ones, or how managerial strategies can facilitate professional engagement with paradox in ways that take account of unbalanced status and influence of different poles. We believe that our study of a developing IPC provides an excellent opportunity to explore our research question: *How do professionals and managers engage with paradox to accomplish interprofessional work?*

RESEARCH SETTING AND METHODS

We investigated an IPC in a Western Canadian Health Authority that brought together professionals holding medical expertise (physicians and nurses), with those holding psycho-social-behavioral (PSB) expertise (psychologists, social workers, and counsellors). In the IPC, professionals were expected to use both medical and PSB expertise to make collective decisions regarding diagnosis and treatment. To understand the paradox created, it is necessary to understand the contradictions and interconnectedness of these approaches (e.g. McGaffin et al., 2015; Roberts, 1989).

PSB and medical poles are interrelated because treatments are focused on the problems of one individual human being (McGaffin et al., 2015). However, the artificial division of professional work creates two poles, drawing attention to the contradictions between them (e.g. Roberts, 1989). Outside of IPCs, these different approaches are provided separately. Medical experts usually work in hospitals, using medical expertise to diagnose mental illness and treat symptoms with medication. In contrast, PSB experts usually work in community settings and support clients in learning how to manage their addiction or mental health concerns, with their

approach grounded in the belief that individuals, through self-motivation, can change their behaviour. In IPCs, the approaches are purposefully brought together.

Data Collection and Analysis

We followed a case study research design to gain a deep understanding of how professionals and managers designed and responded to the dynamics of developing an IPC (Creswell, 2013; Marshall & Rossman, 2010; Stake, 1995). We were fortunate to enter the research site just six months after the IPC was implemented. This meant that professionals and managers had some experience in working together, but the model remained relatively new. We collected three types of data: interviews, meeting observations and publicly available documents about the IPC initiative. Our primary data source is 40 in-depth semi-structured interviews, conducted at three times – T1, T2, and T3. (T1, 6 months after the IPC was operationalized; T2, 1½ years after start-up; T3, 2 ½ years after start-up.) The interviews were designed to help us gain an understanding of how the team made decisions about what treatment to provide. Our interviews at T2 and T3 allowed us to hear about changes over time.

In addition to interviews, we also observed six team meetings where decisions were made about client treatment (two at each of T1, T2 and T3 -- each ranging from one to two hours). In the meetings we took notes based on our observations of professionals and managers as they engaged in discussions debating the merits of alternate approaches to care and deciding what action the group should take. We observed interactions between different professionals and between managers and professionals, providing alternate views of the phenomena and supporting methodological triangulation (Denzin, 2006). Our data set also included documents about IPC and the Health Authority's strategy for improving mental health and addiction services. This background information improved our general understanding of the context. We used an

interpretive approach to analyzing the data (Golden-Biddle & Locke, 2007; Locke, 2001; Stake, 1995), moving between the data, the emergent themes, and extant literature (Creswell, 2013; Miles, Huberman & Saldaña, 2014). In this process we developed codes that we used to categorize our findings. We used NVIVO 10 qualitative software to assist with this process.

In coding the data, our attention was drawn to examples professionals and managers provided where decision-making was particularly difficult. These statements, particularly prevalent at T1, illustrated aspects of *vicious cycles*. Professionals and managers also talked about the contradictory yet interrelated nature of the PSB and medical approaches. Interviewees explained how the approaches were in conflict, leading to opposing decisions with respect to client care (coded as *contradictions*); however, they also insisted both were needed to improve client outcomes (coded as *interdependence*). We also saw, in the data, that professionals found it challenging to make decisions collectively because of status differences (coded as *status and influence on decision making*).

In later interviews our attention was drawn to claims that decision-making in the IPC had improved and that both medical and PSB approaches were being considered more equally (coded as *virtuous cycles*). In further analysis of the data, we realized that professionals and managers had developed strategies that allowed them to make decisions that sustained the tension between contradictory approaches. We observed that these strategies were focused on managing negative anxieties, disagreements, and even anger that arose during decision-making. Below we provide an example of our approach to coding using Strategy 1, *promoting equality between poles*. To start we identified and aggregated data segments that described the practical actions taken to help professionals work ‘in the spirit of IPC’. We saw that managers and professionals set up structural elements that positioned medical and PSB approaches equally, and we aggregated

examples of this under the code *setting up a structure to respect PSB and medical*. We also saw that managers and professionals tried to ensure that medical expertise did not dominate collective decision-making, and that some weight given to the medical approach was shifted to the PSB approach. We coded these data extracts as *shifting weight from medical to PSB*. Finally we saw that developing a common vocabulary helped PSB professionals, in particular, present their treatment approach in ways that were more influential. We coded these data segments as *developing a common vocabulary*. As we abstracted from the practical action codes to a more theoretical level and refined our analyses we adjusted our code labels accordingly. For example the code ‘setting up a structure to reflect PSB and Medical’ was adjusted to ‘promoting equality between poles’. A similar approach was used to identify and develop Strategies 2 and 3. As we refined our coding, and further examined the emergent strategies, we considered how they were linked iteratively and purposefully in an overall process of change.

FINDINGS

At the time of our first interviews, medical (physicians and nurses) and PSB (social workers, psychologists, and counsellors) professionals had been recently co-located in one unit, instead of the previous arrangement that located them separately in the organization.

Professionals were keen to talk with us because they had had time to experience the new working arrangement, and they told us that it was turning out to be much harder than expected to engage in IPC. Although interviewees did not use the term paradox they explained the tensions they were experiencing in a way that was consistent with the definition of paradox.

In T1 interviews, we heard that professionals were trying to keep both the medical and PSB approaches (both poles) prominent in their decision-making because they believed this would improve client outcomes. However, they experienced tensions when they tried to combine

medical and PSB approaches because each supported contradictory decisions about treatment. They tended to slip into established patterns of decision-making based on status and influence, with medical professionals more strongly influencing decisions and PSB professionals acquiescing. Although all professionals were committed to making decisions together, avoiding hierarchical norms was difficult. These tensions spurred vicious cycles in which the medical approach was over-emphasized, as reflected in the following:

We're going through each case ... we have different perspectives about what's the medical version of our plan, what's the [PSB] portion of our plan ... there's butting of heads.
(Manager)

We'll have debates on whether we're going to push for medicines or whether we're going to go conservative. We're still struggling with [conflicting] concepts ... we [medical experts] feel we need to be more aggressive with our adolescent youth with addiction problems. (Psychiatrist)

Someone [can have] a certain clinical impression and it's not supported by the rest of the team or ... a key member of the team ... for example, the psychiatrist. Even though we are a team, everybody looks to [the psychiatrist] for the final decision. (Manager)

What happens ... [other professionals] are not as willing to say things and argue with me.
(Psychiatrist)

By the end of our study, managers and professionals told us that, although it was not perfect, professionals had become much better at collectively making decisions that held the medical and PSB approaches in equal consideration, and that maintained the tension between them. Even though doing so time-consuming and sometimes led to conflict, professionals and managers said that carefully considering contradictory approaches facilitated better quality of care and consequently better outcomes for clients. By T3, professionals described how collective decisions were more equally balanced between medical and PSB approaches and how negative reactions (anger, defensiveness) were less common:

The reason [IPC] works well is because ... most people feel heard ... when we solve problems, very seldom do we have a lot of people being disgruntled after ... It happens, for

sure, but I think people do for the large part feel heard. (Psychologist, T3)

If a client is being assessed ... it's a group decision ... on the really difficult ones we will ... debate whether or not we want to use a medicine ... [or] try a cognitive therapy or therapies or relaxation or things first. We will listen even if we feel strongly [otherwise] ... We will give things a try if the team wants to give it a go. (Psychiatrist, T3)

Strategies to Maintain Tension (Protecting the Paradox)

Our analysis uncovered three strategies that helped professionals more equally emphasize contradictory approaches (poles) but still maintain the tension between them. These strategies are: (1) promoting equality of both poles, (2) strengthening the weaker pole, and (3) looking beyond the paradox by focusing on desired outcomes. We see that the enactment of these three strategies over time served to protect the paradox of IPC. Although we present these strategies in the order that they emerged in the data, there are aspects of the strategies that are overlapping and iterative. The first strategy, *promoting equality of both poles*, was evident in the design and establishment of the IPC. However, over time it became clear that the weaker voices of PSB professionals were not being heard, and therefore the second strategy, *strengthening the weaker pole*, was developed. Finally, the third strategy, *looking beyond the paradox by focusing on desired outcomes*, emerged to sustain the paradoxical tension over the longer term. Below we explain each of the strategies and provide representative quotes to illustrate our descriptions. Additional quotes are provided in Table 1.

— Insert Table 1 about here —

1: Promoting Equality of Both Poles

The concept of IPC was based on a belief that complex problems (in this case, clients with complex mental health and addictions concerns) could be best addressed by bringing different professionals together to consider the problem from different expert positions. Managers and professionals took actions to facilitate open and equal consideration of both the medical and PSB

approaches to treatment by: (a) setting up a structure to respect both poles of the paradox, (b) shifting weight from the higher status to the lower status pole, and (c) developing a common vocabulary. We explain each of these below.

First, managers set up an organizational structure to support equal consideration of the two poles. Professionals were co-located in hospital space where physicians, nurses, psychologists, social workers and counsellors were all situated together. Team leaders were purposefully chosen so that nurses were not always in charge. Regular meetings were held to review clients' diagnosis and treatment plans; at each meeting medical and PSB professionals sat at a large table and everyone was expected to engage in discussions. Managers also developed staffing rotations that paired medical and PSB professionals, equalizing the presence of PSB and medical professionals on the unit.

Right from the beginning [of the IPC] ... at all intakes [weekly intake meeting] we expect everybody that can be there to be in attendance ... when we do clinical rounds on all the cases - all the people are there ... each discipline. (Psychiatrist)

Nurses are used to being in-charge. [But] we don't have 'in-charge' here ... there is no hierarchy of care here. It doesn't go nurse, counselor, LPN. (Manager)

We decided that we needed to shift our staffing complement to further support our integration ... We decided to lessen our intensive nursing complement ... cut back on the RN/RPN complement and ... bring in some clinicians ... psychology, sociology, social work. (Manager)

In spite of efforts to facilitate equality between medical and PSB approaches, the medical approach tended to prevail since people were socialized in a hierarchical system where physicians were most powerful. Managers and medical professionals (especially psychiatrists) engaged in a second set of activities that served to shift some weight from the higher status (medical) pole to the lower status (PSB) pole. Psychiatrists tried to listen carefully to the views of PSB professionals, and managers tried to ensure that at meetings there was relatively equal

attention to both medical and PSB views. In addition, psychiatrists tried to downplay the perception that they, because of their medical expertise, always knew the right answer. Instead they purposefully pointed to gaps and uncertainty:

[Psychiatrists'] voice is biggest ... the bottom line is they [psychiatrists] do have the final decision-making power. (Social Worker)

When I think things aren't as equal as they should be in our meeting discussions ... I will try to stop the psychiatrist from deciding, so I interject by saying, "Well what do [the counselors, social workers, nurses] think?" (Manager)

I'm approachable... I defer to my team ... there is a lot of self-deprecation ... [I'm] very comfortable with telling them, "You know where I've messed up and you know where I'm confused, I don't know what's going on here." I'm not trying to maintain a status of perfection. (Psychiatrist)

The third way that equality was promoted was by developing a common vocabulary.

Professionals realized that collective discussions required that they use and understand terminology in the same way. Psychologists and psychiatrists, in particular, worked to teach other professionals the meaning of specialized vocabulary and how it was used. For example,

Some people ... may not know the difference between the two [terms from DSM] so I'm actually, while I'm talking, I'm teaching at the same time ... People seem to like it because they can get their point across better. (Psychologist)

The team watches the discussions ... they learn when I say schizophrenia what do I mean? When I say bipolar, when we say dissociative psychosis, this is what I mean. It helps us have a better discussion. (Psychiatrist)

PSB professionals became fluent in using terms from the Diagnostic and Statistical Manual of Mental Disorders (DSM), the manual used by psychiatrists to diagnose mental disorders. We heard and observed psychologists, social workers, and counselors increasingly using medical terms in a familiar manner, peppering their talk with terms such as 'DSM,' 'bipolar,' and 'schizophrenic'. Counselors and social workers incorporated this vocabulary into their discussions with medical professionals in such a way that they garnered more attention for their

opinions.

[I] throw stuff [medical terms, medical ideas] out there [in meetings] and [the psychiatrist] would always make sure to ask me, “Okay, where are you coming from and why do you ask that?” ... I think it helped [psychiatrists] listen to what I said. (Counselor)

Our data also contains (relatively rare) instances of medical professionals using terminology associated with PSB expertise. For example, we heard a psychiatrist casually referring to an adolescent as a ‘Seroquel kid’. This is a colloquial term used by counsellors and social workers to refer to individuals taking Seroquel medication as part of schizophrenia treatment. Typically, psychiatrists do not use slang terminology, especially that of lower status professions, and we see that incorporating PSB slang in the common vocabulary helped reinforce and promote a sense of equality in the IPC. In addition, we also heard nurses incorporating PSB vocabulary associated with principles of client-centered counseling.

Although the common vocabulary was skewed toward medical terminology, reflecting the higher status medical approach, we saw that it helped to keep both poles of the paradox prominent. The common vocabulary facilitated more equal discussions and debates about diagnosis and treatment - presenting contradictory approaches in ways that improved understanding of how both could benefit client treatment. Important to how this strategy protected paradox, counsellors and social workers did not use medical vocabulary to argue against a medical approach. Instead, they co-opted medical vocabulary to argue for stronger consideration of the PSB approach. At one meeting a social worker presented a passionate argument for maintaining a PSB approach (continued counseling; avoiding medications) by thoroughly explaining all the side effects of proposed medications and arguing that non-medical treatment would lead to the best outcomes. This example illustrates the importance of using vocabulary understood by all, and how this counsellor used medical terminology to make a case

for PSB treatment.

Strategy 1 summary. Positioning both poles equally protected paradox because it ensured both PSB and medical approaches were considered as legitimate options for treatment. The strategy maintained tension by reinforcing the equality of the contradictory approach (PSB) in the face of the more dominant medical approach, and by avoiding decision-making that defaulted to traditional norms relying on medical status and influence. The strategy helped shift the vicious cycle to a virtuous one in which professionals could equally position contradictory approaches so that both were considered in collective decision-making. While this strategy partially achieved these aims, the medical approach, however, remained inherently more influential in the IPC. This can be seen in relation to the common vocabulary which helped psychiatrists better understand what the PSB professionals were telling them without psychiatrists having to expend effort or make changes themselves.

2: Strengthening the Weaker Pole

By our second round of interviews (18 months post start-up) we heard about other strategies that had been developed to encourage IPC. Managers and professionals told us that attempts to keep both medical and PSB approaches equally important in decision-making were not as successful as they hoped because PSB professionals tended to be quieter and less forceful in explaining their approach compared with medical professionals. Everyone, and managers in particular, was concerned because the ‘less strong’ participation of social workers and counsellors meant that the PSB approach received less attention than it should. They told us that both approaches needed to be strongly represented in lively debates:

Everybody's an expert ... all this expertise makes us a lot smarter ... [IPC only works when] people aren't afraid to speak up and disagree. [It's] not working if some professionals don't speak up. (Manager)

We need everyone's opinion on how [treatment] is going because everyone's looking at it from different perspectives ... [but] we've definitely had clinicians that have taken a very long time to feel comfortable in speaking up. (Manager)

In order to address this concern managers and professionals worked to strengthen the weaker pole by: (a) coaching PSB professionals how to present ideas more effectively, and (b) purposefully engage in after-meeting discussions. We explain each of these below.

Managers told us that weaker PSB voices were too often dismissed as irrelevant because medical professionals relied on the strength of an argument as a key indicator of how strongly an expert opinion was held. In response, managers, in coordination with medical professionals and the most experienced PSB professionals, engaged in two actions aimed at strengthening the weaker pole (PSB), and thus encouraging virtuous cycles in which both approaches were equally considered and the tension between them sustained. The first action was to coach PSB professionals (social workers, counsellors) on how to present their ideas more effectively at team meetings. Managers coached those with 'weaker voices' how to speak up and be heard, giving them specific pointers for how to communicate effectively with psychiatrists and medical experts.

[I tell counselors] ... when you're talking to a [psychiatrist] it's different [than talking to counselors]. Speak more in bullet points ... that's how he wants to hear things ... you need to get to the point. So we have made a template ... on how to present (Manager)

[I tell social workers and counsellors] Maybe you could have presented it differently because you had the right idea but what you were saying wasn't coming across [you were not being heard] ... maybe you might want to try this approach [i.e. the template] next time (Manager)

High status professionals also tried to strengthen weaker voices. The psychiatrists and the psychologists encouraged PSB professionals to speak up and present contradictory expert opinions. During weekly group meetings psychiatrists consistently asked each professional to express an opinion. In our meeting observations we noted that psychiatrists complimented

professionals who brought contradictory approaches forward, encouraging them to continue doing so.

I think it is important if you want people to speak up, you need to compliment them. And when you're alone with them, you tell them the good job they're doing, you encourage them and build them up. (Psychiatrist)

[From meeting notes] Psychiatrist asks social worker to comment on family support available for recently admitted client. After she provides concise statement about mother, absent father, and at-home siblings, psychiatrist says, "Thank you! That is absolutely important information!"

These tactics had the effect of enhancing PSB professionals' presentations, making medical professionals more likely to listen to them instead of passing over their ideas as not relevant. The presence of stronger PSB voices elevated the relative influence of the PSB approach in collective decision-making.

The second action to strengthen weaker voices was to purposefully engage in after-meeting discussions. Recognizing the opinions of PSB professionals were needed for effective decision-making, psychologists (in particular) took extra steps to ensure that these views were considered. Psychologists often remained behind after team meetings for follow-up conversations with PSB professionals to ensure that their ideas were not lost. However, because psychiatrists and nurses were often dismissive of opinions that in their words, "weren't strongly enough held to be raised at the meeting," contradictory approaches expressed only after meetings had less influence than they would have if presented in a formal meeting. As a result, these after-meeting conversations were usually reserved as a way to educate and encourage PSB professionals who were new to the team to provide these same ideas in formal meetings. In the short term, extra care was taken to gather the views of professionals new to the team, but in the longer term it was expected that everyone engage in discussions at regular meetings.

Some people feel much more comfortable if I stay behind [after the meeting] and then they

[say], “Well, I think it’s maybe this, but I just didn’t want to say it” ... I make myself available as sort of an intermediary. (Psychologist)

Our interviews with professionals having potentially weaker voices (i.e. counsellors and social workers) revealed that they appreciated the intentional efforts to encourage and strengthen their voices. Counsellors and social workers told us that, although it could still be difficult to voice their contradictory (PSB) approach, they became more comfortable presenting their views in the group setting. Over time, our observations of meetings showed that weaker voices became stronger and debate became even livelier with all professionals usually fully engaged.

[A psychologist] validated a lot of the things that I said and told me, “Yes, you *are* on the right track” ... [after that] I was more likely to speak up. (Social Worker)

I was fairly quiet and so [a psychiatrist] would say, “What do you think?” ... [The psychiatrist would say], “Yes, you have an opinion. Please tell us.” I didn’t like it at first, but it made me talk more. (Counselor)

Strategy 2 summary. As weaker voices were strengthened, PSB professionals became more comfortable presenting and arguing for their approach, even in the presence of higher status (medical) professionals. Medical professionals gave more serious attention to PSB professionals’ opposing views helping maintain the tension between these approaches, and, according to our interviewees, better decisions were made. However, we saw no evidence that psychiatrists and nurses softened their voices or weakened their support for the medical approach. This was not a rebalancing between poles. Strategy 2 achieved a relative increase in the strength of the PSB pole vis-a-vis the medical pole without the medical pole ceding power. The strengthening of the weaker pole helped maintain tension and began shifting vicious cycles towards virtuous cycles where both approaches were more equally represented in collective decision making. However, discussion and debate remained heated and decision-making remained time consuming and conflictual.

3: Looking Beyond the Paradox to Focus on Desired Outcomes

Promoting both poles equally and *strengthening the weaker pole* helped encourage virtuous cycles where PSB and medical approaches were more equally considered in collective decision-making. However, managers were concerned that the extra effort required to work this way challenged the long-term sustainability of the IPC. As a result they began to encourage professionals to look beyond the contradictory tensions of paradox and focus on the potential to improve quality of care for complex clients. They did so in three ways: (a) steering conversation in meetings to encourage debate but keep focused on client outcomes, (b) taking action to manage negative conflict that arose as a result of heated debates, and (c) working with professionals to ensure that treatment was completed in line with group decisions.

Managers told us that they attended team meetings with the specific intention of watching and listening for professionals who were not happy with collective decisions and who voiced discontent about treatment plans. Recognizing that unhappiness sometimes led to discouragement and even anger, managers watched for these negative emotions, attempting to turn them into something more motivational. When managers observed negative emotions, they interjected in meetings to acknowledge professionals' discontent but attempted to refocus discontent as constructive to on-going collective decision-making and client treatment. Managers told us, and we observed in meetings, that they frequently reminded professionals that the interdependence between the medical and PSB approaches was key to helping clients: they argued for the importance of contradictory approaches and heated debates and discussions that professionals found taxing. By intervening at opportune moments managers were able to 'build up' professionals and 'smooth ruffled feathers', reorienting professionals to the bigger picture - client outcomes - and refocusing attention away from tensions and negative conflict and

encouraging virtuous cycles.

I can see it as I sit in the meeting... I can pick up ... [when ideas are] not going to be received very well and I ... check in with them [professionals] later and see how they're doing ... [I'm] trying to build them back up. (Manager)

My role in meetings is ... to smooth ruffled feathers and help them [professionals] get over perceived attacks. (Manager)

Managers and professionals also ensured that work was completed in accordance with collective decisions. While they encouraged professionals to continue voicing contradictory approaches to treatment (building on strategies 1 and 2), managers held firm that between meetings client treatment plans would not be changed. Professionals mostly agreed, and followed the collective treatment plan, debriefing with managers and each other to develop ideas for upcoming meetings. We heard that as a result the flow of the unit improved, allowing professionals to quickly provide aggressive care to clients while at the same time providing improved access to PSB treatment. We also heard from both medical and PSB professionals that overall there was a greater appreciation and understanding for different approaches in the IPC.

Somebody is fully allowed to disagree ... when we're looking at making any kind of changes to the treatment plan. But my job is to make sure that if we have decided to proceed ... with a particular course of action that everyone is following it. It's what's best for the client. (Manager)

The flow is so, so smooth now ... if I get a ... schizophrenic kid ... I don't have to have the long arguments [about why medical is important] ... we can ... aggressively manage [clients] ... what would happen [before] is those kids would just be kicked out as not ready or not willing to go through [PSB] treatment ... now we say, 'Crystal meth has made you psychotic, you're moody, you're really unwell ... we will bring you up to the ... unit and stabilize you ... and you can continue your [PSB] treatment. (Psychiatrist, T3)

In the last year it's been a lot better ... the level of support and interest in what we're doing as clinicians ... is raised up. I noticed ... more of an understanding of what I do and how I can actually help ... I think it's been great in the last year ... I don't feel the need to hammer home through a series of lectures or e-mails, here's what I do and here's what I require. (Psychologist, T3)

Strategy 3 Summary. This last strategy was critical to protecting paradox because it

reminded professionals and managers why it was important to engage with the paradox, even though this made work more difficult. Focusing on desired outcomes provided a reason for professionals (and managers) to continue engaging in virtuous cycles, even though they found this a difficult way to work. Focusing on desired outcomes and holding professionals to treatment decisions made protected the paradox because professionals were reminded that they needed both approaches to achieve better outcomes. Thus, professionals more consistently included both poles equally in their decision-making, sustaining tension between contradictory approaches and protecting the IPC paradox. As professionals became better at engaging in virtuous cycles and protecting the IPC paradox - in effect becoming more proficient at recognizing the interdependencies between medical and PSB approaches - work flow improved. We see this as a key reason why professionals continued to engage in and support IPC work.

DISCUSSION

We wanted to understand how professionals and managers engaged with paradox to accomplish interprofessional work. We found that engaging with paradox was a purposeful approach to improving the quality of services provided. Our study builds on recent research suggesting that engaging with paradox is increasingly part of daily organizational life (e.g. Smith & Lewis, 2011; Smith, 2014). However, instead of focusing on strategies used by managers to engage with paradox (e.g. Andriopoulos & Lewis, 2009; Smith, 2014), our attention to professionals shows that others engage with paradox in meaningful ways. Our findings expand on suggestions that paradox is important at different organizational levels (Smith & Lewis, 2011; Jarzabkowski et al., 2013; Raisch & Birkinshaw, 2008), and illustrate how professionals engage with paradox as part of their everyday work. With its implicit focus on change, our study moves away from literature that depicts less and more successful ways to engage with paradox - vicious

and virtuous cycles (Lewis, 2000; Lüscher & Lewis, 2008; Smith & Lewis, 2011). Instead, we develop a more dynamic depiction of how vicious cycles can be changed to virtuous cycles, and how this can be accomplished when poles of the paradox are unbalanced in status and influence.

Our study highlights different roles of professionals with respect to paradox. Professionals were motivated to simultaneously consider contradictory approaches (PSB and medical) in collective decision-making because they believed that better treatment for complex clients would result. Professionals and managers together developed strategies that not only attempted to avoid vicious cycles (e.g. Smith & Lewis, 2011), but also changed vicious cycles to virtuous cycles. Achieving this change was made possible because the strategies developed maintained the tension associated from being stretched between contradictory approaches, and also addressed the implicit power (status) differences between the poles of paradox. Collectively, these strategies comprise a change process we call ‘protecting the paradox.’ With virtuous cycles in place and vicious cycles greatly reduced, professionals were able to achieve what they considered to be better outcomes for clients by maintaining the tensions between the PSB and medical approaches.

We contribute to the paradox literature in three ways. First, we develop and explain the concept of *protecting the paradox*. *Protecting the paradox* entails shifting from vicious cycles to virtuous cycles through three strategies: (1) promoting the equality of both poles, (2) strengthening the weaker pole, and (3) looking beyond the paradox to focus on desired outcomes. We illustrate the process in Figure 1, where we show the three strategies occurring over time. Our analysis suggests that the strategies were developed in the order presented; however, we note that their emergence was sometimes overlapping and iterative. Together these strategies helped professionals recognize the interdependencies between contradictory poles, and thereby

recognize the value in the paradox and find ways to safeguard it in their day-to-day work even though their work was more difficult as a result. Our insights into the importance of power dynamics in protecting a paradox may also help to inform emerging conversations that bring together concepts related to organizational paradox with the contradictions and dialectics literature (Putnam, 2015; Putnam, Fairhurst & Banghart, forthcoming). In particular, we see that our attention to protecting the paradox speaks to a process through which tensions can be “kept connected in continual interplay” even when they are underpinned by power imbalances (Putnam, 2015: 707; Putnam, Fairhurst, & Banghart, forthcoming; Seo, Putnam, Bartunek, 2004).

[Figure 1 about here]

Our second contribution is to draw attention to the dynamics involved in protecting the paradox. Previous studies have suggested that, in the face of paradox, managers should create a “workable certainty” to reduce anxiety and defensiveness that could otherwise spur vicious cycles (Andriopoulos & Lewis, 2009; Lüscher & Lewis, 2008; Smith, 2014; Smith & Lewis, 2011). This implies that when paradox is encountered managers must take action to avoid vicious cycles because they easily become entrenched (Lewis, 2000; Smith & Lewis, 2011). In contrast, our study shows how vicious cycles can be shifted to virtuous cycles. At the start of our study, we heard about vicious cycles where tension existed in the form of anxiety and defensiveness and where the over-emphasis of one pole was reinforced by status differentials. However, rather than vicious cycles continuing in perpetuity, negative anxiety and power differentials were managed by strategies that replaced vicious cycles with virtuous cycles. These kinds of strategies must be grounded in an understanding of why tensions arise between contradictory poles, any status and influence (power) imbalances between the poles, and the

ways in which poles are interrelated. The protecting strategies need not be overly complex, for example, people may be able to overcome anxiety through support and developmental coaching from managers or others with higher status. However, because professional work does not typically involve such actions and does not typically welcome uninvited interventions, professionals themselves must be directly involved in developing and implementing protecting strategies.

Our third contribution is to highlight the actions of professionals in shifting vicious cycles to virtuous cycles and thus protecting paradox. In contrast to literature that focuses solely on managerial action (e.g. Andriopoulos & Lewis, 2009; Smith & Tushman, 2005; Smith, 2014), our study clearly shows that other organizational actors - professionals – can be involved in finding ways to engage with tensions that arise from paradox. Professionals were instrumental in developing protecting strategies that helped give voice to a weaker contradictory position and that helped those at the higher status pole understand the contradictory position. Professionals' action was also critical to rebalancing the status differentials between poles. But in addition, managerial action supported professionals. Managers helped professionals experience tension in a positive rather than negative way, encouraging them to use it in a way that improved their work and better equipped them to increasingly engage in virtuous cycles. Importantly, managers did not attempt to influence professionals' decision-making; professionals remained the key decision-makers in their work. Instead, managerial actions shaped the environment in which these decisions were made. Ultimately, our study shows that action from professionals and managers is necessary to shift vicious cycles to virtuous cycles and protect paradox, and our findings point to the need for a strong working relationship between professionals and managers in this process.

Finally, we contribute to the paradox literature by drawing attention to status differences between the poles of a paradox, showing how these initially contributed to vicious cycles and how protecting strategies helped rebalance status and helped shift vicious to virtuous cycles. The current paradox literature hints at such imbalances and suggests that managerial strategies are able to address power differences and thus avoid vicious cycles (e.g. Jay, 2013; Smith, 2014). We show how power imbalance shapes engagement with paradox, describing how the pole linked to higher status is over-emphasized leading to vicious cycles. We also identify strategies that rebalance power resulting in a more equal balancing of poles in decision-making, and supporting virtuous cycles. Going beyond the paradox literature, we see that our attention to how imbalanced poles can be rebalanced could also inform the literature on planned organizational change, especially in relation to change models that attempt to pay attention and select sides of dualities that have traditionally been ignored (e.g. Seo, Putnam, & Bartunek, 2004).

Our first two strategies of protecting the paradox addressed power imbalance by ensuring that contradictory poles more equally shaped decisions (virtuous cycles), instead of one pole being over represented (vicious cycles). Both strategies required action by purposeful actors (here, professionals) at the higher status pole who shifted the focus from themselves to the lower status pole. By focusing attention on the lower status pole, the pattern of exchange changed. Similar to Chreim et al. (2013), our study shows that by encouraging and supporting professionals associated with the lower pole to express their views, higher status professionals served as important role models, providing a visible example of equality. Managers' actions were also important in creating a sense of equality; they were neutral observers, cultivating relationships with the higher status professionals that allowed them to remind these professionals to step back when they were becoming demanding or overly directive. The nature of this

relationship helped managers encourage professionals to be involved in discussions and decision-making, without directly weakening the stronger pole.

Our study also reveals the importance of developing strategies that fit with the higher status pole when the goal is to rebalance opposing poles. Developing a common vocabulary helps elevate the influence of the lower status pole and re-balances poles in collective decision-making. However, this common vocabulary may need to incorporate more terminology from the stronger pole in order to be effective at rebalancing. Similarly, when managers coach actors at the lower status pole how to strengthen their voice, tactics should fit with the ways of talking and listening associated with the higher status pole. In thinking more broadly about our findings, we suggest that protecting paradox when poles are unequally balanced requires both the willingness of those associated with the powerful pole to be open and encouraging of the less powerful pole and also requires those associated with the less powerful pole to develop rebalancing actions that fit the powerful pole.

Finally, we draw attention to the role of managers in re-balancing inequality between poles. Managers must find ways to focus on elevating or strengthening the lower status pole without detracting from the higher status pole. Rebalancing in this way may be an important consideration in avoiding resistance from those affiliated with the stronger pole. This managerial work requires deep contextual understanding and the ability to sometimes subtly and sometimes forcefully intervene in team dynamics. Protecting the paradox requires sophisticated managerial skill to identify and work with status imbalances in a nuanced way.

Thinking beyond our own research setting, we recognize that other work arrangements are likely to create paradox and contradictory tensions that professionals will need to protect in order to accomplish their work and achieve organizational goals. Our findings suggest a particular set

of strategies that can be employed in protecting a paradox, and we draw attention to how both managers and professionals are involved in these strategies. We also suggest that professional work is such that professionals may not see how tensions arising from contradictory approaches and power imbalances spur vicious cycles. They may take vicious cycles for granted, assuming that these are par-for-the-course when contradictory approaches are drawn together. In these situations, managers may be able to subtly lead professionals into engaging in actions that help shift vicious cycles to virtuous cycles. Managers can encourage professionals to think about how seemingly contradictory approaches hold interdependencies, and they can encourage professionals to examine whether the different approaches are being positioned equally in collective decision-making. When vicious cycles are underpinned by status imbalances, managers can encourage re-balancing actions from high status and low status professionals. Finally, managers can help to keep professionals motivated by articulating the importance of engaging with paradox to improve outcomes. Remembering the bigger picture is likely critical in many situations.

CONCLUSIONS

Our study of how professionals and managers engage with paradox in interprofessional work, showed that *protecting the paradox* was achieved through strategies that changed vicious cycles to virtuous cycles. These strategies maintained tension between contradictory poles, made interdependencies visible, and rebalanced status differentials. Although we are confident that the model we developed is representative of our data, some particularities are important. First, the process we observed was iterative and evolving, and continued to be so even as our research involvement ended. Thus, it is conceivable that other strategies were developed, or the strategies we identified incrementally adjusted to further the aims of the IPC. In addition, a particular

feature of the IPC may have contributed to the success of particular strategies, in particular strategies involved with rebalancing power between poles. The geographic location of this IPC, a semi-isolated location, meant that both medical and PSB professionals were embedded in a tight-knit community where they were deeply invested in their work. The professionals truly believed that IPC would lead to improved services for youth in the community. This context may have enhanced professionals' willingness to explore how to protect paradox, and may help explain why high status professionals were willing to cede some power. This is not to say that the process we identified will work only in similar settings, it might however mean that a sense of urgency and "doing better" must be fostered in settings where community engagement is perhaps not as strong.

Our study brings the usual limitations of qualitative case studies. We do not know to what extent our findings can be generalized, but we expect they will be transferrable to other situations where professionals are asked to make collective decisions using contradictory approaches underpinned by specialized expertise. This certainly occurs in health care where complex health problems are often tackled by bringing together professionals with diverse specialized expertise, such as in primary health care, where physicians, nurses, dieticians, rehabilitation specialists, and clients are commonly brought together to engage in shared decision making (Legare et al., 2015). Our findings may also apply in settings where architects and engineers collaborate to develop green building designs, as these professionals often hold contradictory approaches to design (e.g. Hoffman & Henn, 2008). More broadly, we suggest that our study shows the importance of understanding how paradox may be a part of everyday professional work and how tensions arise from contradictory approaches and status imbalances. In professional work we have highlighted the critical importance of protecting paradox.

Our micro-level research draws attention to the process of protecting a paradox and we develop a dynamic perspective that has been previously absent in the literature. We focused on paradox at the level of professional work, drawing attention to a range of actors, high and low status, professionals and managers. We highlight the contradictory demands of opposing poles as well as their interrelatedness, and we show how status imbalance impacts engagement with paradox. We developed a nuanced model that explains how professionals and managers can shift vicious cycles to virtuous cycles as they take steps to improve work quality. We believe that further attention to protecting paradox has the potential to uncover other ways that members of organizations unleash value from paradox, and we encourage other management scholars to join this conversation.

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TABLE 1: DATA TABLE

<p>Interdependence (Why IPC?)</p>	<p>Looking [before IPC], ... we were trying our best to deliver the care that we thought was the best but in retrospect ... if we ... had more of the members of the [IPC] team involved, then it would have been [better] (Manager).</p> <p>The team leaders ... clinical leads ... our full leadership team believed in this [IPC] ... this was going to be our philosophy. We were going to be integrated. And we were going to have multidisciplinary teams. (Manager)</p>
<p>Contradictions</p>	<p>[Medical people] say that clients have a chemical dependency ... or cocaine induced psychosis ... but [we] ... want to focus on the strengths and the resiliency of the individual as opposed to saying, “Well, you have this problem and this problem and ... here, take this pill.” (Social Worker)</p> <p>[In the medical approach] first thing ... you look at is to diagnose ... and to triage and to deal with symptoms. Rather than looking at it, say, structurally as most [PSB experts] would do. So rather than [diagnosis] say, “Okay, we need to look at environment. We need to look at functionality. ... How does it work to have this substance in your life?” (Social Worker)</p>
<p>Vicious cycle</p>	<p>Professionals hold to a particular pole</p> <p>You get into some heated arguments ... I thought that [a client’s] medications were not right and so she’s got to come back [and be treated]. I’m hearing [from other professionals] that I haven’t done my job adequately ... [The meds are] not helping ... I wanted her in [the hospital] pronto, and the feeling [of other professionals] was that, ‘No we need to do other things first’ ... I had to argue strongly. (Psychiatrist)</p> <p>[PSB experts] will think that this person should be discharged because ... it’s social issues. Where [medical experts] think, ‘No, this person’s not ready to be discharged because we need to address [medical] issues.’ ... You get different [experts] with conflicting views. (Social Worker, in administrative role, speaking to polarized positions.)</p>
<p>High status over weighs medical pole</p>	<p>Educational backgrounds tend to take certain precedence ... being a doctor ... your opinion holds more weight (Social Worker)</p> <p>If you’re doing a case review ... [what] was said by a psychiatrist carries more weight than [what] was said by a social worker. (Social Worker)</p> <p>We don’t necessarily always agree [with psychiatrists] for sure. But ... when he wants us to do things ... we’ll try to build that in. (Manager)</p>

<p>Virtuous cycle</p>		<p>It's okay to argue with me. It's okay to say you think my opinion is bad and we need to do something else ... my experience is [IPC is] better ... you get good at this. (Psychiatrist, T3 interview, speaking to how the IPC has shifted towards more positive interactions)</p> <p>The [IPC] has gone from being this massive slow moving bus that doesn't really go anywhere to being ... [a] streamlined handy dart type of a thing ... the handy dart is ... more streamlined and it gets you where you want to go. (Psychologist, T3 interview)</p> <p>[Decisions] ... it's very close to equal. When someone says, "I've noticed this ...," it's taken very seriously. Changes in medications, <i>in approach, in feedback to parents, in after-programs</i> are based very equally on what they say and what they see. (Psychologist, describing that PSB expertise (italics) influences decisions)</p>
<p>Strategy 1: Promoting equality between poles</p>	<p>Setting up a structure to respect both poles of the paradox</p>	<p>In other [non-IPC units] that I work ... the [counselors and social workers] tend to do more of the group work ... whereas in [the IPC managers] expect the nurse to kind of play that role as well. (Nurse, having nurses 'do groups' makes work more equal and is within the scope for nursing practice.)</p> <p>This is one of the few places where [different professionals are equal] ... [Usually] there's clinicians like [psychiatrists] and myself who are the ones that say, "It's this, and this is what we're doing". (Psychologist)</p>
	<p>Shifting weight from the higher status pole to the lower status pole</p>	<p>Everybody's throwing out ... it could be this, it could be that. We were just throwing ideas out ... it was kind of a <i>round table discussion about how to proceed</i> ... [we come to] some consensus to what we should do. (Counselor, my emphasis, round table shifts influence from medical)</p> <p>We do the history ... then I go back and we discuss ... people's thoughts. [I ask others on the team], "What's the diagnosis? What do we think we need to do?" (Psychiatrist, asking for help shifts influence from medical)</p>
	<p>Developing a common vocabulary</p>	<p>The team [counsellors and social workers] is ... comfortable saying "I don't believe in Dopamine enhancers for this kid because ... I think we can do it ourselves ... I think we can [help] using physical health and doing psychotherapy ..." (Psychologist, describing how counsellors integrate medical terms in arguments to support a PSB approach)</p> <p>Depending on if [clients] have a personality disorder compared to bipolar disorder, you're going to work with them in a different capacity than you would be when somebody [has] just behavioral [problems] ... (Counsellor, bringing together medical language when discussing how some clients likely need elements of both medical and PSB expertise)</p>

<p>Strategy 2: Purposefully strengthening the weaker pole</p>	<p>Managers and professionals strengthen weaker voices</p>	<p>I'll talk to people ... outside of meetings to just to say, "Thanks for bring that point up but I think maybe could you do it differently." (Team Leader)</p> <p>We do the history ... then I go back and we discuss people's thoughts. [I ask], "What's the diagnosis? What do we think we need to do?" (Psychiatrist, encouraging weaker voices)</p> <p>[I] encourage people to bring forward their points of view ... other components of treatment that may complement what [the psychiatrist] is trying to do or that he may not have considered. (Team Leader, shifts influence from medical)</p>
	<p>Engage in after meeting discussions</p>	<p>When I think some discipline ... isn't being heard ... I try to get them to add their piece (Psychologist)</p> <p>I try to have everybody heard and I try to connect with people one on one. (Team Leader)</p>
<p>Strategy 3: Looking beyond the paradox</p>	<p>Managers keep the focus on client outcomes</p>	<p>I really like [my managers'] willingness to ...[talk about] ... okay what's the purpose here. What are we trying to accomplish and how is this going to be useful. (Counsellor, participating in discussions focused on outcomes)</p> <p>Where there's a few people not on board, we talk about why they're not on board, we talk about the difficulties that they're having, how we might be able to address things differently. (Manager, debriefing with professionals)</p> <p>[We talk about] ... what's the purpose here. What are we trying to accomplish and how is this going to be useful to this particular youth? (Counsellor, participating in discussions to keep focused on outcomes)</p>
	<p>Managers manage negative tension</p>	<p>We've had some very difficult cases ... that could have scattered us ... We needed a fair bit of debriefing. (Psychiatrist, debriefing with managers helps manage negative tension)</p> <p>Any [professional] that has a concern [can] bring it forward to the team leader or ... you can go to the next level ... and he will set it up in the next meeting or he will work with whoever to see what they want to see happen (Counsellor, managers help professionals deal with negative tension)</p>
	<p>Managers ensure work is completed in line with collective decisions.</p>	<p>All opinions are considered valid, and listened to, and taken into consideration. But from a program wide perspective we have to look at what's in the best interest of the client (Manager)</p> <p>In the end, we have to build a plan and ... their voice is heard but we have to work with the client. And so in the end sometimes it's just doing the work. (Manager)</p> <p>Not every suggestion or every plan that [professionals] put forth is going to be accepted ... if [professionals] felt they've been heard, and understand why [the team is] not going to go forward with [their ideas] at this time, or why we've chosen this route, they can learn to manage the tension. (Manager)</p>

FIGURE 1: PROTECTING THE PARADOX OF IPC - SHIFTING VICIOUS CYCLES TO VIRTUOUS CYCLES

