Escalating Indecision: Between Reification and Strategic Ambiguity

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This paper examines an organizational pathology that we label “escalating indecision”—where people find themselves driven to invest time and energy in activities and decision processes aimed at resolving an issue of common concern, but where closure appears elusive. The phenomenon is illustrated through a case history in which a strategic orientation decision involving the configuration of a group of large teaching hospitals was continually made, unmade, and remade, producing little concrete strategic action over many years before achieving more tangible moves toward implementation. The paper introduces the notion of a “network of indecision” in which participants have become sufficiently attached to a common project to continue working together to move it forward, but their divergent conceptions of what this involves prevent them from materializing it in a tangible form. The paper suggests that networks of indecision are dialectically constituted through a set of practices of reification and practices of strategic ambiguity. The phenomenon is strongly associated with pluralistic settings characterized by diffuse power and divergent interests, and its prevalence is likely to be greater in situations of reactive leadership, uncertain resource availabilities, and long time horizons.

Key words: indecision; decision making; strategy as practice; escalation; reification; strategic ambiguity; pluralism

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We have all come across situations where it seemed that people were gridlocked in cycles of perpetual decision making—bound to continue investing time and energy in a project or issue, but apparently unable to move it forward to implementation. A classic case, immortalized in an Emmy-Award-winning satirical documentary (Brown 2005), is the project to construct the new eastern span of the San Francisco–Oakland Bay Bridge. Discussions about rebuilding this bridge began in 1989 after the Loma Prieta earthquake caused a partial collapse. In 2009, the bridge was at last under construction and projected to open in 2013. However, the process of arriving at this point was characterized by 17 years of stops, starts, delays, rethinking, reports, protests, infighting, blockages, cost increases, and general confusion, much condemned and ridiculed in the press (King 2006, Isaacson and Farber 2006, Vorderbrüggen and Peele 2002).

Another example concerns the failed project to implement a new form of personal public transportation, called Aramis, in Paris (Latour 1996). This project involved multiple decision points and mobilized numerous actors over a period of 20 years. It went through different phases of technical development, but it was never actually completed. According to Latour (1996), no single actor could be “blamed” for the project’s failure, but the people involved appeared to be bound together in a system through which it was hard to let the project go, but impossible to bring it to fruition. Another example documented by Silva (2002) is the decision surrounding the location of the new international airport in Lisbon, where discussions began at the end of the 1960s and ended over 30 years later.

We use the term “escalating indecision” to refer to these situations in which people and organizations continually make, unmake, and remake strategic decisions, resulting over the long term in a large expenditure of energy with little concrete strategic action, the constant possibility of reversal or reorientation, and potential widening scope of decision activity. A priori, this phenomenon appears more likely to occur in pluralistic settings where multiple actors with shared power and diverse goals must interact to produce decisions (Denis et al. 2001, 2007, Cohen et al. 1972). Although indecision is by no means unknown in private sector firms—see, for example, media reports of an indecision culture at Yahoo
(Vascellaro and Lublin 2008, Helft 2007) or speculation about indecision at competing aircraft makers Airbus and Boeing (Done 2006a, b)—large-scale publicly funded organizations or projects seem particularly prone to this phenomenon, almost certainly because of the inherently collective and potentially divisive nature of the decision-making process.

Our own interest in and theorizing of this phenomenon was inspired by an empirical case encountered in the course of research on organizational change. Specifically, this paper will examine the processes and practices involved in trying to formulate a viable strategic orientation for three large teaching hospitals engaged in a merger. By strategic orientation, we mean the formulation and implementation of a plan for the reorganization of clinical services across the three hospital sites. The case illustrates a situation where participants seemed bound to continue investing in decision-making activity, but where final closure of the decision process was elusive, a situation that persisted for over 10 years.

We argue that it is important to understand the origins and dynamics of situations like these because they are quite frequent and can be extremely costly. Perpetual decision making with limited decision outcomes absorbs material and human resources. Beyond the dollar values placed on such resources, the cost to individuals in terms of emotional stress and frustrated effort should not be underestimated.

Drawing on elements from different theoretical frames, the paper introduces the notion of a “network of indecision” as a tool to analyse the practices associated with this phenomenon, and to understand how and why it occurs. We first review the literature dealing with different kinds of decision pathologies, and we then examine three conceptual frames that might help to understand this situation and propose the notion of the network of indecision. Next, we reconstitute the critical events of the case in order to identify the elements that contributed to the fragility of strategic orientations. In the second-order analysis, we suggest that networks of indecision are dialectically constituted through a set of practices of reification and strategic ambiguity. Finally, we identify some contextual conditions that might enhance or diminish the probability of escalation or contribute to its occurrence.

### Table 1 Decision Pathologies in the Literature

<table>
<thead>
<tr>
<th>Concept and key authors</th>
<th>Individual/collective</th>
<th>One time/cumulative</th>
<th>Description of pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indecision —Charan (2001)</td>
<td>Treated as managerial problem</td>
<td>Several decisions</td>
<td>Inability to make decisions. Managerial problem related to absence of social operating mechanisms that enable debate, goal setting, and resolution.</td>
</tr>
<tr>
<td>Escalating indecision</td>
<td>Collective</td>
<td>Cumulative</td>
<td>Decisions are continually taken and retaken. Constant possibility of reversal, reorientation, or widening scope of decision activity over time.</td>
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</tbody>
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### Decision Pathologies in the Literature

Various decision pathologies have been identified in the previous literature, as shown in Table 1. With some exceptions (e.g., Cohen et al. 1972, Langley 1995, Charan 2001, Harris and Sutton 1983), more attention has been given to overly hasty or ill-considered decisions represented by phenomena such as “groupthink” (Janis 1972), “entrapment,” and “escalating commitment” (Staw 1981, Brockner 1992) than to their reverse—a chronic difficulty in reaching decisions. For example, the notion of groupthink refers to a collective decision phenomenon where participants suppress doubts about emerging proposals to maintain solidarity with the group, with the result that choices are poorly thought out (Janis 1972). According to Janis (1972), groupthink...
tends to occur in cohesive and homogeneous groups who are insulated from external input, operating under high stress, and led by authoritarian or charismatic leaders.

The notions of “entrapment” and “escalating commitment” are often used interchangeably. They also imply faulty decisions, but in this case a dynamic element is introduced to explain why people tend to maintain or even enhance commitment to failing projects as disconfirming information accumulates (Brockner 1992; Staw 1981; Ross and Staw 1986, 1993). Early research identified psychological deterrents of escalating commitment such as self-justification (unwillingness to admit error) and attempts to recoup sunk costs (Staw 1981, Brockner 1992). Drawing on case studies of large projects such as Expo 1986 and the Shoreham nuclear power plant, Ross and Staw (1986, 1993) subsequently added social determinants such as self-presentation and commitments to others, as well as structural determinants related to human resource and material investments. The phenomenon of escalating commitment to a losing course of action has given rise to a continued stream of research that has recently focused on ways to prevent escalation or enable deescalation (Royer 2003, Keil and Robey 1999).

Our notion of “escalating indecision” shares with that of “escalating commitment” the idea of accumulation over time. However, the two processes are the virtual converse of one another. In contrast to escalating commitment, escalating indecision implies the perpetual reopening of decisions or a state of chronic collective ambivalence that prevents projects from moving forward while sustaining or even potentially widening the scope of decision-making activity as time goes on.

As mentioned, phenomena associated with overly hasty decisions have tended to receive more attention than their reverse. However, there is some work on notions such as “procrastination,” “indecision” itself, and “analysis paralysis.” “Procrastination” is defined as the delay or postponement of an action one intends to do (Akerlof 1991, Kleiner and Yada 1986, Harris and Sutton 1983). Researchers have examined its causes and consequences, focusing on individual, task, and organizational characteristics (Kleiner and Yada 1986, O’Donoghue and Rabin 2008, Harris and Sutton 1983), and suggested ways to alleviate it through scheduling, goal setting, and rewards. This literature mainly focuses on individuals and is more concerned with timeliness of actions than with decision-making processes.

The notion of indecision itself has been used by a limited number of authors, but with a few exceptions (e.g., Silva 2002), the focus is on managerial behaviour, and the tone has been normative (Charan 2001, Brandt 2005). For example, writing in Harvard Business Review, Charan (2001, p. 2) views indecision as a managerial problem induced by the absence of “social operating mechanisms” that provide occasions for debate, goal setting, and follow-up. Clearly, individual managerial styles and cultures can contribute to unproductive decision making. However, there are many decision situations (including the examples introduced earlier) where individual management authority is not necessarily sufficient to stimulate convergence and where the roots of indecision may be deeper and more systemic.

Another phenomenon that might be related to escalating indecision is that of analysis paralysis or information overload. This involves the collection of more information than necessary to take decisions (Langley 1995, Feldman and March 1981, Brunsson 2000). For example, based on an empirical study, Langley (1995) observed that the risk of “paralysis by analysis” was highest when participation in decisions was widespread, power was dispersed, opinions were divergent, and leadership was diffuse, i.e., where people were highly motivated to use rational means to convince others, but where mechanisms for resolution were lacking. Paradoxically, competing analyses for and against projects can confuse those most open to logical argument (Langley 1995, Brunsson 2000), generating vicious circles in the use of analysis and contributing to indecision. Feldman and March (1981) further argue that information overload is enhanced by the symbolic value attached to “rationality” in Western cultures.

In summary, a number of problematic patterns in organizational decision making have been described in the literature. We define the phenomenon of “escalating decision” as having the three following characteristics that distinguish it from other key concepts (see Table 1). First, it is a systemic phenomenon that has its roots in situations where multiple actors must collaborate to produce decisions. Thus, its appearance cannot be attributed unequivocally to specific individuals. Second, the phenomenon involves cumulative episodes of decision making on the same topic over time, rather than single isolated incidents. Third, in contrast with the notion of escalating commitment, escalating indecision is problematic precisely because although decision-making activities continue, they never seem to produce a stable decision or commitment—in other words, there is a constant risk of reversal, reorientation, or widening in the scope of decision-making activity. Given these features, we now examine three theoretical tools that could help understand this phenomenon, and build on these to introduce the concept of a “network of indecision” that will form the heart of our analysis.

Conceptual Foundations: Networks of Indecision
The examples and descriptions presented earlier suggest that escalating indecision tends to occur in pluralistic contexts characterized by diffuse power and divergent values and interests. Three theoretical frameworks have...
obvious relevance to decision making in such situations. First, classic political models describe decision making in terms of pulling and hauling among different groups (Allison 1971, Pettigrew 1973, Hardy 1995). From the perspective of these models, decisions are political resultants emerging when coalitions of actors can mobilize sufficient power to overcome opposition and impose their perspective on others. When groups are fairly equally balanced, and when interests may shift from one moment to another, one might expect that coalitions would rise and fall, and that decisions might therefore be fragile. In this vein, Cyert and March (1963) argued that as long as there is some organizational slack, incompatible goals among relatively balanced groups can be reconciled through mechanisms such as side payments that enable people to maintain a form of harmony without resolving their differences. However, when the slack disappears, tensions will reemerge and compromises are likely to be reopened. The dynamics by which coalitions among actors are or are not solidified over time thus seems likely to contribute to an explanation of escalating indecision. These ideas are retained in the other two perspectives below, along with additional dimensions that we will incorporate into our analysis.

The garbage can model of organizational choice (Cohen et al. 1972) is a second perspective that comes to mind as a model of nonconvergent decision making, said to be encountered in contexts characterized by “problematic goals,” “unclear technology,” and “fluid participation.” Specifically, Cohen et al. (1972) argued that in these organizations, problems, solutions, and choice opportunities are often dissociated from one another with the result that many choices may not actually solve problems. Rather, choice opportunities become “garbage cans” into which different individuals bring problems that they want to air and solutions they want to implement. Because of the large number of problems on the table and the energy required to solve them, the authors argue that it is often hard to make choices in these arenas. When fluid participation is added, problems and solutions will move in and out of choice opportunities along with the individuals promoting them, generating inconsistency in the way in which problems are tackled, and thus leading to the appearance of either indecision or reversal. The garbage can model provides a powerful metaphor that resonates with experience of committee-based organizations. However as Pinfield (1986) suggests, it has a mechanical character associated with its origins as a simulation model. For example, it does not consider the logical and temporal connections among issues and people, and it is essentially a model of interaction among multiple decisions across an organization. Thus, it is limited in its capacity to explain decision processes on a single issue over several years. Nevertheless, the ideas of fluidity in participation and overload when too many problems are attracted to choice opportunities offer useful ideas that will also find echo in our proposed conceptualization.

Finally, a third perspective that can be considered to incorporate, in a different form, elements of both the first and the second perspectives is actor-network theory (ANT). Actor-network theory or the sociology of translation is a combined conceptual and methodological tool that was originally developed by sociologists of science (e.g., Callon 1986, Latour 1987, 2005) for tracing the processes of scientific and technological innovation. More recently, scholars have applied it to broader organizational issues, including strategy (Sarker et al. 2006, Steen et al. 2006, Denis et al. 2007, Johnson et al. 2007).

According to ANT, an innovation, or in our case a strategic decision, is built up as central actors (called “translators” in ANT’s specialized language) mobilize other participants and nonhuman entities as supporters of their project while simultaneously redefining it in terms that can maintain this support. An innovation or a strategic orientation becomes taken for granted (“irreversible”) as the networks or alliances (or coalitions) surrounding it are solidified (Denis et al. 2007). However, an actor-network may not fully solidify. A corollary of the notion that decisions and their networks of support are mutually constitutive is that there may be situations in which networks fail to cohere and where a strategic orientation is not fully created or rendered irreversible, as in the cases we analyse in this paper. Moreover, actors may “defect” from previously constituted networks, thus reopening previously accepted decisions (reflecting the notion of fluid participation in the garbage can model). Latour’s (1996) study of the Aramis project described at the beginning of this paper draws on this perspective to describe in detail the events occurring in the initiation, development, and eventual demise of that project. The Sarker et al. (2006) study of a failed business process engineering effort provides another exemplary actor-network account that shows how the project developed, proliferated, and ultimately fell apart.

Actor-network theory thus has strong heuristic and illustrative power. However, despite its name, even its originators suggest that it is not really a “theory” but a “method to learn from the actors without imposing on them an a priori definition of their world-building capacities,” (Latour 1999, p. 20). Its application leads to extended descriptive accounts of associations through which people and artefacts come to be connected in particular cases, but it provides no generic predictions about which conditions lead to which results, e.g., to the reversibility or irreversibility of a decision. Nevertheless, it sensitized us to the idea of networks of actors linked to a project, and along with the other perspectives mentioned above, it inspired a key concept we now introduce: the “network of indecision.”
Networks of Indecision
As described earlier, a defining feature of the phenomenon of escalating indecision is that multiple participants find themselves trapped in a kind of twilight zone of perpetual decision making. On the one hand, they have sufficient common interest to have bound themselves to a coalition or network that obliges them to pursue decision making in order to resolve issues that link them together. On the other hand, they have insufficient common interest to actually achieve this resolution in an operational way. We use the concept of a “network of indecision” to describe this in-between zone characterized by continual decision-making activity. The participants have become attached to a common project—they are willing to stay with the network and to continue constructing the object that links them together. However, their divergent conceptions of what that object is prevent it from materializing in a tangible form.

Building on this notion of a “network of indecision,” and armed with ideas about organizational decision making reflected in the models described in this section, we ask the following empirical questions. Why do actors become bound to networks of indecision? Why do they seem unable either to transform them into positive outcomes, to escape their influence, or to let projects die? What managerial practices contribute to the constitution, maintenance, and evolution of networks of indecision?

In this paper, we ground our analysis within a single case, but we argue that this analysis also offers potential insight into practices associated with escalating indecision that may have some generality. Indeed, we situate our contribution in the area of strategic decision making, or, more generally, in the subfield of strategy as practice (Johnson et al., 2007; Jarzabkowski, 2005), where attention is given to the everyday practices of strategists and their impact on more mesolevel outcomes—in this case, the constitution and maintenance of networks of indecision. Drawing on this concept, we now examine how and why a successful mobilization around a clear orientation was so difficult to achieve in the case of the hospital’s attempt to define a strategic configuration. We begin by describing the origins of this project and the methodology used for data collection and analysis.

Methodology
Between 1995 and 2002, we conducted a longitudinal case study of the process of merging three large teaching hospitals called here hospitals A, B, and C to create a new organization that we label “University Hospital.” We were originally inspired by the lack of longitudinal process studies dealing with mergers of large organizations and the need for such case studies in order to better understand developmental change dynamics (Van de Ven, 1992; Langley, 1999). Over time, however, we were struck by the complex and frequently divergent decision-making processes concerning the strategic configuration of the merged hospital, and paid increasing attention to this in our data collection. The extensive empirical materials collected are used in this paper to analyse the phenomenon of escalating indecision. We would add that our assessment of the processes observed as problematic and as imbued by indecision is almost universally shared by the people involved in the case. As one key observer at the centre of the action between 1995 and the present commented in a 2008 television documentary on the saga, “One wonders if we are genetically incapable of making decisions.”

As is usual in case study research, we drew on multiple data sources to capture the phenomenon as completely as possible (Yin, 2003). Specifically, four complementary sources of data were used in this study. First, we directly observed board and management meetings, including over 50 meetings attended after the foundation of the merged hospital (1996–2002) and another 18 board meetings at the three original sites while merger negotiations were still proceeding. Extensive handwritten field notes were taken during these meetings. These were an important source of data on decision processes. Second, we carried out 59 interviews (from one to two hours each) with managers, board members, professionals, and influential figures from outside the organization (including civil servants, politicians, union leaders). All but three interviews were taped and transcribed. Many interviews were carried out by two of the researchers in tandem. Interviews were important sources of data both to capture decision processes that we were unable to observe directly, and for understanding how different individuals viewed emerging issues. Third, we had access to extensive internal documents, including minutes of meetings we were unable to observe directly (e.g., the negotiation meetings between the partners in the merger) as well as draft and final versions of documents used in merger negotiations and subsequent discussions. Finally, we also collected a voluminous database of press reports and editorials.

To develop the account presented here, the data were initially coded by the second author, drawing on the descriptive categories of actor-network theory, and an extended 60-page narrative was written. In this paper, we focus the analysis on seven key episodes in the process, examining in particular the practices that were used by actors in their attempts to forge a viable strategic compromise and ensure its implementation. For this analysis, we drew on the extended case history as a secondary data base for the broad description of the process, and focused on specific interviews and meeting transcripts to illustrate practices associated with escalating indecision. The resulting analysis was submitted to three key informants in the decision process for validation. Only minor corrections were suggested by them.
As in other interpretive studies, we present the findings in two distinct “first-order” and “second-order” steps (Gioia and Chittipeddi 1991). The next section provides a descriptive first-order narrative of the key periods and episodes of the case, remaining as close to the data as possible and using extensive quotations from empirical materials to illustrate the dynamics. The subsequent section will present a more abstract second-order analysis that will revisit the case and develop the conceptual interpretation.

Prior to presenting the case, it is important to note that although the processes we analyse clearly have some problematic characteristics, our purpose here is not to make value judgements about the behaviour of individual participants or in any way to “assign blame,” but rather to analyse and understand the processes that lead to such situations beyond the design of any individual or group. We see the pattern observed as emerging from a complex interactive process in which participants retain some agency, but also become constrained by the network of indecision that they have jointly and largely unconsciously created. Note also that our case study focuses on the decision surrounding the strategic orientation of the merger. During the period studied, managers also implemented several day-to-day initiatives to improve specific services, often successfully. These operational initiatives are not the focus of this paper.

**A Case of Escalating Indecision**

We structure the case history chronologically into three periods. Period 1 covers the beginning of the process and includes the events leading up to the signature of the merger protocol—a document that, we shall argue, plays a major role in the constitution of a network of indecision. Period 1 ends with the legal merger on the basis of this document. Period 2 begins as the newly merged organization attempts to implement the protocol defined in Period 1. This process is aborted when the CEO leaves, and a new project emerges. Period 3 covers the subsequent events as this project takes form. As we shall see, the network of indecision changes in form but expands outwards in this phase.


During the 1990s, the Quebec government undertook a major transformation of its health-care system. Previous autonomous efforts to consolidate existing teaching hospitals had not achieved consensus. Impatient for results, the Minister of Health announced, in February 1995, the merger of three large hospitals in order to create a new University Hospital that would offer a full spectrum of care and that would be a centre for excellence in research, teaching, and technology assessment. This announcement launched a long sequence of struggles and negotiations. Although members of each hospital were keen to be included in the project because it implied the promise of a substantial injection of resources for development, the three hospitals had historically been fierce competitors. As one key informant put it, “They had a very different past, a very different present, different views of the future, a different administrative culture and their medical culture was also different” (interview with planner 1997).

Specifically, founded in the 17th century, Hospital A had a solid research culture and was perceived as serving an elite clientele. However, because of the poor physical state of its buildings and the loss of key specialties, it was more vulnerable than the others (“It was an old rather aristocratic institution that was slowing down”). In contrast, Hospital B appeared to be a leader in the merger. It had an entrepreneurial culture and the strongest academic credentials (“They took it for granted that they were more important than the other two”). Finally, Hospital C served a poorer downtown population. It was the weakest academically but had succeeded in developing some strong specialties related to its specific clientele (“They are the young tigers who think they deserve their place in the sun”). The differences between the three hospitals, coupled with a need for investment in infrastructure at a time of budgetary restraint, constituted the backdrop for a first round of negotiations that evolved in two episodes: first, the ratification of the merger principle (February–September 1995), and second, a strategic orientation project (called the protocol) for the implementation of the merger adopted one year later.

**Episode 1: Ratifying the Merger Principle.** The Minister of Health mandated a civil servant known for his capacity to handle difficult management tasks to obtain an agreement on the merger from the hospitals.\(^2\) The plan was to merge the three organizations but to continue operating on three sites. During the formal and informal meetings organized by the civil servant, each hospital continued to perceive itself as an autonomous entity and tried to take advantage of the project for its own development. Members of Hospital B insisted on the preponderance of its site in the merger, and members from Hospital C argued for equality, whereas members from Hospital A fought for their survival in a significant role. A breakthrough occurred when Hospital A agreed to become a major ambulatory care centre within the merged hospital, seeing this as a strategy for survival and even development. However, arguments continued about what would or would not be included on that site and whether there would continue to be ambulatory care on the other sites.

The civil servant in charge of the process believed that it was imperative to create a point of irreversibility, and after six months of discussions, he managed to obtain
ratification of the merger principle. As one respondent noted,

He felt that if we didn’t do it quickly and if we didn’t go to the essentials, the thing would drag on. So a minimal agreement was proposed (…) and they all signed. The ‘…‘ obsession was to integrate them into a process that would make withdrawal a little bit more difficult.

(planner 1997)

**Episode 2: Signing the “Protocol.”** The ratified document proposed the creation of an “Implementation Corporation” whose board was composed of about 20 members, essentially the same people as the preceding committee with some trade-union members added. To define the structure of the new hospital, a vast consultation involving all medical specialities was organized by the faculty of medicine (over 40 committees). Physicians were invited to examine the situation of each specialty and different reports were produced and voted on.

However, frictions continued concerning the definition of the ambulatory care centre at Hospital A and the sharing of specialties between Hospitals B and C. Hospital A proposed an ambitious vision of their ambulatory care centre, which was constantly redefined by the others. In midprocess, the medical team from Hospital B attempted to negotiate bilaterally with Hospital A to develop a two-site project excluding Hospital C. In reaction to this and to a perception that the working groups were unfavourable to Hospital C, the chairman of that hospital left the negotiations. However, the civil servant—now chair of the Implementation Corporation—used a variety of tactics to get people back to the table, often meeting people in small groups to maintain their interest. One tactic was to remind participants that they did not have a great deal of choice (the “stick”), while at the same time noting that the merger would provide them with immense possibilities for development as a major world-class institution (the “carrot”):

The objective was to convince everyone that this was not simply a rationalization exercise, but that there was an overarching logic in terms of pooling resources to create the critical mass to become a major player in the health care system…anyway—the positive side. The negative side was that they had no choice—otherwise they would die.

(planner 1997)

The fact that a rival teaching hospital consortium was also moving towards consolidation and was even planning to construct a new facility reinforced the credibility of these arguments.

Another key tactic was to promote compromise and solidify commitment by obtaining signatures on a new document called the “Protocol.” This document was more complete than the merger principle and reflected the results of the studies conducted by the working groups on the division of services. However, the precise words written in that text became extremely important. Indeed, as our informants told us, meetings of the Implementation Corporation were often devoted to wordsmithing: “These four paragraphs, they bother you? OK—well let’s work on it, reformulate, add a word…that went on sometimes two hours, three hours, four hours” (planner 1997).

After a year of studies and negotiations, the Health Minister confirmed his intention to inject $300 million into the creation of the University Hospital and added his signature to the protocol. Despite considerable reticence, members from the three hospitals agreed to sign the document. The following comment from one of the signatories illustrates the tense climate surrounding the signature of the protocol:

> Obviously, after 18 months of negotiations around the same issues, all the time, all the time, all the time, all the time, we end up with a protocol that everyone signed because they are fed up, because we’re all forced, because of total frustration, a protocol that divides up a certain number of programs, but that leaves a number of other things in limbo, which defines the number of beds to be 1,200, that everyone knew was 100 beds too many for what was required, but we had to please everyone.

(senior manager 1997)

Nevertheless, the civil servant had achieved what no one had managed to do before—generate agreement on a merger proposal that specified, up to a point, the shape of the new institution. Following this, the three hospitals were legally merged in October 1996.

**Summarizing Period 1: Constituting the Network of Indecision.** We now briefly reexamine the events of the first period from a more analytical perspective. A similar section will follow each of the subsequent descriptive sections, and a more elaborate interpretation dealing with the full case history will appear later.

We have labelled this first period “constituting the network of indecision” because this sequence gradually drew the members of the three organizations into an increasingly binding commitment to work together to develop a new configuration of services despite continuing disagreements. In the first episode, the civil servant delegated by the government was able to create sufficient momentum around a simple project statement (the merger principle) to keep things moving forward. To persuade the participants to sign this document, he focused arguments on the benefits of the merger and on the fact that it would not be possible for any of the three hospitals involved to lead a project for a university hospital alone. This signature enhanced irreversibility, but the network surrounding the merger project was still shaky.

To resolve divergences and increase commitment, the civil servant continued to negotiate during Episode 2, using similar tactics. His major achievement was to obtain signatures from all participants on a protocol that officially consecrated the creation of the University Hospital. The protocol’s existence enhanced the irreversibility of the process. However, again, it was a document that...
left room for resistance and negotiations. This agreement committed numerous people with divergent views to participating in ongoing decision making about the configuration of the hospital. The network had been tightened, but ambiguity remained embedded in it.

**Period 2: From the protocol to the Protocol (1996–1999)**

*The Protocol: Bound Together in Discord.* At the end of the first period, the signatures obtained on the protocol were sufficient to ensure a legal merger. However, as we noted, the protocol hid a variety of unresolved tensions and had been signed with great reluctance. This meant that any attempt at implementation would necessarily reveal the underlying tensions all over again—which it inevitably did:

In the protocol, the first problem we have, the major problem is the content of the ambulatory care centre. We haven’t defined precisely what it is. We basically shovelled the problem forward. There are two interpretations. For sites B and C, the centre was essentially ambulatory with the possibility of hospitalization for 24–48 hours. For those from site A, it would be possible to admit people electively for 48 or even 72 hours, which is the major share of medical practice volume. This came out at the last Board meeting as the consultants need to know where we’re going. It’s a basic question. There was withdrawal from negotiations before on this topic. Now, people from site C are saying that if they had known that site A would have the best medicine, they wouldn’t have signed. (senior manager 1997)

Because of the distrust between institutions, the way the protocol was written also implicitly guaranteed the perpetuation of both the tensions implicit in the agreement and also, in some sense, its very stability, because it imposed a governance structure in which there would continue to be equal representation of each of the original sites in the board and in the medical council. Indeed, the founding board members were almost exactly the same people who had been involved in the original discussion. Thus, the signatories of the protocol committed themselves to becoming part of a new organization whose constitution incorporated within its functioning the tensions that had previously been external.

One of the first decisions the new board had to make was the choice of a new CEO. This took a full nine months, during which the three original CEOs remained in place. However, the board eventually decided to hire a young CEO with no hospital experience but with a strong reputation for effective crisis management. It seemed that none of the three prior CEOs could be considered, perhaps because each was distrusted by at least two-thirds of the board members.

Thus, the protocol essentially led to a new organizational structure that reproduced within itself the network of actors that underpinned the existence of the protocol. When the time came to move forward to implement the planned reconfiguration, this would play itself out in ways not unlike the dynamics that led to the creation of the protocol in the first place. We report on three episodes that illustrate the nature of decision making in the first two years of the organization.

**Episode 3: Choosing Where to Locate the Management Team.** One apparently banal decision that became controversial about one year after the merger was where to locate the management team. The protocol had placed the “head office” at site A—the hospital to be converted into an ambulatory care centre. However, there were other reasons why it seemed to make more sense to locate people at other sites—e.g., to ensure that the clinical directors were as close as possible to patients and to keep costs down. Of course, there were also political reasons why people from different sites favoured different choices. The decision about this issue became so charged that it was only resolved in a board meeting. The final vote for a solution that reconfirmed the protocol passed nine votes to seven.

At the beginning of this same meeting, another item had been placed on the agenda: the potential for revision of the protocol. This had been described as possible in the text of the protocol itself. Some members urged reopening it. Others, and especially those from sites A and C, urged caution. The following is a sample of the dialogue on this from real-time field notes.

Member 1 (ex-site A): I think that wisdom brought us to the protocol. Opening up the protocol can only lead to confusion.

Member 2 (ex-site B): The main directions remain, I understand that, but we can make changes at the time of decisions. . . .

Member 3 (ex-site C): I don’t think we should attach too much importance to the revision part. I would like us to understand that it should be applied in its entirety. There are people outside this Board who are wondering if the protocol will stand the test.

This exchange set the scene for the later discussion surrounding the location of the offices. The management team recommended a cheaper solution that placed the clinical managers’ offices at site B closer to the patients. However, this was contrary to the protocol. Protagonists from sites A and C opposed it, and used the protocol to justify their opposition:

Member 3: The protocol is still warm. If the only purpose of the merger was to be functional, we wouldn’t have needed to meet every day for several months. The central point was the equilibrium between us. The protocol must be our guide. It is our birth certificate. If we do not have this, we have nothing as a reference point.

Member 1: The protocol indicates that there will be an Eye Institute in the ambulatory care centre, that public health will be in site A and that there will be
an emergency room in site A. When we touch one piece . . . we touch another piece. If we touch the protocol, we have nothing. If we are rigorous with the protocol, the offices must be in site A. We got people to believe in that. If we change it, we will have a problem.

The vote confirmed a decision consistent with the protocol. At the same time, this discussion—held in public with a large audience including the media—both revealed and reestablished the foundational (“birth certificate”) and inevitable (“if we touch the protocol, we have nothing”) nature of the protocol while implicitly assigning roles within it. And, this was “only” about administrative offices. What happened when real clinical issues were in play?

Episode 4: Determining the Number of Beds. The protocol also stipulated that the hospital would have 1,200 beds plus another 100 short-stay beds in the ambulatory care centre. Many thought that this was too many. However, as one informant indicated, the number was there to “please everyone” and in particular to ensure the support of site A. Consultants hired by the board recommended just under 1,000 beds as optimal. After a retreat in August, the board concluded that a bed complement of over 1,100 would not be viable and asked the CEO to prepare this proposal for a full public meeting in the fall.

Between August and December, however, opposition to the proposal intensified, especially from the unions. The board meeting on this issue took place in public with an audience of over 150 people (including the media). Many in the audience were wearing buttons bearing the slogan “For respect of the protocol.” A petition with 14,000 signatures from “citizens” demanding the respect of the protocol was tabled by the union member on the board. After a unanimous vote in favour of the status quo, a key board member concluded the discussion by noting, “This is a very important decision. We are beginning the implementation of the protocol.”

A similar dynamic occurred later for proposal to close down the emergency room at site A to begin its transformation to an ambulatory care centre. This too was ultimately reversed. A board spokesperson announced to the press before the board meeting that this solution could not be considered “because it does not respect the protocol.” In dossier after dossier, it became clear that whatever its limitations, the protocol, as written, constituted the only basis for movement. As a senior manager noted, “The Board has made it clear: the protocol is the bible.”

Episode 5: Planning the Ambulatory Care Centre. As a step towards turning the protocol into reality, in the spring of 1998, the CEO convinced the medical staff and the board that a proposal for construction of the ambulatory care centre on site A had to be put forward to obtain a commitment of funds from the government. However, the task of creating a plan that would generate consensus was not obvious in a context where, all year, various factions had been fighting out their differences in public, undermining the credibility of the hospital and its leadership. The work required to plan the new centre was delegated to three consulting firms who came up with a design.

As work progressed, however, it became clear that two important conditions would be required for this proposal to acquire minimum consensus. First, the initial proposal had simply involved a plan for an ambulatory care centre on site A. Key physicians and board members refused to support this unless there was investment in the other two sites as well. This of course increased the cost and the complexity of the proposal. Second, it was clear that a proposal that fully respected the protocol might not be realistic. An opening appeared possible, at least initially: “The protocol is the guiding light. But to move ahead quickly, we have to modify certain aspects of the protocol—to create something that is attractive to everyone” (senior manager 1998 meeting, from field notes).

However, when the modified proposal was presented to the board, old differences resurfaced. No agreement could be reached as to what type of emergency service would be retained at the ambulatory care site. In the end, the project approved in October retained several of the same ambiguities that had plagued the protocol itself. As a senior manager explained, “We’re now in complete continuity with the protocol a bit like the discussion on beds.” Discussions took place on how the project could be presented so that unresolved issues would be camouflaged to obtain approval: “We can’t be more precise without creating problems.” For example, a controversial transition plan for implementation was removed from the proposal to facilitate passage. In other words, the ambulatory care centre plan that was approved contained within itself the same problems as the protocol. In order to ensure agreement, it was inflationary in form and left many controversial issues unresolved. However, there was a semblance of unanimity behind the proposal, at least as long as hope remained that funds for development would be forthcoming.

The euphoria was short-lived, however. The unions were not enthusiastic about the ambulatory care plan, and the government made its support conditional on reducing the operating budget by $25 million/year. The promised investment was offered in chunks spread out over time, and the medical staff, many of whom had been reluctant supporters in the first place, were unhappy with the outcome. It also emerged that the hospital had incurred a larger budget deficit than expected. This further undermined the credibility of the embattled CEO as well as the credibility of the proposal. The CEO finally resigned in early 1999.

Meanwhile, an alternative idea for the hospital had been gathering support. Many in the medical community
were talking about resolving their divisions by building an entirely new hospital on a separate site—a vision that had previously seemed utopian. As a new government came to power at the end of 1998, there appeared to be prospects for a different kind of thinking.

**Summarizing Period 2: Reinforcing the Network of Indecision.** In this second period, the network of indecision constituted in the first period was reinforced. Although the originators of the protocol did not necessarily see it as immutable, the first two episodes of this period reveal how it came to be increasingly reified as key people invested it with metaphors such as “birth certificate,” “guiding light,” “bible.” The episodes also show how the Protocol (with an increasingly capitalized “P”) became an agent of indecision, in the sense that it was more often called upon to define what one could not do rather than what one could do. Even when the CEO attempted to use it positively in the promotion of the ambulatory care plan, attachment to its various clauses converted the plan into an impossibly complex but still equivocal project. Moreover, as in the case of the protocol, the plan had to be reinforced with threats that without acceptance, promised government funding would not be forthcoming. Also, as in the case of the protocol, the plan became inflationary: The cost of the ambulatory care plan increased by 20% during the last month of discussions. Confirming the pattern set in the previous period, it seemed as if members of the organisation were only able to decide as long as some of the most challenging items on the agenda were left open for future decision.

Clearly, many of the people involved in these processes never took the protocol or granted, yet they did seem to be caught in the network of constraints it constituted. At various times, different actors attempted to pursue developments in different directions but were always dragged back to the protocol. As time advanced, it was confirmed repeatedly that the protocol was the only possible basis for movement. However, the protocol was incomplete and sufficient only unto itself—a document and no more. The final episode concerning the planning of the ambulatory care centre confirmed the fundamental paradox: that its incompleteness was the reason for its existence and that if it was to remain the only basis for movement, then no movement at all was possible. The time was ripe for...yet another phase of decision making.

The period between 1999 and 2002 is marked by two main episodes: the arrival of a new interim CEO who launched yet another attempt to design a plan to reorganize services across the three sites, and the development of a competing option for the future.

**Episode 6: The New CEO and the New Reconfiguration Plan.** Following the departure of the CEO, the board and the Ministry of Health brought in a new CEO for an interim period. He was a physician with strong managerial experience and arrived in spring 1999 with a mandate to develop a new consensus around the reorganization of services across the three sites. Given previous poor relations with physicians, the new CEO aimed to rapidly increase their commitment to the project. He proposed a participatory approach to creating a credible plan:

The last thing that people wanted to see was to start doing more studies... what are the needs, etc. So what we did was to put together a working group of about 15 people,... (…) who were all doctors, who were from different schools of thought but who were all leaders on the sites. And we said, we won’t do any studies... we’ll just try and simulate what might be in a reasonable starting point. (…) We just asked everyone: prepare a scenario. Forget everything. What do you think might work? It was as simple as that. (senior manager 2002)

This approach generated a modest plan for reconfiguration that seemed initially to receive support from the medical community. However, opposition began to emerge again as comparisons were made concerning the types of services that each of the three sites would receive. In particular, a vote among the medical staff showed that although the overall majority favoured the proposal (around 70%), there was almost unanimous disapproval from the physicians at site A. The presentation of this plan in a board meeting in December 1999 confirmed the difficulty of securing commitment. One senior manager’s plea at that meeting is particularly poignant: “We need a project. If you say no, there won’t be many people who will get on board again.” Some adjustments were made to appease opposition from site A, and a modified plan for the reorganization of services on the three sites was finally adopted in January 2000:

It was a chaotic period (…) We got calls constantly from the Minister of Health who wanted the problems to stop and was upset that things were in the newspapers all the time… In January 2000, the plan was accepted with several minor modifications. (…) So the first battle with the Board was resolved amicably. (…) We had several marathon sessions with the doctors that ended at midnight, one in the morning. (senior manager 2002)

By that time, however, the plan had been somewhat overtaken by other events.

**Episode 7: The Emergence and Adoption of the Single-Site Option.** In parallel with this process, a competing alternative to the initial protocol was promoted by some physicians. In April 1999, the Medical Council held a “closed retreat” to discuss the results of a physician opinion survey and to discuss various position papers. The results of the survey were unambiguous: The
majority preferred the construction of a new hospital downtown instead of a reconfiguration across the three existing sites, a project similar in concept to that being advanced by another local teaching institution. It was proposed that the new hospital have between 1,000 and 1,400 beds, and the physicians demanded that the government make a formal commitment rapidly and allocate a transition budget. This option was seen as a solution to increasing pressures from some groups to demerge the hospitals:

Yes, doctors from site B and perhaps site C, but definitely site B made representations to the government. . . . I don’t know how close they got to the minister . . . to demand de-merger. (senior physician 2002)

In late 1999, the single-hospital site option received support from political elite:

The new minister arrived and started looking at the situation and of course, she was new. All the delegations from the University Hospital who were there requested an audience. ( . . . ) She was very generous with her time. ( . . . ) She built up a distressing image of the University Hospital where, “It would be awful, they would never stop complaining, they would continually make demands, and that it would be extremely difficult.” Something was required to calm them down . . . that’s a pure interpretation on my part. But the move from the hospital on three sites to the hospital on one site—that came from the Minister. (planner 2002)

The announcement in winter 2000 by the Ministry of Health of the single-site option converted the existing plan for the internal reorganization of the hospitals into a transition plan to ease the movement towards a new single-site hospital in the future. At first sight, here was a highly attractive solution that would surely enable members of all the founding hospitals to look forward to their future together with enthusiasm. However, things are not quite so simple. The decision-making process now had to begin again to decide what would be in the new hospital, how it would be designed, and where it would be located.

Thus, in 2000, the government put in place a public corporation separate from the University Hospital administration, mandated to plan the new single-site hospital. This corporation had the power of recommendation, but no executive power over the evolution of current installations. A broad consultation process was set up to design the future hospital:

We created 45 committees, by area of activity, by disease group etc. ( . . . ) And the 45 committees worked for six months and each one produced a report. To our great surprise, because everyone said, “You’ll get an incredible grocery list”—on the contrary. ( . . . ) The plan was accepted by the university by the Regional Board, by the Board of the hospital, by the hospital association, in fact by just about everyone, except the government. The government received it and said, “Let us look at it and we’ll see.” (senior physician 2002)

Towards the end of our formal data collection in 2002, following two interim CEOs, a new CEO was appointed, a physician with managerial training. From then on, increasing concerns at central government level about the costs of the new hospital project delayed its realization. Also, fierce controversies emerged concerning its physical location. Although the people involved changed, decision-making activity concerning the configuration of the new hospital continued unabated. In 2006, politicians announced the construction of the new hospital in the near future, on Hospital C’s site. However, further changes were made to the plan in 2008 to accommodate physician discontent. At the time of writing in September 2009, the project continues to be plagued by controversy and construction has not yet begun.

**Summarizing Period 3: Reconstituting the Network of Indecision.** Overall, this period reveals the tipping of the balance between reorganizing services on three hospital sites and building an entirely new hospital on a single site. The period also illustrates the constant difficulty in closing the arena of decision making. The participants from the three hospitals finally escaped from the network of indecision constituted by the protocol. However, a new, more encompassing network had been created around the idea of the single site.

The third period began with a need to reconstruct commitment and trust in the project or, to put it differently, to redesign the project to make higher commitment possible. To regenerate commitment, the new CEO (building on strong legitimacy with the medical community) worked toward the formulation of a plan that tried to bring the project down to a more clinical level. The plan was sufficiently convincing—after some watering down—to receive approval, but only when a condition concerning the future single-site project—a new alternative—was included in it at the insistence of certain board members.

The single-site option contributed to redefining the problem around which the network of indecision had been constituted. However, the parameters for the feasibility of this project were not well established. Not all political factions favoured investing such extensive public resources in buildings. In addition, well-organized stakeholders had different views on the appropriate location for the new hospital. The network of indecision had been reconstituted around a new project. It was a project that was at least initially welcomed by all participants, but it was even more imbued by ambiguity and inflationary forces than the projects that preceded it. Overall, this phase ended in a situation where the parameters of the single-site hospital were unclear while leaving open the evolution of internal reorganization on current sites. Which reorganizations should be performed? How much investment should be made on the current hospital sites to maintain functionality, knowing that a new hospital will soon (hopefully . . . ) be constructed?
Second-Order Analysis: Practices Underlying Networks of Indecision

This study focuses on the emergence of networks of indecision surrounding the development of a strategic reorientation for a large teaching hospital. At first glance, the processes described here were not completely vain. At each period, the actors were driven by a sincere desire to create an organization that would become a model of high-quality health care—a noble objective. Moreover, from the initial merger project between the three hospitals to the single-site solution, some points of convergence were achieved. For example, it seemed important to sign the merger principle and then the protocol in order to bind the actors together, thus creating a point of irreversibility, even though people still had different positions and interests. The efforts to create the ambulatory care centre (period 2) and the transition plan (period 3) were further attempts to pull the pieces together. However, although closer to reality, that dream is still in development in 2009. Moreover, the people involved have invested unimaginable amounts of energy in the processes of deciding, sometimes quite fruitlessly—as we saw above.

What we observed in this case study is the constant coexistence between points of irreversibility (e.g., the binding force of the protocol) and points of reversibility (e.g., the ability of various actors to value alternatives that prevented implementation and reopened the arena of decision making). The networks of indecision surrounding the merger are the product of this dialectic between practices that push toward the materialization of reorganizations and practices that prevent them. We will now discuss how this dialectical tension shapes the conditions for constituting, reinforcing, and reconstituting a network of indecision. This discussion is based on the conceptual model presented in generic form in Figure 1 and applied to the case history in Figure 2.

Recall that we defined a network of indecision as a state in which people have sufficient common interest to pursue decision-making activities in order to resolve issues that link them together, but they have insufficient common interest to actually achieve this resolution in a concrete operational way. In other words, they become attached to the idea of a joint project but are unable to agree on its details. Based on the case analysis, we argue that the initial conditions for the dynamics observed appear to be a combination of “constraint” (a need to work together to obtain certain benefits) and “divergence” (opposed interests and identities), as shown in Figure 1.

Specifically, in our case the three autonomous teaching hospitals were obliged by the Ministry of Health to become involved in the merger under the threat of losing their university mission and promised opportunities for development (constraint). However, although the three hospitals perceived what was at stake, they maintained a strong sense of identity and were determined that the merger would not be configured in ways that might diminish the role of their institution with respect to the other two (divergence). These initial conditions create a fundamental tension. The different influences that shape the decision-making process must be interpreted within the context of this tension between centrifugal and centripetal forces.

Once these conditions are in place, the participants engage in practices to advance the decision-making process. We cluster the set of practices observed in the constitution, reinforcement, and reconstitution of the network into two broad categories: practices of reification and practices of strategic ambiguity. Practices of reification are aimed at achieving irreversibility by attributing symbolic value, importance, and immutability to the collective project. In contrast, practices of strategic ambiguity are aimed at making decisions acceptable to participants by creating “space” within which multiple interpretations by stakeholders are enabled (Davenport and Leitch 2006, p. 1604). It is expected that such practices will help a variety of stakeholders to identify with the strategic change initiative for different motives because ambiguity provides room to accommodate potentially divergent or even irreconcilable preferences (Eisenberg 1984). The practices identified in this category also recall Cyert and March’s (1963) discussion of the “quasi-resolution of conflict” discussed earlier, in which devices such as side payments, sequential attention to goals, and organizational slack maintain coalitions in place despite underlying conflict. Cyert and March did not, however, explore the dynamic consequences of these practices and their interaction with practices of reification.

As shown in Figure 1, we argue that the consequences of the interaction between the two types of practices is
to enhance constraint and commitment (through reification) while masking but maintaining divergence (through strategic ambiguity), thus leading to “decisions” that embed within themselves the need for further decision making. This is the dynamic that maintains the network of indecision and that can lead to escalation. We now describe the particular sets of practices observed in our case.

Practices of Reification
Recall that we grouped under the heading “reification” those practices that are aimed at assigning symbolic value and importance to decisions. We identified four types of practices of reification labelled **idealization**, **requiring signatures**, **ratification by boards**, and **assigning importance in public discourse**. These practices can be observed at different periods of the evolution of the
case (see Figure 2) and help to understand the emergence of networks of indecision. The first reification practice that we label “idealization” was used repeatedly to keep actors and organizations attached to the project. We refer here to the use of enthusiastic language implying prestige, progress, and technological leadership that added symbolic value to continued involvement and that made it difficult to withdraw without losing face. For example, in period 1, a preamble to the protocol described how the new institution would be “a major twenty-first century teaching hospital” whose functions would all be “developed to their full potential.” A board member described the project as the materialization of a long-standing provincial ambition to create a “very major university center capable of rivalling other large academic health care centres in the US and Europe” (interview 2002). Implicit in the practice of idealization was the idea that resources would be forthcoming to enable this development. When tensions emerged on the way, people were threatened with losing these opportunities. In period 3, when the new site was announced, the language became even more enthusiastic. The image of progress and modernity associated with this collective enterprise could not create instantaneous agreement, but it was a strong means to maintaining attachment of actors and organizations to the network. They could not afford not to be part of this important project.

“Requiring signatures” is a much more mundane, but particularly powerful, reification practice that was used twice by the civil servant in the first period to enhance irreversibility and solidify involvement of the three organizations in the initiative. Signatures on the merger principle and then on the merger protocol were obtained through multiple informal negotiations and adjustments of the wording of these documents. Although these documents, and specifically the protocol, had no legal status, they gained major importance in the whole process. Signed documents were a tangible sign of commitment for the organizations involved, the government, the university, and indeed of particular individuals (three from each hospital): “A protocol that is signed has a value… a moral value.”

The third practice of reification “ratification by the board” reinforced the commitment represented by the signatures. This practice tightened organizations to the network, while it also clearly indicated that each board would be the guardian of the interests of their own organization. It ensured that members delegated to the new merged board would be vigilant concerning the respect and integrity of the protocol on the part of others, indirectly increasing that document’s symbolic value. “[The protocol] has a greater value than many legal contracts because it is a very strong institutional and personal commitment. People will remember those episodes around the table…they’ll remember everything that was required in terms of discussion and compromise” (planner 1997).

Finally, the fourth practice of reification “assigning importance in public discourse” became particularly salient in period 2 as the importance of the protocol was reaffirmed. Public references to the protocol as the “birth certificate,” the “guiding light,” the “reference point,” or the “bible,” as well as the dramatic events surrounding these discussions, further enhanced its symbolic value and with that its immutability. The fear expressed by one board member, “When we touch one piece…we touch another piece. If we touch the protocol, we have nothing,” shows how this very imperfect and non-legally binding document came to achieve such a high degree of significance to the point of rigidity, at least for a time.

These four practices of reification all contribute to the symbolic value, importance, and immutability accorded to the collective project, and in particular, to the text of the protocol. Indeed, the form of agreement chosen by the civil servant (signed documents ratified by the board), combined with the public reaffirmation of its importance, made this text particularly powerful, giving it a kind of agency in the process (Cooren 2004) that reached beyond the original intentions of its designers. This text established constraints surrounding the orientation of the teaching hospitals from which it became difficult to escape. This document only fully lost its power when a significantly more attractive project—the single-site option—came to the fore. These reification practices help explain why the different actors remained bound to the network of indecision despite their differences. However, these practices do not fully explain what persuaded the groups involved to sign on to such agreements in the first place, nor why they seemed so hard to bring to fruition. To explore this dimension, we need to examine another set of practices.

Practices of Strategic Ambiguity
Recall that we defined practices of strategic ambiguity as aimed at rendering decisions acceptable to participants by masking divergence. Five practices that we associate with the notion of strategic ambiguity were observed empirically: equivocal language, inflation, postponement, preservation of rights to participate in the future, and equivocal commitment. “Equivocal language” refers to the content of agreements generated along the way (merger principal, protocol, reorganization plans). These provisional documents were characterized by ambiguity in the sense that several of the most challenging points remained vague and unsettled. For example, the initial versions of the merger principle provided more detail than the final version about the configuration of services on each of the sites. Details were deliberately removed to allow people to sign in comfort. Similarly, in period 2, a transition plan was removed from the ambulatory care plan and decisions about locations of various
specialties were kept deliberately vague: “A lot of strings were not attached” (senior manager 1998).

“Inflation” is another practice used by actors to sustain commitment to the project. This practice involves finding ways of upgrading proposals over and above what is obviously realistic as a condition to maintain participation. While additions might sometimes be expressed in quite concrete terms, their illusory character and the need to subsequently reconcile them with each other and with resource constraints sustains confusion concerning the overall shape of the project, while making it acceptable in the short term. For example, the protocol included more beds than seemed appropriate in order to please all participants. The cost of the ambulatory care centre plan increased by 20% during the last month of discussions to accommodate those who feared losing. Similarly, the Ministry of Health in period 3 announced the adoption of the “single-site option” with an estimated number of beds that was superior to what could be reasonably achieved. Indeed, the CEO’s last-ditch attempt at a reconfiguration plan on the old sites was accepted by participants only when the construction of a new single-site hospital was added as a condition. Again, inflation was used to ensure or maintain support for the project. Although people were often very aware that this was happening, it became particularly problematic when attempts were made to implement the proposed projects: Something would clearly have to go, but what?

“Postponement” is a practice that consists of leaving controversial issues open in order to maintain commitment in the short term. In the negotiation of the merger principle and protocol, some decisions were deliberately postponed: “There was some shovelling forward of issues in the process. I think that was OK because if there hadn’t been any shovelling forward, there would not have been an agreement” (physician 1997). For example, it was unclear whether hospitals B and C would maintain ambulatory services and what the nature of inpatient services at hospital A would be. In period 2, all agreed on the need to make some kind of progress toward the development of the University Hospital. However, there were some things that simply could not be clarified without risk of losing support. Finally, in period 3, the announcement of the single-site option left a whole raft of new issues open for future debate.

The practice of “preserving rights to participate in the future” consists of constructing safeguards to ensure the ability to intervene later. For example, in period 1, the protocol specified a future governance structure that gave all participants in the process equal decision-making rights in the future implementation of the merger. It also included a provision for future revision on specified dates. The presence of these potential points of influence helped persuade people to agree to the protocol despite some discomfort: “The protocol is a starting point... you can question it in two or three years” (planner 1997). This was another way to incorporate ambiguity into the agreement.

Finally, another practice that injected ambiguity into agreements was what we call “equivocal commitment.” Several actors used this practice in different ways during the signature of the protocol. For example, a union representative agreed to sign the protocol, but wrote under his signature that this was on the condition that an alternative scenario with a full complement of beds and ambulatory services on all sites would be examined after the merger. The Regional Health Board agreed to sign the protocol as a “witness,” but not as a full participant in the agreement. The board of Hospital B signed the protocol, whereas the physician group voted against it. These equivocations were again tolerated in order to allow people to save face and to obtain those precious signatures that enabled the project to move forward.

Overall, these five practices contribute to increasing the ambiguity surrounding the configuration project, masking but maintaining divergence within the constrained network. Commitment is obtained and maintained by leaving issues unsettled (postponement and equivocal language), by promising more than realistically possible (inflation), by preserving a kind of veto on plans for reorganization (preservation of rights to participate), and by maintaining rights to exit (equivocal commitment).

The Dynamics of Reification and Strategic Ambiguity
As illustrated by the horizontal arrows between practices in Figures 1 and 2, practices of reification and of strategic ambiguity work in dynamic and dialectic tension. The reification of an agreement between divergent parties reinforces the need to ensure that it incorporates sufficient ambiguity to allow the participants to live with it. However, that ambiguity combined with the symbolic value of the agreement condemns participants to pursue decision making in a context where what they have agreed upon remains contentious, inflationary, and unclear. This is the very nature of a “network of indecision.” For example, in our case, although the solidity of the network is confirmed by the existence and reification of a text (the protocol), the nature of this text is imbued with ambiguity reflecting the compromises that had to be made to permit its signing. The dynamic between practices of reification and strategic ambiguity lies at the heart of the evolution of this project. As illustrated in Figures 1 and 2, constraints push actors with divergent identities and interests to get in and stay in. The reification of agreements (signed and ratified documents, public reaffirmation, idealization) solidifies commitments. However, to achieve this commitment, agreements must be made minimally appealing to divergent interests. Practices of ambiguity such as equivocality, inflation, postponement, and preservation of participation rights help to
create short-term comfort while simultaneously perpetuating the underlying tensions, and embedding a need for further decision making. The result in our case was an inertial decision-making machine that generated greater and greater tension and frustration throughout period 2.

That tension eventually came to a head. Frustration and disillusionment manifested themselves in defections and political activism. As the tensions became more insistent and were widely exposed in the media, the government sought a more definitive solution. The building tensions within a network of indecision appear to operate according to a kind of punctuated equilibrium logic (Gersick 1991). In our case, this culminated in period 3 in a sharp switch from a three-site reorganization to a single-site option. Note, however, that this new option appeased the tensions and dereified the protocol by further widening the scope of the project, enhancing its ambiguity and, indeed, its inflationary potential. A new and equally challenging sequence of network building and decision making was set in motion.

Figure 3 offers a schematic illustration of the evolution of networks of indecision between period 1 (based on the protocol) and period 3 (oriented around the single-site option). As shown in the first diagram of Figure 3, the initial group of actors came together around a project that was imbued with ambiguity (as represented schematically by its fuzzy boundaries), and which meant different things to different people (as represented by the variety of points of attachment in the diagram). As tension mounted between the actors’ attachment to the project developed through practices of reification and their inability to agree on its precise form, the solution chosen was to expand the project outwards as shown in the second diagram of Figure 3, increasing the level of ambiguity and introducing additional actors with further diverse attachments to the project, thus widening the scope and complexity of the problem to be solved.

The Context for Escalation

The dynamic processes of escalating indecision described above are grounded in our case and have a form of conceptual coherence that suggests that they might plausibly occur in other circumstances where people seem to become trapped in perpetual decision-making cycles. Indeed, we see echoes of these processes in Latour’s (1996) novelistic account of the failed Aramis project. Latour describes how a protocol to build the transportation system is signed in 1984. The researchers observe, “Everybody agrees not to make any decisions. Complete unanimity not to find out whether the set of things being agreed is an empty set or not!” Later, the narrator fumes, “Everybody who signs the protocol to build Aramis hopes to do something other than Aramis. That’s really not normal, is it?” (Latour 1996, p. 197). The paradoxical emptiness of agreements surrounding this project and the multiple meanings it held for different actors resonate with our analysis of the role of strategic ambiguity, as does the way in which actors seem to have bound themselves irrevocably to a project that many believed impossible.

Yet, were such processes inevitable given their context? What makes them so? And could there be complementary explanations of escalating indecision or of this case in particular that are not incorporated explicitly into the model presented so far? In this section, we briefly explore four contextual conditions that might enhance or diminish the probability of escalation or contribute to its occurrence: pluralism, leadership, resource availability, and time horizons. This section takes us somewhat beyond our data because the analysis sometimes requires reflecting on what might have been. However, we believe that it is important to suggest possible boundary conditions that can be examined in future research.

We identified pluralism as a favourable context for the emergence of escalating indecision at the beginning of this paper and we defined pluralistic settings as characterized by diffuse power and divergent interests. In such settings, strategy making is understood to be broadly participative in contrast to the discourses and practices found in more hierarchical settings (Mantere and Vaara 2008). Drawing on a political model, it is clear that if a dominant coalition had been able and willing to impose solutions on others, there would have been greater likelihood of convergence despite divergent interests. Pursuing this thought, it is worth considering how
successive decisions in a sequence might alter the distribution of power over time so that the context becomes more or less pluralistic. The avoidance of escalation would be assisted by the progressive concentration of power at each cycle. However, in our case, the fragmentation of power persisted in period 2, in part through the practices mentioned earlier of preserving rights to participate, and was even enhanced in period 3 as the single site option introduced a wider range of actors to the debate (the city, the general public, industrialists, environmental lobbyists, etc.—see Figure 3). Pluralism perpetuated itself, contributing to escalation. Nevertheless, this suggests that those who wish to move forward and avoid escalating indecision need to consider not only the substantive outcomes of decisions, but also their consequences for future distributions of power.

Leadership itself—or rather its absence—is a second potential contributor to escalating indecision worth reconsidering here given the emphasis on this factor in popular accounts (Done 2006a, b; Brandt 2005). We argued earlier that the dramatic situations of escalating indecision observed in public infrastructure projects are systemically determined and cannot be blamed purely on individual deficiencies. However, even in pluralistic settings, it is fair to ask whether the problem is inherently one of diffuse power, or of restraint or timidity on the part of individuals who might have made a difference. For example, it seems that the minister in our case had sufficient power to impose the merger, so why could he not have imposed aspects of the configuration as well?

In a private firm, this might well have been put down to a deficit in leadership or a weakness of managerial style as suggested by Charan (2001). In a public context, the phenomenon may be more intelligible as a reflection of the pressures on and vulnerabilities of politicians in an electoral system imbued by pluralism. Nevertheless, the willingness of formal leaders to mobilize whatever influence they have could modulate the probability of escalating indecision even in pluralistic settings. For example, an act of leadership that might have made a difference here would have been for the minister to actually sign a cheque—i.e., provide the investment required to satisfy all the competing stakeholders in the case. This leads us to another dimension of the context.

Resource availability is the third contextual factor that could moderate the probability of escalating indecision. As noted by Cyert and March (1963), “organizational slack” beyond the level of resources needed to operate enables the satisfaction of divergent interests and the quasi resolution of conflict. We would argue that the optimal conditions for escalating indecision are a form of ambivalence about resources. On the one hand, the potential availability of resources (implicitly associated with practices of idealization) is one of the attractive features of a project that keeps people attached to a network of indecision: It is for this reason that they have sufficient common interest to work together in the first place. Otherwise, they could walk away, removing the potential for escalation. On the other hand, continued uncertainty around the real availability of resources contributes to preventing convergence. In our case description, we showed how one of the practices used for maintaining acceptability and masking divergence was inflation—adding to the project to “please everyone” at each stage. Had the government been able to live with a degree of inflation and cover its cost, convergence might have occurred sooner.

Finally, a fourth condition that contributes to escalating indecision concerns the length of the time horizon. It is perhaps no accident that most of the examples introduced at the beginning of this article concerned major public infrastructure projects. These generally require several years to bring to fruition, even if all goes well. They have to be planned and detailed in advance and cannot be implemented instantaneously. The long time horizon in a pluralistic context punctuated by elections provides plenty of opportunity for defections and reversals. An interesting contrast to the present case is provided in the study by Denis et al. (2006) of hospital closures that also occurred in a pluralistic setting. The decision was taken with remarkable expedition despite the presence of divergent interests. Part of the explanation lies in the way protagonists managed the power dynamics surrounding the decision. However, the fact that hospitals can be closed quite quickly by turning off the resource tap certainly helped prevent reversal.

**Discussion and Conclusions**

This study offers several contributions to the literature. First, it introduces a new concept—that of escalating indecision, a pathological phenomenon that seems relatively common at least in pluralistic contexts, but that has received little attention in the organizational literature. This is a systemic phenomenon that has its roots in situations where multiple actors must collaborate to produce decisions. It involves cumulative episodes of decision making on the same topic over time, and it is problematic because although decision-making activities continue, they never seem to produce a stable decision or commitment—in other words, there is a constant risk of reversal or of reorientation, and a potential for widening the scope of decision activity.

Second, drawing on an in-depth case study, the paper suggests an approach to understanding the phenomenon. We argue that escalating indecision is a cumulative process that can be linked to the very practices that are used to move decisions forward in contexts of divergence. Indeed, the central observation from this study is that escalating indecision arises when participants become trapped in a set of practices and constraints that promote a particular project while at the same time
preventing its implementation or stabilization. Managers may thus become stalled in a perpetual decision-making cycle that we have labelled a “network of indecision.” As the tensions within the network build up, the network must eventually shift. In our case, it escalated outwards in order to maintain the commitment of its participants while introducing new sources of ambiguity. The notion of a “network of indecision” was initially inspired by actor-network accounts as well as by political and garbage can theories. However, the dynamic model emerging from the research was developed through an in-depth analysis of the case. Clearly, further research will be required to explore its applicability to other situations. The model is also complementary to ideas about information overload (Langley 1995) and process failure (Charan 2001) that provide alternative perspectives on pathologies associated with overinvestment in decision making.

Third, the study contributes to the decision-making and strategy-as-practice literatures by describing key dimensions of two sets of important practices associated with organizational decision making and exploring their dynamic and dialectic implications. The first set of practices that we labelled “reification” was derived inductively from the analysis of our case. It refers to practices that attribute importance and symbolic value to particular decisions. The practices we identified here are quite similar to those suggested by others as useful for enhancing commitment (O’Reilly 1989). For example, getting people to sign or formally ratify a document provides a strong symbol of personal responsibility. This has been found to be related to decision commitment, especially when reinforced by public affirmation (Haunschild et al. 1994, Ross and Staw 1986). In their work on a sociocognitive model of organizational downsizing, McKinley et al. (2000) also use the term reification (based on Berger and Luckmann 1966) to describe a process through which negotiated agreements become transformed through social interactions into external realities. In this process, managers lose some of their agency and ability to choose and to contemplate other alternatives. Reification practices are essentially aimed at achieving irreversibility.

It is important to realize that the practices of reification we identified and that were used by the key actors in our study (e.g., the civil servant in period 1 and board members in period 2) were ostensibly very effective in the shorter term, and in other times and other places, could have been successful in the longer term as well. Studies that examine strategic practices and their impact at the micro level (e.g., Samra-Fredericks 2003, Kaplan 2008) have produced some very interesting insights into the knowledge and skills involved in strategic influence. However, the dynamic effects of these practices need further study. For example, the civil servant in period 1 was applauded for his skill in getting the protagonists to sign an agreement to merge their operations. This was very impressive given the history of these organizations. Empirically, however, whereas his practices were successful in the short term, in the long term they contributed, along with the similar practices of those who followed, to launching a long and painful process of upheaval and indecision from which the organization has not yet fully recovered.

Similarly, practices of strategic ambiguity have often been viewed as potentially valuable. In a classic contribution to communication theory, Eisenberg (1984) noted the power of strategic ambiguity for achieving unity in the face of diversity. For him and for others (Davenport and Leitch 2006, Gioia and Chittipeddi 1991, Tracy and Ashcraft 2001), strategic ambiguity is a positive approach to enabling harmony amid diversity, and stimulating creativity in organizations where attempts to clarify would produce conflict. However, our data suggest that to the extent that a strategic configuration cannot be implemented unless it is clarified, strategic ambiguity can become a way of postponing decision and ultimately amplifying tension. Its positive impact may therefore be temporary. Moreover, to the extent that strategic ambiguity involves the inclusion of dimensions that together make a project almost impossible to implement (e.g., inflation or attempts to please everyone), the difficulties of decision making are multiplied, especially when they are embedded in reified commitments. In other words, strategic ambiguity may become problematic when there is a need for concerted action. Interestingly, in parallel work, researchers in international diplomacy (Scott 2001, Pehar 2001) have been debating the pros and cons of ambiguity or precision in the texts of international peace agreements. Clearly, strategic ambiguity can be of assistance in moving destructive processes forward in the short term, but whether or not it will ultimately suppress conflict, or rather simply prolong the agony, is a topic of some interest and debate.

Overall, then, our work thus suggests that the study of strategic practices and their effects must be carefully contextualized (Johnson et al. 2007, Whittington 2006) and considered more dynamically. The practices that emerged from our analysis ostensibly contained in themselves the potential for merger success as well as the seeds of its failure. This case study provides a view of the potentially paradoxical nature of strategic practices that warrants further research attention.

Finally, we asked ourselves what might have allowed the outcomes to be different. Specifically, what aspects of an organizational context might enhance or diminish the probability of escalating indecision? Our analysis identifies four such conditions that merit further study. It reiterates that the phenomenon is strongly associated with pluralism, and in particular with the persistence of power fragmentation and divergence over time. We also note that it may be more prevalent in situations...
where potential leaders take a relatively passive position, where resource availabilities are unclear or ambivalent, and where time horizons are long enough to allow defec-
tions and reversal. However, it is hard to second guess
the actors. For the most part, they deserve not blame but
sympathy as they become trapped in networks of inde-
cision that they have unwittingly contributed to creating
through practices that seemed, at least at first sight, to
be both expedient and sensible.

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Endnotes
1Some quotations have been lightly edited to protect con-
identiality where necessary. Informants are labeled in four
categories: planners (including people in staff positions, con-
sultants and government officials), senior managers, board
members, and physicians.
2A committee led by the civil servant was formed with equal
representation from each hospital, including a board member,
the three CEOs, and a member of the three physician groups.
Government and the university were also represented.
3See headlines from media in 1998: Hospital loses 80 doctors;
Malaise at the University Hospital; Dr. X leaves the University
Hospital in a cloud of controversy; Tempest at the University
Hospital; Strike in the Kitchens; etc.

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