Professionals as strategists? Channelling and organizing distributed strategizing
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Professionals as strategists?

Channelling and organizing distributed strategizing *

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Abstract
Many contemporary organizations claim to be moving towards forms of increased inclusion and transparency in the strategy formulation and communication processes. This paper explores how organizations can enable wide participation in strategy making while keeping a coherent strategic direction. In particular, it investigates how strategizing takes place in professional, pluralistic contexts, supposedly characterized by open participation in strategy-making. Drawing on a strategy-as-practice perspective and on a case study of an Italian public hospital that introduced a new participatory planning system, it focuses on how professionals participated in strategy work and the tools they drew on to do so. The study shows how professionals’ empowerment is likely to be subject to managerial endorsement and how the simultaneous opening up and holding together of strategy may be accomplished through the boundary spanning activities of planning officers and the channelling and organizing roles of formal planning tools. These findings contribute to an understanding of how distributed strategizing occurs in professional settings and how ‘open strategy’ may play out in organizations more generally.

Keywords: Strategizing; Professionals; Strategy as practice; Planning; Open strategy; Pluralistic settings.

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Introduction

Conventionally, strategy has often been viewed as the exclusive and privileged domain of senior executives (Andrews, 1971; Hambrick & Mason, 1984; Mantere & Vaara, 2008), with strategic plans shrouded in secrecy to ensure that they are not undermined or pre-empted by competitors. However, Whittington, Cailluet and Bakis-Douglas (2011) recently argued that there is a developing trend toward more ‘open strategy,’ i.e., strategic planning processes that are more inclusive in terms of who is encouraged to participate, and more transparent in terms of communication with both insiders and outsiders. Several researchers have indeed documented moves towards more ‘distributed strategizing’ involving a wider range of participants (Regnér, 2003; Mantere 2005; Laine & Vaara, 2007; Mantere & Vaara, 2008). The trend towards more inclusive strategizing seems likely to be even more pronounced in pluralistic settings (such as universities, hospitals and arts organizations) where the nature of the organization’s work is highly dependent on professional expertise and where professionals’ autonomous activities contribute *de facto* to defining emergent strategies (Mintzberg, 1979; Denis, Langley & Rouleau, 2007). ‘Openness’ is also a common characteristic associated with public and non-profit organizations (Stone & Brush, 1996; Bryson, 2011) where strategic planning processes are often intended to generate commitment from internal groups as well as to acquire legitimacy from external stakeholders such as regulators, government bodies and funders (see also Langley, 1988; Mintzberg, 1994).

The openness of strategy-making processes raises however the question of how organizations can enable wide participation while pulling the diverse contributions of a range of stakeholders into something approaching a coherent strategic direction (Denis et al., 2007). In other words, once one opens everything up, how does one then keep it all together? Moved by this question, this paper focuses more particularly on professional organizations where the open nature of strategy work and the tensions between ‘opening up’ and ‘keeping together’
should be particularly visible. This paper aims to dig into the black box of strategy work in professional settings, focusing in particular on the work of professionals in strategizing. Shedding light on this poorly understood work and how it is accomplished should increase our understanding of how distributed strategizing occurs in professional settings. This in turn may offer insight into how ‘open strategy’ may play out in organizations more generally, i.e. in settings where the phenomenon is more novel and our knowledge about its dynamics still uneven (Whittington et al., 2011).

We explore these issues empirically drawing on a case study of an Italian public hospital that introduced a new formal planning system with explicit emphasis on empowering clinical professionals by involving them in strategizing. The planning system is composed of three formal components: strategic planning, budgeting and project management. We analyze in particular how professionals participated in strategy work and the tools they drew on to do so. We found that the organization’s strategy, constructed as an open process, is indeed a form of order emerging from clinical professionals’ contributions, at least in part. Yet this order was achieved only through the crucial but apparently invisible work of another type of operating professional: the planning officer. Finally, we observe that the formal planning system is barely used for strategy formation, but contributes by playing a channelling role, as it both enables and constrains professionals’ strategic discretion, and an organizing role, as it integrates different bodies of knowledge and different parts of the organization. The study shows how the simultaneous opening up and holding together of strategy may be accomplished through the boundary spanning activities of a particular type of professional and the channelling and organizing roles of formal planning tools.

In the next section, we review three literatures with relevance to professionals’ strategy work. While these streams of research all identify a role for professionals in strategy making that informs our study, they stop short of providing a fine-grained understanding of how this
occurs, and of how different actors, activities and tools contribute to defining organizational direction. After the methods section, we present the actors, activities and tools involved in strategy-making in the setting under analysis, along with our findings on how professionals’ strategizing work actually occurs. In the conclusion, we highlight the contribution of the study to the conversation concerning professionals’ role in strategy-making, relating our findings to the bodies of literature discussed below.

Three perspectives on open strategy in professional settings

Three streams of literature seem relevant to understanding the work of professionals in strategy-making. A first reference point is Henry Mintzberg’s classic work on professional bureaucracies (1979). A second body of research that has addressed the issue of strategy-making in professional settings is the literature on managerialism and the trend towards ‘post-bureaucratic’ organizations. Finally, ‘strategy as practice’ scholars have drawn attention to the crucial contribution of operational-level employees to strategy formation, especially in professional settings (Mantere, 2005; Laine & Vaara, 2007; Spee & Jarzabkowski, 2011). We examine each of these literatures in turn.

The literature on professional bureaucracies: Professionals as de facto strategists

In his influential treatise on the structuring of organizations, Henry Mintzberg (1979) defined professional bureaucracies (hospitals, universities, accounting firms, etc.) as a particular type of organizational structure relying on expert employees (professionals such as doctors, academics, accountants, etc.), and characterized by horizontal and vertical decentralization where coordination is achieved principally through the standardization of professional skills acquired by long training and socialization. Typically, professionals are powerful decision-makers in these organizations because they are able to exert direct control
over their own activity and because they influence collective administrative decisions (such as recruiting, promotions, resource allocation, restructuring, etc.) by virtue of the specialization, complexity and valued nature of their professional work (Mintzberg, 1979). Thus, according to Mintzberg, professional bureaucracies typically encompass two parallel hierarchies: a professional hierarchy, characterized by bottom-up decision-making flows (from the front-line professionals to top management), and an administrative support hierarchy, characterized by more mechanistic top-down decision-making flows.

In this context, strategy as the expression of a clear centralized intention and a deliberate top management process may seem rather loosely connected to what the organization actually does (Denis et al. 2007). Instead, strategy emerges as a pattern of actions (Mintzberg & Waters, 1985), resulting from the accumulation of autonomous local decisions (individual projects or initiatives) where professionals play the role of entrepreneurs (Mintzberg, 1979). Such cumulated autonomous decisions can be considered strategic in as far as they potentially impact organizational outcomes – e.g., new working procedures that improve or change the services provided, the creation of new departments, technology adoption, etc. (Mintzberg, 1979). Clearly, this argument applies to some degree to all organizations, but it particularly applies to professional organizations, given their highly pluralistic nature (Denis et al., 2007) and the autonomy individual professionals retain in such settings. In these contexts, characterized by diffuse power, multiple, often divergent objectives and the knowledge-based nature of work, strategy has been found to evolve through clusters of individual actions more than elsewhere, eventually emerging as some kind of ‘unintended order’ imposed from within, rather than from outside (McMillan & Carlisle, 2007).

From this perspective then, professionals are de facto strategists although they may not necessarily see themselves this way. Moreover, ‘open strategy’, to the extent that it implies involvement of a wide range of people in the making of strategy (Whittington et al., 2011), is
also a *de facto* feature of all professional bureaucracies even in the absence of any formalized participative process labelled strategic planning. This raises the question as to what happens to professionals’ strategy work when such formal processes – perhaps intended to enhance professionals’ involvement – are introduced. This brings us to the second body of literature.

*The literature on post-bureaucratic organization: Professionals as ‘empowered’ strategists*

The empowerment of professionals and of employees in general in organizational decision making is directly addressed by the literature on managerialism and post-bureaucratic trends. In the late 1990s, organizational scholars began to theorize about the emergence of a ‘post-bureaucratic’ turn (e.g. Alvesson, 2004; Greenwood et al., 2006) represented by a new emphasis on the softer aspects of managerial work (e.g., Total Quality Management, culture management, creativity and entrepreneurship), post-industrial forms of production (networks, project-based organizations), and New Public Management (prompting decentralization, devolving autonomy and quasi-market phenomena in the public sector). These trends all seemed to converge on the idea of the demise of old ideal-type bureaucracies (characterized by hierarchy, standardized tasks, routines, and vertical levels of authority), in favour of the notions of empowerment, workers’ initiative and participation in decision making, peer-based control, and distributed leadership.

Post-bureaucratic tools and organizational forms such as self organizing teams, cross-functional or inter-organizational collaborations and networks, project management, participatory planning, often accompanied by performance indicators to enhance accountability characterize much of today’s organizational landscape. Some have therefore referred to our epoch as a ‘post-managerial era’, either because ‘we are all managers now’, or because we are witnessing a ‘demise of management’ in favour of new forms of control, organizing, and strategizing (Grey, 1999: 562).
Critical scholars have advanced the counter-argument that these post-bureaucratic organizational forms are paradoxically a refurbishment of bureaucracy - simply old types of dynamics repackaged as new (Josserand et al., 2006). For example, Courpasson and Clegg (2006) showed how in project-based organizations the old political dynamics (e.g., the distinction between elites and sub-elites, prescriptive tasks dictated by milestones and performance indicators) continue to apply, making project organizing just a new type of iron cage. Others argued that output targets and legitimized general guidelines have substituted for vertical control and process standardization, but constitute a different form of a still intrusive and intensive control. Moreover, even in flat organizations, formal hierarchy persists for example in traditional managerial privileges, such as the formulation of goals, of strategies, and reorganizations (Hales, 2002; Courpasson, 2000) or is substituted by informal hierarchy (Diefenbach & Sillince, 2012), as documented for example in network organizations (e.g. Ahuja & Carley, 1999) and in public sector and professional service settings (Ackroyd & Munzio, 2007; Kirkpatrick et al, 2000).

However, recent studies have attenuated the critique, acknowledging the persistence of hierarchy/bureaucracy in modern organizations, but stressing its co-existence with important forms of horizontal authority that are combined in different ways. In particular, Lundholm et al. (2012) focused on the relationship between ‘verticalization’ and ‘horizontalization’ in decision making, theorizing three typical combinations, corresponding to a larger or smaller social and epistemic distance between managers and employees, especially in knowledge work: loose coupling (when discretion is accorded to employees and managers have indirect influence through the articulation of strategies and cultural messages); translation (when managers collaborate closely with employees and formulate directives, while operational staff have the discretion to translate them into actual work); integration (when vertical and horizontal dynamics of authority merge) (Lundholm et al., 2012). Others have stressed the
alternation of different dynamics, where traditional formal authority is bracketed by moments when space for expert authority emerges, especially in case of complex processes or decisions for which subordinates are better equipped (Birkjeflot & DuGay, 2012).

Clearly, these accounts of post-modern organizations can be re-conceptualized as favouring forms of inclusiveness in line with the notion of ‘open strategy’ as proposed by Whittington et al. (2011). Moreover, to some degree, these forms of post-bureaucratic organization resonate well with the traits of Mintzberg’s professional bureaucracy as an ideal type (knowledge intensive, decentralized, characterized by diffused authority and by the co-existence of vertical/control and horizontal/professional autonomy dynamics). And yet, in contrast with the notion of professional bureaucracy where inclusiveness is seen as a de facto phenomenon associated with the nature of the work itself, post-bureaucratic or managerialist ideas imply the deliberate mobilization of structured tools such as participative planning and performance indicators to promote inclusion and empowerment. Given this, it would appear that post-bureaucratic trends might enhance professionals’ roles in strategy formation. However, the critics warn that these trends implicitly incorporate forms of vertical control, and some writers on professional organizations (Greenwood, Hinings & Brown, 1990; Brock et al., 1999; Lawrence, Morris & Malhotra, 2011) see managerialism as potentially limitative of professional autonomy. It remains to be seen how more traditional forms of professional autonomy and formalized managerial processes mix to influence professional roles in strategizing. Thus, despite the empowerment discourse, it is fair to ask whether professionals are empowered or disempowered by such practices. In relation to this, the recent ‘strategy as practice’ stream of literature has devoted particular attention to understanding how strategizing activities actually occur in organizations, focusing notably on the role of individuals beyond managerial elites. It is therefore also particularly relevant to this study.
In response to a perceived need to humanize strategy research (Whittington et al., 2002), the ‘strategy as practice’ stream of scholarship has been concerned with re-focusing research on what people do, i.e. on the myriad of micro actions through which human actors shape activity (Jarzabkowski et al., 2007). One of the core questions of strategy as practice research has been ‘who is a strategist?’ and ‘what do strategists do?’ Hence, amongst other things, attention has turned to strategy practitioners, i.e. the individuals who, drawing upon specific practices, actively – albeit often perhaps unintendedly – construct activity that is consequential for the organization and its survival (Jarzabkowski et al., 2007).

This stream of research suggests that strategy practitioners are not only and not necessarily located in senior management positions. According to Mantere (2005), believing so would entail a risk of ‘ideological managerialism’ that could be misleading for strategy research and possibly detrimental to strategy practice. Indeed, drawing on the notion that organizational outcomes are heavily influenced by what happens in the middle of organizations, rather than at the top (Burgelman, 1983; Floyd & Lane, 2000), one of the ongoing themes of strategy as practice thinking has been to identify a much wider group of actors as potential strategists in addition to top management, focusing attention on other individual and collective actors, such as middle managers and operational employees.

Some of this research developed in the particular context of professional or pluralistic organizations, investigating for example how the work of professional-managers and their identity construction changes with the introduction of managerial techniques, like business planning (Oakes et al., 1998), or studying how the work of top managers in these settings is shaped by influences and tensions from other parts of the organization (Jarzabkowski & Fenton, 2006; Smith et al., 2011; Spee & Jarzabkowski, 2011). Considerable research on the role of middle managers in strategy formation has also accumulated (for a review, Wooldridge
Middle managers are seen for example to be key actors in change processes (Balogun, 2003; Currie, 1999; Huy, 2002), and across organizational boundaries, scrutinizing, championing, synthesizing information (Floyd & Wooldridge, 1992, 1994; Dutton et al., 1997) and promoting strategic change with key external stakeholders (Rouleau, 2005).

A few scholars have focused deliberately on contributions to the formation of strategy spread throughout the organization, without confining their research only to top or middle management. For example, Mantere (2005) looked for ‘strategic champions’ among people at all levels of several professional service organizations. He showed how not only top managers, but middle managers and operational employees too constructed themselves as strategic champions, albeit differently, and how different practices enabled or disabled their strategic potential. Laine and Vaara (2007) found three ways of making and giving sense to a strategic development discourse in an engineering firm, corresponding to three alternative ways of socially constructing reality by top managers (mobilizing a strategic development discourse for hegemony), middle managers (creating an alternative strategic discourse as a space for manoeuvre) and professionals (distancing themselves from management-initiated discourse, and arguing that true strategic activity lay in fact in the development work they carried out for specific projects at the heart of the organization’s success). All in all, as the few studies that investigated strategizing at different organizational levels (Mantere, 2005; Laine & Vaara, 2007) or in pluralistic settings (Spee & Jarzabkowski, 2011; Smith et al., 2011) suggest, the contribution of operational employees’ day-to-day activity, especially in professional contexts, is significant for strategy formation, though often under-recognized.

In summary, all three literatures on professional bureaucracy, on managerialism/post-bureaucracy and on strategy as practice suggest that strategy is crafted everywhere and that it would be misleading or anachronistic to consider it as confined to top management functions only. This has always supposedly been so in professional bureaucracies, but it is true for all
organizations, especially when based on professional work, and it is expected to be even more so in today’s (post-modern) organizations, though co-existing with vertical dynamics also. Put differently, in so far as they participate in strategy formation, professionals too are strategists. But how does this occur? How does distributed strategizing happen in professional settings? And how is the opening up of strategy through participative mechanisms achieved while holding the organization’s overall strategic direction together? Despite the claim that strategy happens at the middle and at the bottom of the organization as well as at the top, how this occurs in fact, i.e. how professionals contribute to constructing organizational activity and how this is managed is not entirely clear. Shedding light on this issue is important because it may increase our understanding of how, in the end, organizational strategy is shaped in professional settings and how different actors, activities and tools contribute to organizational direction. This may in turn have something to say about how ‘open strategy’ may be enacted in organizations more generally, i.e. in settings where the phenomenon is more novel and our knowledge about its dynamics is still uneven (Whittington et al., 2011).

Methods

**Empirical setting and contextual background**

To explore this issue, we draw on a qualitative, in-depth case study, based on a single case. The research setting is an Italian public hospital (here referred to as ‘Salute’) that went through a process of change following the application of managerial reforms of the national health system in the 1990s (introducing notions of greater autonomy, accountability, comprehensive planning, and new managerial roles for clinicians). In particular, in recent years – and especially under the two mandates of the present General Director – Salute dedicated substantial effort to the development of a system of participatory planning, that we
label the ‘planning system.’ The expressed rationale of the planning system is to empower professionals by involving them in strategizing through the development of strategic planning, project management and budgeting activities. In order to pursue this goal, a planning office was established to support and field-train clinicians. Given the special emphasis on the involvement of professionals in organizational strategizing through the establishment of the planning system in recent years, Salute seemed a suitable extreme case to explore the work of professionals as strategists.

*Data collection*

We collected data from three main sources. First, we collected fieldnotes and – whenever possible – transcripts of recorded material gathered through participant observation of the processes in which clinical professionals engage with planning practices. This concerned several activities related to strategic planning, budgeting and project management, and it included both organization-wide meetings and one-to-one interactions between individual clinical professionals and the planning officers. The participant observation activity was carried out by the first author over eight months (October 2009-May 2010), for an average of two days a week in the field (over 300 hours of observation). We took on-site fieldnotes and used a formal research diary to record notes, observations, and interpretations. Participant observation was an important aspect of the data-gathering strategy, especially to track professionals’ activities in relation to the newly established practices of the planning system, but also to bridge among and make sense of the different informant views.

Second, we conducted interviews to access the views of professionals on their own work. Overall we carried out twenty-one formal interviews, and had numerous other informal conversations. In terms of professional staff, we interviewed all twelve clinical directors of the hospital. This study focuses particularly on these interviews. Each interview purposely
followed an open design: clinical directors were simply asked to narrate their job and to reflect on how it had changed over time, if at all, as we were interested in understanding how the actors made sense of their work, whether, how and how much this spontaneously included a strategizing discourse and whether and how much it was related to the practices of planning/budgeting/projects introduced with the planning system.

Third, we collected documentary evidence including all triennial strategic plans and all annual operational plans since 1996 (i.e. since the hospital began to produce them). We collected and analyzed also several other organizational documents, such as organizational reports, internal regulations, power points or other kinds of presentations posted on the intranet, and the operational units’ budget files. These archival documents provided qualitative, longitudinal data on the progressive establishment of an official discourse of participatory planning and professionals’ involvement in organizational strategizing.

Data analysis

How does distributed strategizing occur? And how is the opening up of strategy through participative mechanisms achieved while holding the organization’s overall strategic direction together? To answer these questions, we explored the nature of professionals’ strategizing activity. We began with a first-order descriptive analysis, composed of a review of the official, formal organizational narrative on the planning system and a thick description of professionals’ engagement with all the strategic planning, budgeting and project management practices as we observed them in the field. On the basis of these raw data, we proceeded with a second-order interpretative analysis, coding all sources of qualitative data according to our analytical objectives and an inductive design. In particular, we applied a strategy as practice analytical framework to orient analysis, untangling the following dimensions of strategizing proposed by Whittington (2006) and Jarzabkowski et al. (2007): (a) Actors (practitioners):
which professionals (which actors/at what organizational level, in which function) participate in strategy work? (b) Activities (praxis): what type of strategizing occurs? How do professionals participate in strategy work? What do they do? (c) Tools (practices): what enables strategy work? Which tools are drawn on and what is their role? Moreover, we made a distinction between the officially espoused theory concerning professionals’ strategizing (the official discourse, as reported in documents and in individuals’ accounts) and what professionals do in fact (from observational data and individuals’ accounts). In so doing, we noted how much and how strategizing activities draw on the strategic planning, budgeting and project management practices (the planning system).

Based on this analysis, we present our findings in three main sections. First, we show how the official organizational discourse constructs clinical professionals as strategists; second, we consider how clinical professionals construct themselves and act as strategists in turn; third, we zoom in on an emergent finding of our research: the key role of planning officers in enabling clinical professionals’ engagement in the planning system.

The construction of professionals as strategists

Building on the general definition of strategizing as the myriad of micro actions through which practitioners construct activities that are consequential for the organization and its survival (Jarzabkowski et al., 2007), we can affirm that the organizational narrative embedded in official documents depicts the planning system at Salute explicitly as a means to enable professionals to participate in strategy making. The planning system is composed of three tools, each one designed to involve professionals through different activities. In Table 1 we summarize the official discourse of the participatory planning system introduced at Salute, presenting the tools (the main features of the strategic planning, budgeting and project management practices), the actors (the professionals that are expected to be involved in every
practice in the official planning discourse), and the activities (the expected form of professionals’ strategizing attributed to every tool in the official discourse).

[Table 1]

**Strategic planning: Strategizing as participation in higher level organizational decisions**

Strategic planning is defined as the process of formulation of ‘the basic document of the organization’s planning, where the organization’s strategic lines over a three-year-period are defined and where the individual operational objectives are articulated on an yearly basis’ (Strategic Plan 2010-2012). It is promoted as the ‘compass’ to set the broad orientation for the whole organization (Power Point presentation of Strategic Plan 2010-2012) and it is represented as a participatory process of reception, adjustment and alignment of different ‘inputs’ from clinical professionals through their representative bodies, higher level regulatory sources, other external stakeholders (Strategic Plan 2009-2011; 2010-2012). Planning officers are expected to assist top management in this process and in the presentation of the final strategic plan to all stakeholders. Clearly, from the way it is conceived, the strategic planning practice is not seen as a top management function only, but is designed to involve – albeit indirectly – clinical professionals in the formulation of the organizational strategy, through the formal provision of inputs to the plan and through the advisory function of some professional representatives in intermediate versions of the plan. In other words, Salute interpreted the strategic planning practice as an opportunity to embed professionals’ voice into higher level organizational decisions.

**Budgeting: Strategizing as local operational decisions**

The budgeting practice at Salute consists of the definition of annual activity targets and related resources by hospital unit. According to the formal procedure, such targets are negotiated yearly at ad hoc meetings between the top management team, on one side, and
each clinical director and nurse coordinator for every department, on the other side. In other words, clinical directors and nurse coordinators – assisted by planning officers – are supposed to negotiate budget targets for each hospital unit within their department, upon consultation (pre-negotiation) with each head physician (Salute Budget Regulations). This notion of budgeting at Salute explicitly espouses the view of the ‘clinician-manager’, according to which professionals (head physicians, clinical directors and nurse coordinators, in particular) are conceived of as decision-makers running a portion of the organization, whose decisions have important consequential outcomes both in terms of delivered service and in terms of resources employed (Presentation of Strategic Plan 2010-2012; Budget Regulations). In other words, they are micro-strategists at the level of local operational decisions. The budgeting practice is thus presented as a tool to empower these professionals as accountable decision-makers as well as to harmonize their activity with the higher organizational levels.

**Project Management: Strategizing as micro-innovation/entrepreneurship**

Project management at Salute is the activity of proposing and managing organizational projects ‘as a tool and a way to realize the goals stated in the strategic planning documents’ (Project management regulations, Salute internal document). An organizational project is defined as ‘any innovative (not routine) initiative, aimed at the achievement of precise operational objectives within specific time and cost limits, usually involving several heterogeneous units/roles that are temporarily aggregated in a multi-professional team’ (Project management regulations, emphasis in the original). Salute distinguishes between ‘top-down’ projects (‘organizational project activities considered to be overriding and strategic by the Direction and impacting several structures transversally’, project management regulations), and ‘bottom-up’ projects (‘tools proposed by any unit in order to achieve the operational objectives of the strategic plan’, ibidem). Proposing a project is an
opportunity (not an obligation) available to any professional in any organizational position. Clinical professionals, with the support of planning officers, thus structure project proposals but must connect them to specific goals of the strategic plan; the top management team, assisted by planning officers, reviews all project proposals and selects, revises, or approves their implementation. Project management is thus conceived as a tool to enable or stimulate professionals’ local innovations (or micro-entrepreneurial activity) and structure them within the overarching planning system. Put differently, it is a way to enhance and structure professionals’ strategizing potential as it expresses itself at the level of local solutions on how to reach major organizational goals.

Taken together, professionals are constructed as strategists in the official discourse, in several ways. Their power, their voice, and their contribution to the strategy making of the organization is emphasized in the official organizational narrative. The planning system as here conceived, i.e. as an interlocked set of practices (strategic planning, budgeting and project management) is the tool through which such strategizing potential of professionals is channelled. Note however, that although the participation of professionals in the strategic planning component officially enables them to provide ‘input’ to organizational goals, those goals may depend on other inputs also. Moreover, professionals’ strategizing roles in budgeting and projects are always qualified in the official narrative in terms of their fit with ‘major organizational goals.’ Already we see some ambivalence – professionals are constructed as strategists, but within a well-defined framework that is not necessarily theirs to determine. We now examine how the discourse is translated into practice.

What people do: professionals as quasi strategists
Beyond the official discourse, how are professionals actually shaping strategy in this context? Drawing on empirical evidence from our observations and interviews, a somewhat different picture emerges on the different forms of professionals’ strategizing.

**Professionals’ quasi participation in higher level organizational decisions**

A close analysis of the actual unfolding of the strategic planning process reveals that clinical professionals’ active participation in higher level organizational decisions is present only in part. Indeed, although presented as the result of several ‘inputs’ to be fit together, the strategic planning process is less influenced by the inputs than it might seem at first. In particular, of the inputs coming from professionals (proposals from the multi-professional teams, specific plans of the new clinical directors, the ‘primary care plan’), only the former are actually embedded in the plan, as explained and shown by a planning officer:

*They [multi-professional teams for the quality accreditation] have produced a number of recommendations having the quality of service in mind. We [planning officers] must acknowledge them and I have already identified strategic and operational objectives with them [multi-professional teams]. Basically, I have translated their recommendations into schemes that are handy for the strategic plan [P.O.#01, September 2009].*

The other professional inputs are only mentioned in the strategic plan as a generic reference, but the contents of the former were not processed and aligned in fact. Moreover, the real sources of input to the plan are concentrated in just a portion of the document – namely, strategic goal 1 (‘the organization of services’) and strategic goal 4 (‘clinical governance’). Hence there is a big portion of the strategic plan (three strategic goals out of five) that should be understood as driven by the initiative of the top management team for this triennial period, and not the result of a consultation process with the professional base. The inclusion of professionals’ contributions and feedback into the formulation of the strategic plan is limited
to the multi-professional teams’ proposal for quality accreditation. Other professional inputs are more ceremonial than effectual.

In fact, the consultation process of the strategic plan (i.e. the meetings with the clinical directors and other professionals’ representative bodies) was seen by participants to be more of a ritualistic activity to obtain legitimacy for the plan, rather than a true participatory planning moment. Such ceremonial involvement of professionals in the formulation of the plan was noted by the clinical directors in their interviews, all converging on this point.

*Very rarely – and I have discussed this with many colleagues – very rarely is the staff involved in the formulation of these plans, more often than not… I mean, we are involved in the phase of presentation of the plans. Erm… there is no bottom-up, as they say. Let me correct myself: there is in theory, because in theory every year clinical directors say what their department did and what it wants to do then, but then in practice… [C.D.#03, April 2010]*

*[The plan] is made by them, though. We are only minimally involved… In fact, the planning of strategies, of the program- we don’t do it, I mean, we are involved only very marginally; in principle we could propose ideas, but in the end who decides is not us. [C.D.#08, April 2010]*

Nevertheless, though not within the actual structure of the strategic planning formulation process, evidence of professionals’ participation in and influence on higher level organizational decisions is manifested in other more clandestine ways. During the budget negotiation meetings, for example, some clinical directors advance requests or suggestions for major service changes or improvements:

*Here we [doctors of the rehabilitation department] wanted to put forward a broader issue: this activity shouldn’t take place within the hospital completely. It would be appropriate to keep at the hospital outpatient treatments only, because they are strictly connected to the hospital activity… but this is a broader issue to be discussed… [Budget negotiation meeting, rehabilitation department; March 2010]*

Other important decisions arise from certain professionals and then follow direct, informal channels with the Senior Manager, around (and not within) the planning system:
I have checked my pharmaceutical expenditures in 2009 and I already agreed with the Pharmacy division for a X.Y million € for my 2010 budget: I know it’s an increase by 6.5%, not more, but it’s motivated. I also already told the General Director, things are like this. [Budget pre-negotiation meeting, oncology unit; March 2010]

The idea is to merge the competences in micro-biology with the ones in infectious diseases and to create a functional department of diagnosis and care of infectious diseases between different hospitals of the region, with one special access... The evolution of this idea, well, I had the idea and I told you the reasons, then I submitted this as an idea to the General Director and to the Mayor. They liked it, so I pursued it and I submitted it to the regional body. [C.D.#07, April 2010]

In sum, as far as the participation in higher level organizational decisions is concerned, it can be seen that professionals are indeed consulted, but strategic decisions concerning the content of the organizational objectives happen beforehand, at the top management level, or emerge in a more dispersed way around not within the planning system, while the participatory consultation of professionals in the strategic planning process works rather as a retrospective sanction of decisions already taken, in fact.

Professionals’ limited power in local operational decisions

As seen, according to the official organizational narrative and as reported by some professionals too, the budgeting practice should be ‘the tool through which you say: I am going to orient my activity towards this or towards that’ [C.D.#02, April 2010]:

‘That is, I could in theory move a doctor or a nurse from one division to another; I could decide that a machine should be moved to another unit; in reality this is something we cannot do, because there are others who decide on these things’ [C.D.#08, April 2010].

In fact, virtually all professionals stated in their interviews that the budgeting process is limited in its potential value by the fact that the budget file is a mere quantification of a unit’s activity and ‘not a real budget of resources to be managed’, which makes another clinical
director refer to it as a ‘Monopoly game’ [C.D.#04, April 2010; implying fake money]. This lack of a direct control on resources for the head physicians and clinical directors confirms that many decisions escape local control – or at least, escape the Budgeting process. Since there is no real negotiation of any kind on resources during the Budgeting process, it is clear that the decisions ‘that count’ are taken elsewhere and through other channels.

*Ours is a virtual budget that more often than not is ‘all resources being equal’. [...] Periodically the organization can benefit from new funds, so periodically there may be meetings between the Departments and the Steward’s Office and the Medical Director, where we try to reason on choices on a priority basis.* [C.D.#09, April 2010].

This downplays the role of Budgeting (and, indeed, indirectly, the whole planning system) as a locus where professionals exert their real decisional power.

This is confirmed also by a close analysis of the contents of the budget files. Despite the emphasis on resources in the official budget narrative, a discourse of resources is virtually missing. Some financial resource amounts do appear in the budget files, but they are a mere representation of a unit’s activities in economic terms and not a matter of allocation of real resources to be managed. In the budget negotiation process, what is negotiated is the target to be achieved within the current year, in terms of amount of expected increase/decrease or maintenance of a certain activity, and in terms of accomplishment of a certain project, and *not* the type of activity or the amount of resources for every unit. As a Planning Officer noted: ‘*Ours is a budget of objectives, not of resources*’ [P.O.#02, March 2010].

This leads to the conclusion that where local operational decisions are concerned, in theory head physicians can negotiate their unit/department’s objectives through the budgeting practice, but in fact they are *not* empowered decision-makers: a close analysis of their activity suggests that they lack real control over resources, they appear unable to decide on personnel issues (e.g. recruitment), on new acquisitions, on technology adoptions, etc.
Micro-innovation/micro-entrepreneurship: the locus of professionals’ strategizing?

While observations of the planning and budgeting practices provide limited signs of professionals enacting the role of strategists, empirical evidence confirms both the existence and growth of entrepreneurial behaviour among professionals in the project practice, manifested in the way they mobilize this formalized framework to promote their ideas, push them forward, and finally implement them. Indeed, project management is a widely diffused activity. Proposing projects now involves hundreds of people every year. In terms of participation, projects are run by head physicians, clinical directors and, increasingly, line doctors or nurses. Moreover, project work groups tend to bring together different professions in multi-professional teams: doctors, nurses, technicians, administrative staff, etc. Since the activity began, Salute has recorded over 700 projects and had a wide number of organizational members involved (over 500 project leaders, plus the personnel involved in every project work group) from different levels among physicians, technicians, nurses, administrative staff (Report 2003-2007). A boom in project practice took place in 2005, when 124 new projects were proposed. Since then the trend has stabilized, with the majority derived from bottom-up proposals while a few major inter-departmental projects are proposed by management.

The project management practice is framed at the beginning of every year as top management gathers for a project selection meeting, where all new project proposals are introduced by the planning officers and discussed by the directors. On this occasion the directors ‘select’ the submitted projects, or rather adjust them (extending a project to other units/departments, merging similar projects proposed from different parts of the organization, etc.). However, it is interesting to note that in the observed project selection meeting, the directors rejected only a few projects because ‘they are institutional activity’, as opposed to an innovative proposal or idea promoted by professionals from the bottom of the organization.
What kind of projects are we talking about? In 2010 142 projects were proposed. Most of them were clinical projects (71). Of these, only 8 were top-down: six IT projects (concerning the digitalization of patient’s medical chart in different units or departments); one is for the quality accreditation program, and one about a major hospital restructuring project to come. The remaining 134 projects were all bottom-up. The bottom-up projects proposed by professionals can be considered strategic to the extent that they involve activities that are consequential for organizational outcomes. We can distinguish projects by degree of ‘strategicness’, depending on the range of the impact of the project. A quote by a clinical director hinted at this distinction too:

*Then I think of some projects that are well targeted, very nice ones and I tell myself: no! These served to modify the organization. If it is about a real project that rises from an organizational need, from some problems you actually believe in, then it is useful. If not… [C.D.#09]*

For example, projects that concern innovations in working procedures (new workflow, new protocols, etc.), can be considered to be strategic, yet at a low degree, in that they represent local solutions to better serve patients’ needs. They do affect organizational outcomes, because they imply changes in the service provided, but at a local level. In contrast, projects that concern minor or major organizational restructuring (the creation of a new unit, of an inter-departmental service, or the establishment of an inter-departmental new practice, etc.), for example, can be considered as highly strategic, in that they often reshape the organization of services more extensively, implying high impact changes in terms of units involved, resource savings, and low reversibility of the proposed solution. Table 2 displays two examples of projects that can be considered to be more or less strategic. In both these examples the solutions (either with low or high strategic impact) are completely conceived, proposed and carried out by professionals themselves. The fact that a project practice is established enables and stimulates entrepreneurial initiatives, as in these examples.
A closer look at the way professionals talk about their projects further reveals the way entrepreneurial initiatives may be prompted by the project practice. A first piece of evidence in this sense comes from the recurrent referral to the pronoun ‘I’ when describing certain projects: e.g., ‘I did it, because I reasoned in the following way (…). It originates from me, right from me’ (C.D. #07). Secondly, often professionals, when structuring a project, make reference to the sensing of a problem or a need as a departure point that prompted the idea of the project itself as a way to address that need (something that is very distant from a merely procedural and routinized activity). For example:

*Let me see, the first step is this: when you sense that something should be done in a sector, in a spot, in a path, in a situation, in a condition, in a pathology… and… you feel that things must be improved in that point of the mechanism (because this is a big machine working with many trains of gears), then you see that you have to put some new wheels to go for new ways.* [C.D.#06]

The same can be identified in the following passage, where a nurse of a surgery department was designing a project on the reduction of anxiety in patients’ pre-surgery phase with a planning officer. Not only it is clear how the idea of the project came from a perceived problem in the service, but also how this professional looked for information and found inspiration from formal analysis and good practices elsewhere:

*I… to get to this point, what pushed me to do, to think of a project like this was that the patient doesn’t seem to be informed about anything. Then I conducted an epidemiological study with a data collection and it turned out that… that patients are not aware of much. (…) I am also in touch with [names a University] because they have a very advanced evidence by nursing, especially on this project: they set up an entry protocol, where the patient is introduced, a protocol on paper first, because some studies showed that what the patient retains from oral communication is never sufficient…* [Nurse #01]

To conclude, the project practice seems to enhance bottom-up, yet structured, decision-making flow. It appears to enable professionals’ strategizing acting at a very local and micro level, but that ultimately has important organizational outcomes (the creation of new
structures, new working processes, better service, etc.). In other words, it seems to be a way through which the potential of dispersed autonomous decisions is at the same time enhanced (as we saw, more professionals take initiatives) and controlled (because these projects are however screened by the top management – the selection meeting – and channelled within the planning system – in that they are all explicitly linked to one of the strategic plan’s goals and to the relevant units’ budget files).

**The planning officers’ boundary role**

In our review of the official discourse of the planning system we noted how the planning officers (a Chief Planning Officer who is a former doctor and two planning officers with an accounting and management background) are expected to provide technical support, accompanying each phase of the prescribed planning cycle: they closely collaborate with top managers in the actual formulation of the plan and in its presentation; they meet with clinical directors and head physicians prior to budget negotiation meetings in order to help them with the interpretation of the budget file and the definition of realistic and reasonable target proposals for the budget negotiation with the direction; they are present at all budget negotiation meetings, to smooth the discussion and provide additional data, if needed, during the discussion between the clinical directors and the top managers; they help professionals in each phase of the back-office work of project development, from the structuring of the idea, to the monitoring to its formal conclusion; they play an important role in the project selection meeting too, where they present one by one all project proposals to top managers and discuss potential amendments with them.

Taken together, it seems that the whole apparatus of the planning system is dependent on the work of the planning officers. Failing to consider their role when analyzing the doing
of strategy would be misleading. Looking closely at their activity, two main patterns in what they do emerge, that go way beyond the simple ‘technical support’ prescribed role.

**Translation work: Reducing cognitive distance**

Beside their technical support function, and through that, planning officers also mediate between otherwise disconnected bodies of knowledge that often remain opaque to each other, like two foreign languages: management/accounting logics and clinical professional ones. We call this specific type of mediation *translation work*. Evidence of translation work can be seen in planning officers’ contribution to the formulation of the strategic plan, in the budget pre-negotiation meetings they hold with some of the head physicians and clinical directors, and in their support activity to clinical professionals in the setting up of a new project.

**Translation work in the formulation of the strategic plan:** In general, the formulation of the strategic plan was composed of three main phases: reception of the inputs, discussion within the top management team, final writing. In particular, in the last phase the planning office received, on the one hand, the draft list of the strategic goals already conceived by the top managers and, on the other hand, some of the inputs to the strategic plan (in the form of directives from the Regional regulations, proposals from the quality accreditation teams, organizational data reports from 2009 – as previously illustrated). Especially as far as professional input is concerned (the quality accreditation team proposals), the task for the planning office was then to adjust/revise the inputs, translate them into operational objectives, group them and align them under the most pertinent strategic goals. On the basis of this process of assemblage, the planning office presented then a first draft of the strategic plan to the top managers who discussed it in detail in a formal meeting. On the basis of the
recommendations expressed by top managers, the planning officers adjusted the objectives of the strategic plan in turn and finalized the document.

_Translation work in the budget pre-negotiation:_ Every third month, the management control unit sends a data report file to all head physicians and clinical directors. All head physicians are expected to analyze and monitor their own data. Clinical directors are expected to access also the budget files of the units belonging to their department. In accomplishing this they can contact the planning office to receive help in interpreting the data. We observed four episodes where clinical directors or a nurse coordinator went to the planning office to analyze budget data together. During these one-to-one meetings the clinical professional and the planning officer discussed the contents of the budget file, providing explanations about the numbers, and making hypotheses about the causes of increase or decrease of certain values, by analyzing all budget file data as a whole. An example:

Planning officer: _I saw that the mean value of your DRG increased a lot. Probably this is due to the fact that you had more patients with a longer DRG [she shows that in the budget file]. This mean value is increasing because the number of discharged patients with a more complex DRG increased, it is the complexity of single cases that increased._

Doctor: _Right. Then you circled this datum and I’m going to circle it too, because you are right, it’s both things._

As illustrated in this passage, the planning officers were showing familiarity both with the accounting logics embedded in the budget files and with some of the clinical issues that characterize the activity of a hospital unit, while also making these two spheres of knowledge transparent to each other. This translating role of the planning officers in support of the budgeting practice was for example underlined by a clinical director in an interview:

_At a certain point they [the top management] started to establish a staff unit that could be of support in the construction of numbers, in the understanding of numbers and of all these things. Then it’s clear that_
a budget file cannot be just a listing of numbers; there must be an assessment, an understanding. [...] I mean, the terminology itself [of the entries of the budget file]... I don’t think that a doctor, although tending to be a ‘manager’ more and more (and I say that with quote, unquote and four exclamation points!), I don’t think that in his/her culture can perform this [budgeting] activity without support.

Translation work in the project management practice: The clinical professionals who wish to submit a new project may go to the planning office for technical support in setting up the file in one-to-one meetings. The one-to-one meetings between a clinical professional and the Planning officer lasted in average 20 minutes each (the planning officer used to schedule half an hour for every single meeting). Typically, in these one-to-one meetings the proponent of a project explains the idea to the planning officer who helps him/her to formulate the project proposal by filling in the fields required in the proposal file (title, objectives, indicator, time range, other units involved, etc.). In the observed meetings, the planning officers’ support and suggestions were mostly given to identify the relevant strategic goal a specific project could be connected to. In most cases it was indeed the planning officer who linked the projects to the strategic plan on the basis of the description of the project proposal carried out by the professional:

Planning officer: Alright, for the strategic goal I put the first one (the organization of services) and as strategic lever I put the revision of patients’ path, because this [project] is about a new protocol; and the [this] as operational objective, which is the definition of new protocols. So it fits perfectly there.

The planning officer also helped professionals with the identification of indicators, as in the following case:

Planning officer: So, the indicator: can you also implement this project?

Dr: We wish to make it become a practice, let’s say.
Planning officer: *Then as an indicator you can put ‘Number of patients to whom the path is applied’: current value ‘zero’, because the path does not exist yet, right? Expected value? How many at the end of the project?*

Finally, suggestions were also provided by the planning office for the identification of the units that could or should be involved in a project, with questions like: *‘Have you considered involving a psychologist in this project?’*, *‘Won’t you also need the Day surgery unit?’*, *‘Didn’t you mention also the department of anaesthesia? We should include it in the project file’*.

In the process of providing technical support, planning officers often operated some translation moves from the clinical sphere (the substantive content of a project, the specificity of what a professional wants to do) to the administrative sphere of project management categories (objectives, indicators, link to the strategic plan, etc). All these translation moves started with similar questions by planning officers, such as: *‘But what do you want to do in this project?’*, *‘Let me understand what you mean’*. In other words, planning officers attempted to restructure the professionals’ detailed narrative of a project idea in measurable and synthetic terms. Figure 1 reports an illustrative example of this process: from the professional’s rich narrative to standardized project stages and related outputs, passing through some translation work carried out by the planning officers. Next, they developed together realistic deadlines for every project stage. Normally, it was the planning officer who proposed a date and filled in the Gantt diagram. Then the planning officer interrogated the professional about the different actors involved in the project and their roles, in order to lead the professional in filling out the project responsibility grid (‘who does what’). Finally, the planning officer had the professional validate the project directly on the computer, or gave the professional instructions on how to validate it.

[Figure 1]
Bridging work: Reducing social distance

The planning officers also play another role concerned with mediating between different and often conflicting parts of the organization, bridging the professional base and the top management - reducing not only cognitive distance but also social distance.

Bridging work in the presentation of the strategic plan: These presentations took place in December in six different meetings lasting from 30 to 60 minutes. During these meetings, the Chief Planning Officer illustrated the strategic plan with a Power Point presentation. In general these presentations were structured as follows. First, the Chief Planning Officer introduced what planning is and why it is important – which can be conceived as the organizational espoused theory of planning. Second, the Chief Planning Officer presented the official flowchart to outline how the planning process unfolds. Then the emphasis was placed on explaining the five strategic goals. What followed was a debate with the audience. In this process the Chief Planning Officer aimed to legitimize the plan, both the process followed (the need to plan, the fact of planning) and the specific contents, by bringing it closer to clinical professionals’ sensitivity. To do this he used the fact that he was a clinician too, ‘changing hats’, alternately identifying himself with the direction and with the clinicians. As a manager, he was as a key actor in sensegiving and in engaging clinical professional staff, while for a professional audience, he could switch identity to ‘us professionals’ and was able to explain the meaning of each strategic goal. The following shows examples of sensegiving of the strategic plan as a tool (making managerial knowledge familiar):

What does planning mean? To make choices. To set objectives, priorities, timing. […] If you plan in time you are able to make choices.

The strategic plan is a plan that gives direction, like a compass, while the annual plan is the navigator towards the budget.
The annual plan is like ‘a handbook of the budget’: its role is to make every unit’s budget ‘fluid’, in order to prevent one from inventing the budget objectives without understanding how to reach the strategic goals.

It is an articulated system. It responds to the question ‘where is the unit heading?’

(Excerpts by the Chief Planning Officer and the Medical Director from some of the presentations)

Below is an example of the identification of the Chief Planning Officer with the clinical audience, while illustrating the meaning of one of the strategic goals (Clinical Governance), dealing with the need to measure performance and account for results.

This implies major cultural growth. The motto is: ‘measuring to know, to decide’. It’s not something new. The logic of the indicators always makes us think of savings, but we are clinicians, we understand that the best indicators are clinical outcomes indicators. This is not about theoretical stuff. It has concrete impacts on our activity.

Bridging work in the project selection meeting: In the official narrative (Project management regulations) all project proposals must be evaluated by a selection committee composed of top managers with the support of the planning office staff during an annual project selection meeting. The meeting unfolded as follows. Prior to the meeting the planning officers prepared a single excel file where they imported all information from the submitted project proposal files (one project per line, while the columns reported the content of the required project proposal files information: title, project director, project chief, objective, proposing unit, involved units, dates, etc.). During the meeting the planning officers projected the excel file on a screen and went through all the project proposals by reading loud the project title. The planning officers not only introduced every project, but often also deepened them, explaining them in more detail when requested (e.g., on the rationale, the intentions of the proponent, etc.). For example, during the project selection meeting held yearly by the top managers, the planning officers showed that they knew many of the project proposals in
detail: they explained and justified them in front of the top managers in many cases. This is something that the planning officers can do thanks to the translation work previously done with the professional in setting up the file (and, where applicable, thanks to their participation in the pre-selection meeting at the department level). In other words, the planning office acted as a bridge between the professionals’ intentions and the directors’ understanding.

Discussion and conclusion

Many contemporary organizations claim to be moving towards forms of increased inclusion of the range of people involved in the making of strategy and of increased transparency in the strategy formulation and communication processes – a phenomenon labelled ‘open strategy’ by Whittington et al. (2011). In this paper we aimed to shed light on how, in particular, strategizing takes place in professional, pluralistic contexts, supposedly characterized by open participation in strategy-making. We investigated the nature of professionals’ strategizing in a public hospital that put open strategy at the core of its identity and of its organizational narrative. We explored how professionals’ strategizing was depicted by the organizational discourse, what professionals actually did, how the adoption of a participatory planning system was taken up and what it enabled in terms of strategy work.

When considering which actors took part in the shaping of strategy and how, we found that clinical professionals (ranging from clinical directors, to head physicians, to nurses, etc.), although constructed as strategists both by the literature and by the official organizational narrative, were not provided with a real control over resources, i.e. there was inconsistency between the goals and the means they were provided (especially in relation to the strategic planning and budgeting practices). In other words, they were not fully empowered decision-makers in relation to these practices. However, they were much more so as far as the project management practice was concerned. Moreover, it emerged that nothing of this could happen
without the smoothing role of an initially unconsidered type of professionals: the planning officers. Based on the tacit knowledge developed in the boundary positioning of planning officers’ work, bridging the administrative/accounting and the clinical sphere, these professionals accomplished considerably more than their official function of provision of technical support in the planning cycle. This was mainly due to planning officers’ familiarity acquired in the field with clinical projects and clinical departmental/unit problems; but also to the crucial role of the Chief Planning Officer, who was a doctor in the same hospital before, and had both in-depth clinical knowledge and professional authority, combined with expertise in top managerial problems. This allowed these officers on different occasions to understand both clinical issues and managerial needs and perform a translation and bridging role.

Shifting the focus to the role of tools in the process of strategy formation, two co-occurring dynamics emerged. On the one hand, the planning system enabled professionals’ strategizing, because, especially since the establishment of the project practice, virtually all professionals were free to come up with new initiatives for consideration. On the other hand, the planning system constrained professionals’ strategizing, because these initiatives were subject to the top management approval and had to be formally linked to the strategic goals of the plan. While some form of informal strategizing (e.g., doctors taking decisions or proposing initiatives through personal channels with the CEO) had always existed, what has changed is that after the introduction of the planning system at least part of this shapeless bubble of informal strategizing has been officialised within a more or less controlled system. Moreover the system gave an opportunity to all (including line nurses and doctors, not only the heads of units) to come up with initiatives through the project practice in particular.

Whether the planning system was a tool for strategy formation in this context is another question. As our results illustrated, some decisions escaped these formal channels, rather following more autonomous, informal routes (via personal exchanges with the top
management for the endorsement of certain projects or for other particular requests); others happened above or around, and not only within the planning system (see the frequent mentions by professionals of decisions often taken ‘elsewhere’ or ‘up there’).

Overall, several thematic conclusions can then be drawn from these findings. First, in an open strategy system such as this, the empowerment of professionals is likely to be conditional: participation is subject to managerial endorsement. Because of this partial nature, we can consider professionals to be quasi-strategists. Second, the role of a third party, like that played by planning officers, is crucial inasmuch as through their work they reduce the cognitive distance between clinical and managerial/accounting spheres, while at the same time reducing the social distance between the top management and the professional base. Then in these settings, to paraphrase Mintzberg, strategy seems indeed to be the result of accumulated autonomous, yet constrained decisions. The planning system enables and stimulates professionals’ autonomy, while at the same time constraining it, which leads us to affirm that it performs a channelling role. It stimulates professionals' strategizing, and channels it within a system. However, it will never comprise it all, as some forms of informal strategizing will always persist. Finally, even though many of the most strategic decisions happen without it, or around it, the planning system performs an important organizing role, as far as it integrates different bodies of knowledge and different parts of the organization.

Although relying on a particular case, this study contributes to the more general debate on strategy making in professional, pluralistic settings. First, this paper offers a contribution to the literature on how strategy happens in professional bureaucracies. Supposedly, as seen, in these contexts strategy happens everywhere; professionals are important players in this sense, as strategy is the accumulation of autonomous decisions largely coming from the professional base (Mintzberg, 1979; 1995). While confirming the fact that strategy happens throughout the organization, we moderate Mintzberg’s argument on professionals’ actual
power, by showing how professionals are not quite fully empowered strategists. They are rhetorically constructed as such, but they are only limitedly empowered in fact. Moreover, the situation looks more complex than Mintzberg’s (1979) dichotomy of ‘top-town and bottom-up’ hierarchies of strategizing. Strategy (intended as what the organization actually does) is really a co-constructed order emerging from a bundle of tensions and loops: bottom-up and formalized (in this case, the initiatives and decisions by professionals channelled within the planning system); bottom-up and informal (the decisions escaping the formal system and going on through informal and personal channels); top-down and formalized (e.g. the strategic goals that are direct expression of the top management vision); top-down and informal (the decisions ‘taken elsewhere’, i.e. around and not within the planning system). What emerged is then a more complex picture, a more fine-grained picture that goes beyond simple bottom-up versus top-down dichotomies, beyond vertical versus horizontal authority divides, and even beyond a simple planned versus emergent view.

Second, critical scholars have questioned the claimed post-bureaucratic turn – according to which in today’s organizations (including public services, especially under New Public Management trends) power is devolved to the operational work base, promoting horizontal dynamics of effective authority, rather than traditional, hierarchical ones – and showed how vertical forms of bureaucratic control persist instead (Josserand et al., 2006). This paper, showing how professionals act as quasi-strategists, criticizes an excessive rhetoric of professionals’ empowerment, but it does not deny that some dynamics have changed anyway. In this case professionals, albeit limitedly, do strategize and apparently more than before, especially through the project management practice – a typical post-bureaucratic organizational form (Courpasson & Clegg, 2006). Our conclusion is thus closer to some of the most recent reflections on the alleged end of bureaucracy (Clegg, 2012), which document a complex co-existence of both vertical and horizontal forms of authority (Lundholm et al.,
The findings emerging from our case suggest a need to overcome rigid vertical/horizontal divides and to recognize a complex mix of multiple dynamics where, in Lundholm and colleagues’ terms, integration occurs. Yet in our case the small distance between top management and professional work is not created because the manager is also a proficient expert in operational work (as in Lundholm and colleagues’ (2012) example of small firms where those who work at the operating level also own and manage the firm); rather the distance is reduced by the work of the planning officers. As argued, the planning officers not only play a technical support role, but also perform a translating role (reducing epistemic/cognitive distance) and a bridging role (reducing social distance) between top managers and professionals. In other words, while confirming the co-existence of complex patterns of horizontal and vertical decision making dynamics, we posit another form of integration in professional bureaucracies, where boundary work like that carried out by the planning officers in this case, plays a crucial role.

Third, the paper may contribute to the strategy as practice literature in a threefold way. It scrutinizes what professionals actually do when they are supposed to participate in strategy formation in their day-to-day activities – an area that has remained only marginally touched on by research on strategizing. Somehow surprisingly, despite the fact that various studies hinted at the crucial role played by professional employees in strategy formation beside middle and top managers, what professionals actually do and how has rarely been the object of research. Moreover, this paper reveals the boundary role of another type of practitioners (planning officers, in this case, but it could be other staff professionals in other contexts) who conduct crucial work for strategy formation, but acting from the margins, or from the background. Further research is needed on these only apparently marginal roles for strategizing. Focusing more on these types of boundary work could enrich research on strategizing, especially in pluralistic settings. Finally, this study can contribute to research on
strategy as practice by providing insights on the role of formal strategy practices, like the planning system, not only as the locus of strategy formation, but as a powerful organizing apparatus too. The planning system is a strategy practice (Whittington, 2006) that enables strategy formation (Mantere, 2005) and constrains or channels it at the same time. Indeed, the channelling role of the planning system can be seen as a way to cope with the typical strategizing and organizing tensions of a pluralistic setting, i.e. problems of enacting multiple conflicting goals and problems of orchestrating bureaucratic processes and autonomous knowledge work (Jarzabkowski & Fenton, 2006). In particular, the channelling role of the planning system – although imperfect – works as an attempt to make strategizing and organizing tensions interdependent, i.e. ‘mutually reinforcing, creating organizing practices that are tailored to the demands of different strategic goals, and strategizing practices that recognize the interests and identities of different organizational groups’ (Jarzabkowski & Fenton, 2006: 642). Furthermore, the channelling role of the planning system as it emerged in this study may contribute to the stream of strategy as practice research interested in the role of strategy tools and, more generally to the debate on the roles of formal planning (Langley, 1988; Grant, 2003; Whittington & Cailluet, 2008; Jarzabkowski & Balogun, 2009).

We hope that this study can be useful for practitioners too. The most immediate implication for practitioners willing to engage in participatory planning processes or in other forms of ‘open strategy’ is that real empowerment needs consistency between means and ends: professionals, to be genuinely empowered decision-makers, need to be given not only the ability to make decisions, but also the means (such as some control over the resources) to take them up. Failing to provide control over the means makes the claimed empowerment short-lived or only rhetorical. Moreover, real empowerment does not come without governance. This may not mean vertical control, but it could come from more complex forms of organizing. For example, the present case showed how through the channelling actions of
the planning system, professionals’ dispersed autonomous decisions and initiatives are at the same time stimulated and kept together. Finally, and most importantly, the key to make this all happen is some form of ‘cultural work’, in this case embodied by the planning officers, to make reciprocal understanding and collaboration possible.

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<td>Goal setting, future orientation; Guide; Control; Involvement</td>
</tr>
<tr>
<td><strong>Budgeting</strong></td>
</tr>
<tr>
<td>Definition of annual activity targets and correlated resources by hospital unit.</td>
</tr>
<tr>
<td>Negotiated yearly between the hospital Strategic Direction on the one side, and the Clinical Directors with the department’s Nurse Coordinators on the other side.</td>
</tr>
<tr>
<td>Clinical Directors and Nurse Coordinators negotiate budget targets for each unit within their department upon consultation (pre-negotiation) with each Head Physician.</td>
</tr>
<tr>
<td>Clinical Directors (and Nurse Coordinators) and Head Physicians become thus accountable for their department and unit, respectively.</td>
</tr>
<tr>
<td>Ostensive roles:</td>
</tr>
<tr>
<td>Managing resources; Monitoring; Coordination; Motivation; Responsibility.</td>
</tr>
<tr>
<td><strong>Project Management</strong></td>
</tr>
<tr>
<td>Setting up of specific organizational projects as a means to implement strategic and operational goals.</td>
</tr>
<tr>
<td>An organizational project is defined as ‘any innovative (not routine) initiative, aiming to the achievement of precise operational objectives within specific time and cost limits, usually involving several and heterogeneous units/roles that are temporarily aggregated in a multi-professional team’ (Project management regulations).</td>
</tr>
<tr>
<td>Opportunity (not obligation) for any professional at any organizational position.</td>
</tr>
<tr>
<td>Professionals structure project proposals (connected to plan’s objectives); the Strategic Direction reviews them and approves them.</td>
</tr>
<tr>
<td>Ostensive roles:</td>
</tr>
<tr>
<td>Goal orientation; Innovation; Governing complexity.</td>
</tr>
<tr>
<td><strong>Clinical Directors</strong></td>
</tr>
<tr>
<td><strong>Clinical Directors and Nurse Coordinators</strong> in budget negotiation with the Strategic Direction.</td>
</tr>
<tr>
<td><strong>Head physicians</strong> in budget monitoring and pre-negotiation.</td>
</tr>
<tr>
<td><strong>Planning Officers</strong> in assisting clinical directors and head physicians in preparing their budget files for negotiation.</td>
</tr>
<tr>
<td><strong>All professionals</strong> (Clinical Directors, Head Physicians, other Doctors, Nurses, etc.).</td>
</tr>
<tr>
<td><strong>Planning Officers</strong> in assisting all clinical professionals in the setting up and the monitoring of every project, while also helping the top management in the yearly selection of project proposals, once submitted.</td>
</tr>
<tr>
<td><strong>Micro-innovations; micro-entrepreneurship</strong></td>
</tr>
</tbody>
</table>
Table 2: Examples of projects by degree of ‘strategicness’

<table>
<thead>
<tr>
<th>Degree of ‘strategicness’</th>
<th>Project ID and title (when applicable)</th>
<th>Quote or project description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOWER</td>
<td>P126: ‘Definition of intra- and extra-hospital rehabilitating paths for persons with serious brain damage’</td>
<td>Yes, that is a project whose outcome is that now there is a formalized path for brain damaged patients. We even presented this at a congress at the beginning of the year, we presented the results of the first three months of experience; [the project] is active and has now entered our ordinary routine, with interesting implications, by the way, in terms of resource use, because, compared to the previous situation of absence of this project, we have witnessed a considerable decrease in patients’ hospitalization in Intensive Care. Therefore, not only the person who doesn’t really need it exits the Intensive Care in a shorter time, but also that leaves space for people who need Intensive Care, I mean [C.D.#02].</td>
</tr>
<tr>
<td>HIGHER</td>
<td>P721: ‘Integrated management of hospitalized patients with acute respiratory problems’</td>
<td>The goal is to establish a practice to be shared across departments (the project involves units pertaining to different departments: anaesthesia, medicine, geriatrics, emergency). Need that stimulated the project idea: ‘at present these patients are treated randomly. They can go to all hospital units without any guaranteed homogeneity in the treatment they receive. The main consequence is that many patients, right because of this, end up in the Intensive Care, and hence are an additional cost’ [Obs. 10.04.20] Content of the project: Thus what will the work group do? We will define different levels of guarantee and a clinical path for every degree of seriousness (…). We would like to guarantee non-invasive ventilation to all these patients and since the beginning, we would like that anaesthesia be just the extreme solution’ [Obs. 10.04.20] Expected organizational outcome: ‘from this project we expect the creation of a unit serving the whole area, just like the stroke unit, where 24 hours a day, non-invasive ventilation is guaranteed. So, in the end this is an internal path’ [Obs. 10.04.20] Expected service outcome: ‘The number of patients going to Intensive Care is drastically reduced’ (…) ‘we intend to guarantee the best care in this field. If I am able to demonstrate that this entails less co-morbidity… at the end I will have provided a better and cheaper service too. So, the project is not bad, it’s nice, it can become a new standard, like the stroke unit’ Expected economic outcome: ‘Every patient less that goes to Intensive Care involves a considerable amount of cost saving for the hospital’.</td>
</tr>
</tbody>
</table>
**Figure 1: Example of translation work – from a professional’s idea to a project management structured grid**

<table>
<thead>
<tr>
<th>Professional’s narrative</th>
<th>P&amp;P translation work</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr: We have a weekly outpatient clinic every Wednesday morning and we distribute a survey to patients on the quality of life, on the most critical parameters that concern the disease and the treatment – especially.</td>
<td>P.O.: As a first stage what can we put here? Analysis of the extant situation, since you do not know beforehand if it’s better to do a surgery or a radio or chemotherapy and, thus, analysis of the patients’ typology. Will you distribute the questionnaire to all patients?</td>
<td>Project stages</td>
</tr>
<tr>
<td>P.O.: Do you already do it as a routine?</td>
<td>Dr: To the outgoing patients.</td>
<td>1) Analysis of the extant situation</td>
</tr>
<tr>
<td>Dr: No, not as a routine. But we wanted to. It’s about two questionnaires that we give out at the end of the examination and that the patient fills out.</td>
<td>P.O.: The output is the concrete translation of the fact that you have accomplished your [project] stage. It’s about internal working documents for you and that can be helpful for your final study, so it can help your work.</td>
<td>2) Identification of the survey participants among the patients and of the questionnaire.</td>
</tr>
<tr>
<td>P.O.: And you do this in order to...</td>
<td>Dr: To compare the outcomes in function of the treatment: for example, which problems do the chemotherapy patients have, which problems do the radiotherapy patients have, etc. Because a patient with a cancer can be treated with an intervention or with the chemo, but the two treatments can lead to different problems. [...] In the end we elaborate a table with the results from those surveys. The questionnaire is ready-made, it’s external, it’s standard.</td>
<td>3) Distribution of the questionnaire.</td>
</tr>
<tr>
<td>Dr: To compare the outcomes in function of the treatment: for example, which problems do the chemotherapy patients have, which problems do the radiotherapy patients have, etc. Because a patient with a cancer can be treated with an intervention or with the chemo, but the two treatments can lead to different problems. [...] In the end we elaborate a table with the results from those surveys. The questionnaire is ready-made, it’s external, it’s standard.</td>
<td>P.O.: Do you have to share this project with the radiotherapy?</td>
<td>4) Data elaboration.</td>
</tr>
<tr>
<td>Dr: Yes, they will be involved.</td>
<td></td>
<td>5) Final report.</td>
</tr>
</tbody>
</table>