CONFIGURING SPACES FOR CONSTRUCTIVE DEBATES

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De Boeck Supérieur | « Journal of Innovation Economics & Management »

2019/3 n° 30 | pages 191 à 212

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ABSTRACT
When various professionals engage in collaborative work, they face the major challenge of striking a delicate balance between consensus and controversy. This article investigates the process of developing constructive debate within a space in the healthcare sector. It does so through a longitudinal case study of a space that gathers together different professionals who propose innovative practices to meet the unusual needs of mental health clients. Using the angle of boundary work, we identified three successive configurations during implementation of the space and three forms of boundary work practices engaged in by managers to develop constructive debates. Our contribution to the literature is twofold: 1) we show the supportive effect of creating new boundaries for constructive debate; and 2) we enrich the literature of ecology of spaces by suggesting that interactions between spaces are not restricted to external spaces, but also include embedded spaces.

KEYWORDS: Space, Collaboration, Debate, Boundary, Boundary Work
JEL CODES: I10, M19, M59

Given the growing complexity of clinical problems in a context of limited resources, the members of different professions are called to work together to improve health services (Koeck, 1998). Thus, professionals gather together and set up spaces, i.e. areas in which to reflect and adapt their practice in order to improve healthcare services, process efficiency, and organizational performance (Heinemann, 2002; Leathard, 2003).

DOI: 10.3917/jie.030.0191

These spaces are both an innovation in their own right and a renewed form of organization supporting the development of innovations. They represent an innovation in themselves as they transform the institutionalized practices of professionals who have traditionally worked independently or sequentially (Abbott, 1988; Hall, 2005). They may also be considered a mechanism for fostering clinical innovation, i.e. for developing interprofessional interventions that are consistent with and adapted to the needs of the patients. By bringing together different expertise, spaces have the potential to create new practices.

However, it is not enough to bring together professionals in a space to achieve these anticipated benefits. Developing spaces can be particularly challenging. Their dynamics are sensitive and fundamental to supporting innovation. Given that professionals work within an exclusive occupational sphere, uniting them in a common space can confront and threaten their respective professional identities and roles (Hall, 2005). Minimal tension among members can be conducive to constructive criticism, in turn enabling learning and improvement (Tjosvold, 1998). However, too much confrontation and tension can also impede this process. Innovative spaces rely on constructive debate, i.e. discussions in which the actors openly weigh multiple perspectives and exchange arguments to foster mutual benefits. In other words, they depend on a relative balance between consensus and controversy (Isaksen, Ekvall, 2010; De Dreu, 2008; Tjosvold, 1998; Rapoport, 1960).

While the literature highlights the contribution of these opposed forces of controversy and consensus, little is known about how actors navigate between them and specifically how they can design a space with a view to building constructive debate. Along these lines, Grenier and Denis (2017) underline that more research is needed on the role that debate methodologies can play in developing innovations in these spaces. Our paper responds precisely to this call. Our research question is: How can spaces be configured to create constructive debates? This question is fundamental as innovations need constructive debates in order to develop. Based on interviews and non-participant observations (Houghton *et al.*, 2013), our paper presents a qualitative longitudinal case study that examines how managers shape and "work" boundaries in their space. Our paper contributes to the literature by showing the supportive effect of creating new boundaries for constructive debate and by enriching the literature of ecology of spaces by suggesting that interactions between spaces are not restricted to external spaces, but also include embedded spaces.

Literature Review

Space can be defined as "*bounded social settings characterized by particular types of interaction*" (Bucher, Langley, 2016, p. 600). It refers to an area where individuals create resources to develop new capacities and practices (Aggeri, Labatut, 2010). As such, space has been used regularly to analyze innovations (Cartel *et al.*, 2018; Simon, 2009; Hatchuel, 1996).

There are various types of spaces, including reflective, experimental, relational, discursive and interstitial space (Bucher, Langley, 2016; Kellogg, 2009; Mair *et al.*, 2012; Marcandella *et al.*, 2012; Mair, Hehenberger, 2014; Hardy, Maguire, 2010; Furnari, 2014). Reflective spaces are places where actors develop a reflection on one or more subroutines, evaluate the original routine, and develop an envisioned routine. These can be combined with experimental spaces, where actors experiment with and test these new routines (Bucher, Langley, 2016). For their part, relational spaces are bound settings where institutional opponents or unequal actors interact (Kellogg, 2009; Mair *et al.*, 2012). They can be located inside the organization or outside, as in the case of field-configuring events (Mair, Hehenberger, 2014). Discursive spaces constitute a physical or virtual site where actors discuss, contest and dispute "issues they perceive to be of consequence to them" (Hardy, Maguire, 2010, p. 1367). Finally, interstitial spaces are small-scale settings where actors interact occasionally and informally to break free from existing institutions and try out new activities (Furnari, 2014). Interestingly, Cartel, Boxenbaum and Argyris (2018) noticed that spaces are fueled by emotional energy, such as fun and enthusiasm, which spurs the actors to modify their usual patterns of interaction and develop alternative models. In sum, spaces are where micro-institutional changes can occur.

Closely related to space is the concept of boundary. Different kinds of boundaries could be summoned to define space (Bucher, Langley, 2016, p. 600), including social (indicating who is included), physical (indicating location, face-to-face or not), temporal (indicating duration and recurrence over time), and symbolic (indicating markers such as labels and artifacts). From this perspective, a meeting is a place defined by social boundaries (who is invited, who is not?), symbolic boundaries (the label and the meaning of the space), physical boundaries (are we inside or outside the organization?), and temporal boundaries (when will the meeting be held and for how long?). Boundaries can protect and even support innovations by giving them room to develop (Gulliver *et al.*, 2002; Kellogg, 2009; Burger-Helmchen *et al.*, 2011). On a related note, flattening social boundaries inside the space (Carlile, 2004; Furnari, 2014) and reducing the permeability of the boundaries around

it (Hendry, Seidl, 2003) seem to facilitate the innovation process. Spaces marked out by semi-permeable (as opposed to fully permeable) boundaries are likely to transfer ideas back into the organization or other space. Thus, spaces coexist and interact: this is the perspective of the ecology of spaces (Bucher, Langley, 2016; Touati *et al.*, 2017).

Interactions among Spaces: The Concept of Ecology of Spaces

The ecology of spaces refers to the interactions between different spaces and the way in which the actors alternate in their use of each and make the innovation process explicit. For instance, Bucher and Langley (2016) show how reflective spaces initiate and inform experimental spaces. Ideas are generated in the reflective spaces and tested in the experimental spaces. Mair and Hehenberger (2014) also look at the interaction between spaces, by drawing on the frontstage and backstage concepts. Frontstage represents formal spaces, where actors adopt and uphold their institutionalized practices, whereas backstage constitutes a less formalized convening where actors openly discuss and strive to overcome challenges. Backstage convening can be considered relational spaces since they offer opportunities to interact closely with other actors from other fields practicing other domains to develop one's own practices further and adapt them in a meaningful way (Mair, Hehenberger, 2014). Cohendet, Grandadam and Simon (2010) observed a similar pattern at the city level. Analyzing the creative process, they underscore that firms – designated as *upperground* – cannot directly absorb the knowledge of creative skilled individuals who constitute the *underground*. The middle ground play a key role in creative process in cities because these creative communities integrate, transfer and transform the knowledge of the *underground* so that it can be used by the *upperground* (Cohendet *et al.*, 2010; Béraud *et al.*, 2012; Grandadam *et al.*, 2013; Capdevila, 2015). In summary, different spaces are likely to interact to generate innovation. However, the question that remains underexplored so far is, how can these spaces be configured to develop constructive debate for innovation?

Configuring Spaces in Order to Build Constructive Debates

As stated in the introduction, innovation is supported by constructive debates (Isaksen, Ekvall, 2010), i.e. discussions in which actors openly consider multiple perspectives and exchange arguments to foster mutual benefits; they are characterized by a relative balance between controversy and

consensus. One valuable ingredient for supporting constructive debates in spaces seems to be heterogeneity (De Dreu, 2008). Indeed, spaces ideally bring together actors from various fields, domains, professions or disciplines (Grenier, Denis, 2017; Boiteau, Baret, 2017). Heterogeneity provides a diversity of perspectives, which stimulates the creation of new activities (Carlile, 2004; De Dreu, 2008). However, heterogeneity can also multiply boundaries and conflicts (Isaksen, Ekvall, 2010). In addition, Detchessahar (2003) discusses the value of using reporting tools to give clear indications on results and focus on discussions about work, i.e. how work is done and how it is achieved, to gear discussion toward construction and cooperation instead of competition. Finally, the presence of managers can also be beneficial (Detchessahar; 2003), and more importantly these actors can play a decisive role in the creation of constructive debate (Quick, Feldman, 2014).

Chreim, Langley, Comeau-Vallée, Huq and Reay (2013) uncover three boundary work practices used by managers (team leaders) to support collaboration in multidisciplinary teams, namely opening, closing and contesting/negotiating boundaries. Boundary work refers to any kind of effort involved in creating, maintaining, blurring or shifting boundaries (Gieryn, 1983; Lamont, Molnár, 2002). Opening boundaries consists in smoothing the boundaries between actors, e.g., professionals, to encourage knowledge sharing and cooperation. Closing boundaries, on the contrary, consists in preserving boundaries between actors in order to better segment roles. Finally, contesting/negotiating boundaries consists in challenging boundaries, which may reshape interactions among the actors (Chreim *et al.*, 2013). Furthermore, Quick and Feldman (2014) inform us about other boundary work practices, focusing on the way managers can use boundaries as junctures. These boundary work practices are: translating across differences, such as adopting a new language that creates a shared domain; aligning among differences by recognizing complementarity among differences; and decentering differences by changing the meaning of difference. Overall, these authors show how leaders can contribute to collaboration by opening up, and sometimes connecting, boundaries. Although without specifically addressing leaders' boundary work, Cartel *et al.* (2018) have also advanced the knowledge on boundary work in spaces with the practices of distancing work and anchoring work. Distancing work refers to setting rules and procedures that diverge from actors' loyalty while anchoring work implies designing rules and procedures that help connect and disseminate the alternative model developed within the space. These two boundary work practices are viewed as complementary in the innovation process (Cartel *et al.*, 2018).

In sum, the literature offers some insights about how spaces can stimulate innovations. Nevertheless, we know very little about the possible spatial configurations that help give rise to constructive debates and on how managers can support their emergence and functioning (Grenier, Denis, 2017). These debates are fundamental because they are catalysts of innovation. By engaging in constructive debates, the actors may change the routines of their spaces and transpose these changes into their daily practice (Sandberg, Tsoukas, 2011; Feldman, Orlikowski, 2011). Therefore, we raise the question: How can spaces be configured to create constructive debates? More specifically, we address this research question through the lens of boundary work.

Methodology

Case Study

We conducted a longitudinal qualitative case study with an interprofessional team[1] (pseudonym "*Sky is the limit*") in the mental health sector in Quebec, Canada, from 2011–2013. *Sky is the limit* provides services to adult patients with severe and persistent psychiatric disorders who have been refractory to usual treatments (e.g., outpatient, day hospital, etc.). It is an "intensive community-based team" (ACT) initially established in 2002 (following a pilot project) which, based on the government's mental health policy guidelines, seeks to bring intervention closer to the living environments of people with serious mental disorders (Québec, 1998). ACT teams are more specifically inspired by the PACT (Program of Assertive Community Treatment) model, which has demonstrated its effectiveness on the international scene (United States, Canada, United Kingdom, etc.) (Vanderlip *et al.*, 2014). Essentially, the PACT model promotes intervention in the community through the support of a multidisciplinary team (consisting of 10 members belonging to different professions) that takes a long-term, proactive approach with users, with a special focus on basic needs such as housing, food, medical care, and the like (Thomson *et al.*, 2002).

PACT principles call upon professionals to act as general practitioners, providing treatment, support as well as rehabilitation for a set of shared clients. To be designated an ACT, the team has to rigorously follow the PACT principles. *Sky is the limit* is subject to audits on an annual basis for this purpose.

1. Space is the concept we use to analyze our data. Most of the time, professionals prefer to use the word "team." In order to respect their language, we use the word "team" when we quote them or professional documents.

Such teams advocate principles, practices and roles very differently from traditional interprofessional teams, as described by the physician of *Sky is the limit:*

> "*Our team is very different from the others: we visit clients in the community (instead of receiving them at the hospital), we have odd hours, weird customers, we do weird business, we see strange homes (…) This is the PACT.*" (Physician)
> "*Everyone shares the same clients. It's the genius and the difficulty at the same time. A social worker who distributes pills and then a nurse who conducts a psychotherapeutic intervention!*" (Physician)

Members share all the clients within a specific territory and intervene according to their professional expertise, but also by accomplishing common tasks, such as delivering medication or handling routine daily tasks for patients (they all go shopping with them, eat with them, etc.).This is completely at odds with traditional professional work, in which each professional occupies a specific sphere of intervention.

We consider *Sky is the limit* an ideal setting to address our research questions, since this space gathers various healthcare professionals who debate collectively in order to solve complex problems and perform non-traditional work to support a marginalized clientele. In addition, as we will see in detail later on, when the researcher (the first author) entered the field, she was rapidly informed about the challenges the space had faced since its inception. As the research began, the space was in the process of reconfiguration. This offered us an opportunity to analyze such a process of transformation and how it affects debates.

Data Collection

The data collection was conducted from 2011–2013 by the first author, who attended a total of 20 clinical meetings. These were the weekly events during which all the members (i.e., the professionals, the physician and the program manager) discussed clinical issues and follow-up for their clients. Each meeting lasted on average 3 hours. To preserve clients' confidentiality, the clinical meetings were not recorded. Thus, extensive fieldnotes were taken for each observation (200 pages in total), including a diagram showing the arrangement of members around the table, verbatim notes of utterances, observations of gestures, and descriptions of the atmosphere. The observations of these meetings shed light on the dynamic at play among the professionals, and more specifically how they engaged in debates. In addition to the

Table 1 – Summary of data collection

Types of data		Quantity	Source
Interviews	Phase 1	10	Respondents
	Phase 2	13	
	Total	23	
Observation reports	Phase 1	9	Researcher's fieldnotes
	Phase 2	11	
	Total	20	

observations, two rounds of interviews were conducted with all members, one at the beginning of the study in 2011 and another in 2013. The interviews included questions such as, "How are your meetings configured/organized?" and "How does this configuration differ from before?" These questions led respondents to identify some social/temporal/physical/symbolic features in the configuration of their space. The interviewer then encouraged the respondents to deepen the discussion with questions such as, "How does this configuration impact your interactions?" and "What advantages and inconveniences do you perceive with this configuration"? The interviews were also an occasion to discuss the efforts made by the leaders (program manager and physician) to improve the dynamic of the space. Each interview, roughly 60 minutes in length, was recorded and transcribed. The research was approved by the ethics committee of the first author's home institution, and all members of the space agreed to participate.

Data Analysis

All data sets (verbatim interview transcriptions and observational field notes) were transferred and analyzed using qualitative data analysis software (Atlas-TI). Drawing on a grounded theory approach (Charmaz, 2006; Corbin, Strauss, 2008), we coded each passage in the data related to the key concepts identified, namely social, physical, temporal and symbolic *boundaries* used to organize the space; the *constructive debates*, and the *boundary work* to create/modify the space. This analysis rapidly led us to note that the managers (program manager and physician) were the main actors who managed the configuration of the space, which leads us to focus on the boundary work undertaken by the managers in the current paper. We identified three configurations during the data collection process. For each configuration, we noted their types of boundaries and the nature of the debates (was there more controversy or consensus, or were both relatively well balanced?). These factors trigger managers' boundary work practices to maintain or enhance the

constructive debates, in turn stimulating the shift from one configuration to another.

At the end of the study, the three configurations as well as their associated explanations were presented to the members of the space. This presentation was a way to confirm our interpretation, thus ensuring the trustworthiness of the study. The findings section below presents the initial context, followed by the evolution of the three configurations as observed over time.

Findings

In this section, we detail the evolution of the *Sky is the limit* by outlining the trajectory of the main configurations of this space over time. We present three configurations and their temporal evolution. For each configuration, we explain the main boundaries that characterize the space, the presence of controversy and consensus (dimensions of constructive debate) and the boundary work undertaken by the managers to maintain or enhance constructive debates. Before presenting these findings, we explain the initial context, in order to capture the circumstances in which the space emerged.

Initial Context

Sky is the limit was created in 2002 by local actors. It followed a government call to adopt PACT principles, which bring intervention closer to clients living environment, primarily in order to offer alternative care to a specific clientele suffering from severe mental problems.

This space gathers professionals from different institutions, namely hospital and rehabilitative centers. In the beginning, *Sky is the limit* included nine members: one program manager, one occupational therapist, two nurses, one addiction worker and one physician (all affiliated with a hospital), two educators and one social worker (affiliated with two rehabilitation centres). These members met each week, at the hospital, to work together to better serve their clientele:

"*We wanted to be a PACT team, to work differently, to better meet the specific needs of our patients*." (Program manager)

Sky is the limit emerged in a context characterized by specific boundaries, namely social (various professionals belonging to different organizations), temporal (every Wednesday), physical (at the hospital office) and symbolic (labeled and functioning as much as possible according to the PACT principles) boundaries. However, conflicts appeared early on as members from

different organizations, i.e. hospital and rehabilitation center settings, had a different vision of their work:

> "*On one hand, we had experienced professionals who came from the hospital, who were used to treating patients: (…) and were thoroughly familiar with the mental illness. On the other hand, we had the specialized educators from the rehabilitation centers, who had no psychopathology education. They did not know the disease, but they were accustomed to the community and to empowering the clients. (…) However, as an ACT team, we needed to find the right balance…. It was really hard to build up a balanced collaboration.*" (Program manager)
> "*Conflicts emerged … An opposition between treatment and rehabilitation… I think that the two institutions did not see the mission the same way. I have the impression that the messages given to people from each of the institutions were not the same. At the rehabilitation center, they said: "you're rehabilitation specialists, do rehabilitation! Your mission is to do rehabilitation on the ACT team". But this is not true. On an ACT team, everyone's mission is to do rehabilitation, treatment and support in equal measure (…). There was also another issue with people from the hospital doing more treatment than support.*" (Program manager)

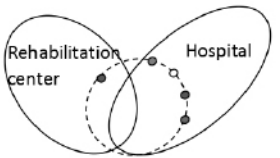
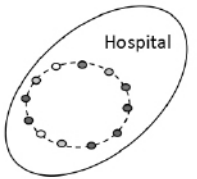
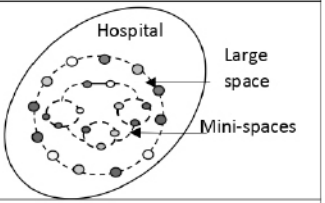
These conflicts induced controversies in the space, which gave rise to debates. Nevertheless, these debates were not really organized: no deep reflection took place during the implementation of *Sky is the limit* to develop constructive debates, i.e. debates that balance controversy with consensus.

> "*Our notion was: 'Everyone gets together and works together'. But it made for an obvious culture shock. We had not taken the time to sit down and agree on a common language. We jumped in and we learned by doing.*" (Program manager)

Rapidly, the managers realized that it was not enough to bring professionals together to apply the innovative principles of PACT; in other words, constructive debates would not emerge naturally. They needed to seriously reflect on the space's configuration to ensure the development of constructive debates.

The first author entered the space as a researcher in 2011, after these initial issues, at a time when the managers were trying to modify the space. Table 2 illustrates the three configurations observed, their boundaries, the level of consensus and controversy as well as the boundary work.

Table 2 – Space configurations, boundaries, level of controversy and consensus and boundary work in the case of *Sky is the limit*

T	2011	2012	2013
Configuration			
Boundaries	*Social:* One program manager, four nurses, one physician and two social workers from the hospital, and two educators from one rehabilitative center *Temporal*: Meetings occur every Wednesday afternoon *Physical:* Meetings are held in the hospital *Symbolic*: The space is called an "ACT team" although it does not meet all criteria (especially the criterion of a diversity of professionals)	*Social:* One program manager, five nurses, one physician, two social workers, two psychoeducators and one addiction worker – all from the hospital *Temporal*: Meetings are held every Wednesday afternoon *Physical:* Meetings are located in the hospital *Symbolic*: The space is called an "ACT team"	*Social:* Four nurses, one physician, two social workers, two psychoeducators and one addiction worker – all from the hospital (program manager does not regularly join the meeting as before) *Temporal*: Meetings occur every Wednesday afternoon *Physical:* Meetings are located in the hospital *Symbolic*: The spaces are called the "large ACT team" and the "mini-teams"
Level of controversy and consensus	The departure of several participants led to an imbalance between consensus and controversy (too much consensus)	Imbalance between consensus and controversy (too much controversy)	A relative balance between consensus and controversy (constructive debate)
Boundary work	*Diversifying* the space: The program manager tried to introduce the psychosocial approach, which was not really represented within the team	*Grounding* the space: The leaders (program manager and physician) promoted consensus by trying to build common ground (for example through a "collective retreat")	*Creating internal boundaries:* Mini-spaces allow for a lower level of debate to better support professionals through deeper work on cases, to meet clients' needs while maintaining the larger space, and foster a higher level of constructive debate.

Configuration 1: A Space that Develops Innovative Practices but Is Too Homogenous – Leaders Work to "Diversify" the Space (2011)

In 2011, *Sky is the limit* was reconfigured. The previous conflicts led several members to leave the space. One rehabilitation center also opted out the space. Consequently, the proportion of hospital nurses increased. The clinical work was therefore strongly oriented towards nursing expectations, abandoning the concerns upheld by other (psychosocial) professionals.

> "*Currently, we are not balanced at all. You know, we have two psychosocials for a lot of nurses there. Great people, I don't doubt it, but there are no real interprofessional discussions there.*" (Program manager)

In contrast with the initial context in which the debates were too controversial and conflictual, this first configuration, mostly composed of nursing professionals, was characterized by too much consensus. The program manager did, however, strive to balance this out:

> "*I always try to bring up the psychosocial concerns. (…) We have experienced people who know that (the psychosocial dimensions) and who don't forget it even if they are nurses. Nevertheless, I personally insist on this aspect. I would not say that all we do is nursing. (…) However, I think we can go further in this psychosocial aspect and we will do it better.*" (Program manager)

The program manager assumed a significant role in facilitating the debates. She clearly made efforts to include psychosocial concerns within the boundaries of the space. Thus, we saw the managers try to "diversify" the space by introducing into the debates the views of professionals who were absent, such as psychoeducators.

The practice of diversifying the space was also witnessed in the form of the manager's intensive recruitment efforts.

> "*That's a big effort to find the right people to be on a team like this one. The manager is really working hard on that!*" (Physician)

By recruiting new professionals, the program manager worked toward expanding the social boundaries of the space. However, this was a real challenge, as she explained:

> "*The challenge is to find the right people who will fit with the team, and with the PACT principles. Not everyone has the abilities and the values to work in an ACT team.*" (Program manager)

> "*We had so much trouble. We had big, big problems that we can't repeat.*" (Physician)

Sky is the limit hoped to be more diversified. Nevertheless, the managers still remembered the conflicts encountered at the beginning and seemed to worry about them recurring, if they brought a greater variety of professionals into the space.

Configuration 2: A Space that Is More Diversified but Needs to Build Common Ground – Leaders Work to "Ground" the Space (2012)

In 2012, *Sky is the limit* reported a better balance of various professionals. It was now composed of more than 10 professionals: one physician, five nurses, one program manager, two psycho-educators, two social workers, one addiction worker and one peer specialist. This diversity allowed the space to reconnect with PACT principles, which emphasize professional diversity.

This change had a significant impact on the discussions during meetings. While in configuration 1, the focus was mainly on the nurses' logic, in configuration 2, interdisciplinary discussions gained ground.

> "Now, it's even possible to identify each person's professional affiliations during the clinical discussion. Before, the words were much more interchangeable." (Program manager)

Configuration 2 ushered in a diversity of viewpoints, thus enriching the debates with more controversies compared to configuration 1. These were, however, less intense than at the beginning of the space. Indeed, the managers exerted effort to build common ground for all these professionals, first by no longer partnering with other institutions and second by organizing internal activities such as a "collective retreat":

> "*Before, people came from three institutions, so there were three managers with three very different visions of the work. Whereas now, there is only one institution. All professionals are affiliated with the hospital. We do not want to risk other partnerships with other institutions.*" (Physician)
>
> "*Next week, we will organize a 'collective retreat.' This will give us an opportunity to spend the whole day together, to exchange views on our working practices, to learn from one another.*" (Program manager)

Thus, managers were seen trying to "ground" the space. This practice was intended to create consensus, and a collective identity. Since its beginning,

Sky is the limit had suffered from high turnover. In this new configuration, the managers really desired to strengthen stability and cohesiveness within the space. This seemed to be beneficial as the debates became more constructive. Nevertheless, some issues progressively surfaced.

> "*We are certainly a more rounded-out and cohesive team now, but we realized that we canot do an 'intervention plan' for a client with 10 professionals at the same time*." (Program manager)

As the space became more mature, the managers noticed that the professionals desired to progress in their professional roles and develop clinically robust intervention plans. However, this was difficult to achieve with 10 professionals around the table.

Configuration 3: A Space that Favors Constructive Debates to Improve Practices – Leaders Work to Create Internal Boundaries (2013)

Faced with the issue of diversity, the managers engaged in additional boundary work in order to support constructive debate while avoiding the cumbersomeness that could threaten the value of the space. More specifically, they responded by "creating new internal boundaries" within it:

> "*[If too many professionals participate] we will never finish. And conversely, we don't want to be alone in drawing up an intervention plan. It is too burdensome and difficult. So we're building mini-teams. We choose three or four people devoted to a client, to try and cover the client's main needs*." (Program manager)

Configuration 3 was characterized by "mini-spaces". Bringing together three or four professionals (all members of *Sky is the limit*) resulted in mini-spaces built on the needs of and relationships with clients. By definition, mini-spaces are multiple, temporary and evolving. Their composition may change over time, in step with the client's evolution.

The addition of mini-spaces did not entirely supplant the previous space: all members continued to meet each other in the "large" space. The mini-space meetings took place in the meantime, to discuss very specific or daily clinical issues pertaining to clients.

The mini-spaces were appreciated as they offered what was missing from the previous configuration: namely, they allowed professionals to delve a little deeper, in a more sophisticated way, in order to better serve the specific needs of clients and to progress in their own professional roles. Professionals

were assigned to mini-spaces according to the quality of their relationships with the client, but also according to their potential strengths (professional, personal, etc.) in terms of better meeting their needs.

Regarding the debates, the back-and-forth between the large space and the mini-spaces seemed to maximize the benefits of the interdisciplinary nature of the space, without obliging all the professionals to discuss all the cases. Thus, this new configuration was perceived as more efficient. It yielded better service for the clients, which also improved the external evaluations from PACT auditors:

> "*The statistics are really nice. We do not have hospitalized clients. In terms of the team's performance, I can tell you that it works, we have no losses, in terms of performance.*" (Program manager)
> "*We are evaluated by the National Center there, we are top there, we are among the leading teams in Quebec.*" (Program manager)

Nevertheless, this performance could not be taken for granted. *Sky is the limit* was still fragile because the boundaries of the space could always be redefined. As stated below, the members could always decide to leave the space because of the demanding nature of the work and the practice of collaboration:

> "*Our challenges evolved over time. The big challenge that we have now is to maintain what we have. It's always very fragile, it keeps moving around.*" (Physician)
> "*Transdisciplinarity is very difficult, it's a challenge every day all the time. We always have to make all these different visions converge every day, at every meeting, at every intervention. We go from one professional to another to see who has a different approach. I mean, it's a massive challenge.*" (Program manager)

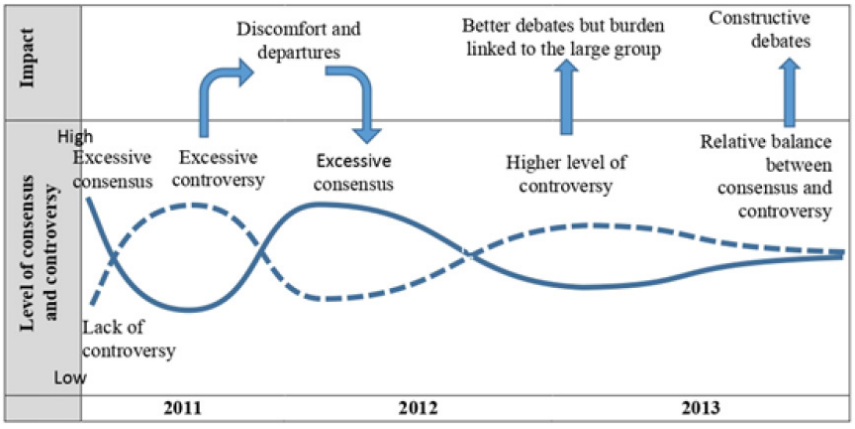
Transdisciplinarity and, in some sense, constructive debates require true self-denial.

Over time, however, *Sky is the limit* seemed more solid as it was supported by a configuration enabling a relative balance between controversy and consensus. The large space offered room for all the members to interact and build common ground, whereas the mini-spaces provided the psychological safety and trust required to discuss the specific issues of clients.

In sum, our results show how managers used boundary work to reach a configuration that stimulates controversy without compromising the collaborative dynamic crucial to maintaining the professionals' participation. Indeed, at the beginning of the period studied, the creation of a new space

raised debates but led to the departure of various actors. The resulting configuration (1) left the nurses in a dominant position, which was perceived as favoring the medical view at the expense of other groups. More generally, configuration 1 was too consensual to favor constructive debates. Consequently, managers engaged in deliberate efforts to *diversify* the space, e.g., by injecting psychosocial ideas into the discussions and by recruiting psychosocial professionals. This time, professional from only one organization were part of the space. These efforts led to a professionally diversified space (configuration 2). Aware of the potential risk of too much controversy, managers paid more attention to the cohesion and stability of the group. For instance, we saw them organizing a collective retreat and trying to develop a solid *esprit de corps*. On the one hand, this configuration encouraged debates, but on the other, the space was not considered satisfying for professional collaboration or for prompting deeper clinical discussions because of the burden of debating in an overly large group. Therefore, consistent with PACT principles, the managers created mini-spaces, i.e. small-scale settings gathering only three or four professionals to discuss their clinical activities in greater depth without burdening the functioning of the large group. The mini-spaces made it possible to meet the professionals' needs and to shield the large space from criticism about the cumbersomeness. Figure 1 summarizes the evolution of the debates (level of consensus and controversy) in the case of *Sky of the limit*.

Figure 1 **– The evolution of the debates (level of consensus and controversy)**



Discussion

Analysis of the evolution of the space helped to uncover three different configurations and revealed the process of boundary work that led to each. More precisely, our results offer two main contributions. First, we discuss an original type of boundary work undertaken by managers to support constructive debates within space. Second, we enrich the concept of ecology of space, by shedding light on an original interaction of spaces, made up of embedded spaces.

Boundary Work: Managing a Delicate Balance between Consensus and Controversy

By showing how managers engaged in boundary work to develop constructive debates among professionals, we confirm that leaders can play a decisive role in configuring a space to support constructive debates, which are necessary for innovation (Chreim *et al.*, 2013; Quick, Feldman, 2014; Touati, Maillet, 2017). Furthermore, the three boundary work practices identified, namely diversifying space, grounding space and creating boundaries inside the space, offer a sequential yet processual view of how a space may develop over time. We noticed that after diversifying by including a degree of heterogeneity (De Dreu, 2008), the space gains when it focuses on its internal forces to stabilize and develop a cohesion. These first two boundary work practices are consistent with the literature, which stresses the benefit of heterogeneity of actors as well as a degree of stability and cohesion among them (Isaksen, Ekvall, 2010; de Dreu, 2008; Tjosvold, 1998).

Interestingly, our results added that the creation of new boundaries, beyond those already existing, can also contribute to constructive debates. This diverges from the literature, which tends to view the boundaries as impeding collaboration and needing to be mitigated to support innovations (Furnari, 2014; Carlile, 2004). In our case, the creation of new boundaries appears in the form of mini-spaces. This configuration was perceived by the actors as the most productive: the large space allows the professionals to discuss main principles and general modes of operation related to the space whereas the mini-spaces give them the opportunity to deepen discussion on specific clients' needs.

These mini-spaces have similarities with interstitial spaces (Furnari, 2014) in that they are more informal than the large space. In contrast with the large space which sets regular weekly meetings, the mini-spaces meetings are *ad hoc*. However, unlike interstitial spaces which usually consist of hobbyist

clubs or hangouts (Furnari, 2014), the mini-spaces still focus on work; professionals interact to expand their (clinical) work. Furthermore, regarding the presence of positive emotions in spaces as mentioned by Cartel *et al.* (2018), we observed that the mini-spaces constituted an important place of mutual support for the professionals. They actually provide a protected space (Zietsma, Lawrence, 2010; Mair, Hehenberger, 2014; Cartel *et al.*, 2018) where professionals can share their clinical discomfort with colleagues. This trust and mutuality also nourish the large space; fulfilled by the close relationships they gained in the mini-spaces, the actors were able to be more reflective and further contribute to the large space (Fan, Zietmas, 2018).

Thus, we have seen that it can beneficial to create new boundaries in a space and that different types of spaces can coexist and interact. This leads us to discuss our second main contribution.

Boundary Work: Building Boundaries to Create an Internal Ecology of Spaces

While others researchers have highlighted the coexistence of and interactions between separate or parallel spaces (Mair, Hehenberger, 2014; Bucher, Langley, 2016; Touati, Maillet, 2017), our results illustrate how different spaces can be embedded. As stated above, this appears in our case through the creation of new boundaries within the large space, which led to the mini-spaces. This result enriches the concept of ecology of spaces as studied by other authors. For example, Bucher and Langley (2016) show that professionals assess their routines in "reflective spaces" and then test out the new envisioned routine in "experimental spaces". In our case, we have seen that some internal spaces can interact together. The interaction between the large space and the mini-spaces can also be closely tied to the relationship between the frontstage (formal space) and backstage used by Mair and Hehenberger (2014). The large space constitutes the formal lieu of discussion and formalization of practices whereas the mini-spaces allow for close interaction between professionals to address complex clinical issues and develop their professional roles and practices. However, our study diverges by underscoring the internal nature of the interactions between spaces. We propose that smaller spaces can be embedded within a larger one. In contrast with Mair and Hehenberger (2014), we also suggest that the interplay between the two spaces does not only occur at the field level, such as field-configuring events, but also at the micro level (e.g., organizational level and even team-level).

Conclusion

This article aimed to analyze spatial configurations that support constructive debates, which are conducive to the development of innovation. Building on recent calls to consider the evolution of spaces (Grenier, Denis, 2017), we monitored a space for almost 3 years, analyzing how its configuration evolved. Our results depict three successive configurations, supported by three different types of boundary work practices by managers. More specifically, we observed that the final configuration, which includes mini-spaces in the larger space, supports a relative balance between controversy and consensus. Contrary to the literature which tends to emphasize the benefit of mitigating boundaries to favor collaboration and innovation, we propose that creating new internal boundaries can also serve actors' interactions. In addition, this finding enriches the concept of ecology of spaces by showing that different spaces can coexist internally. While we acknowledge that they are context-specific, we argue that these results could probably be found in other cases, in pluralistic organizations which gather a diversity of actors belonging to different institutions and driven by different goals. Given that our study reveals that space is not limited to serving constructive debates alone, but can also support various actors, it would be valuable to further investigate the other social purposes a space can serve.

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