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2008

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MPRA Paper No. 39432, posted 14 Jun 2012 13:52 UTC

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ISRICH Working Paper No. 06

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ISSN 1789-6517

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The Role of Relational Knowledge in the Structuring of Health-care Networks: a Methodological Contribution

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Revised draft : July 2008

ABSTRACT

A network is an organizational form for collective action whose main features rest on the variety and intensity of relations between actors. We rely on the work of Austrian sociologist Friedberg, for an integrated analysis of organization studies. Studying a healthcare network located in eastern France, we intend to understand how this organization has been built by an unsuccessful professional bureaucracy.

Keywords: French health care network, relational knowledge

JEL-Classifications: I19, M12, Z13

1. Introduction

New organizational forms highlight the importance of relations between actors. However, during the steps of organization structuring (emergence), various organizational models are often mobilized to frame and design networks, leading to various ways of considering relations in the structuring of organizations: from formal modes of coordination to more informal ways of interacting with competitors. We mobilise the perspective on Friedberg' structuring (1993) to better understand the development of organizational forms viewed as relational forms. According to Friedberg (1993), structuring is formed around the following stages; formalization, internalization, delegation and finalized.

We postulate that the emergence of organizations will become much easier when the actors have relevant acknowledge of the other actors they interplay with, as well as when they have relevant acknowledge of the issues they pursue through their participation in the collective process. Knowledge of others and of the issues with which to interplay is called Relational Knowledge (Pauget, 2006; Grenier and Pauget, 2006). Studying the structuring of a healthcare network, we will highlight the nature and characteristics of Knowledge Relational and we examine how such Knowledge is mobilized by actors during the network structuring process. Finally, we discuss the structuring of the network. We show in particular how Relational Knowledge is a critical knowledge.

2. Theoretical background

2.1 Definition of the network as a reticular organisation

We base our work from the relational perspective on Organization Theory and we consider organizations as forms for collective action which is more or less formalized (Livian, 1998). Relations between actors and social networks play a critical role in supporting collective action. And we stress in particular the duality of relationships, either formal and structured or more flexible, or informal and potentially destructive.

We rely on the work of Friedberg (1993), highlighting to what extent interdependence and interplay between actors may contribute to explain how organized actions may be structured and lead to more or less stabilised, networked and distributed organisational forms (Grenier, 2006). A network of professional actors is understood as a system of organised action (Friedberg 1993), based on a "process by which stabilized and structured interaction between a range of actors

placed in a strategic context of interdependence” (1993: 15) plays a critical role in the structuring for the following reasons:

- organised action is considered as the answer of intentional but always provisional cooperation modes for achieving collective goals;
- organised action is structured in ways ranging from diffused and informal to stable and formal modes; but we consider that "there is no longer any difference between a formal organization and more diffuse forms of collective action, at most a difference" (Ibid: 154).

Consequently, we consider healthcare network as reticular organization. The adjective *Reticular* means that relationships are critical, meaning that knowledge and practices are created and diffused through relations (and then coordination). By the word Organization, we postulate that our work is included in the general Organization Paradigm, especially by recognising the role of structure ‘(through and as structuring process). Understanding relationships between players is then critical, and actors have to acknowledge each other, their points of view and their occupation and position within and around any structure, as well as to evaluate their role and position compared to others. This knowledge is called “Relational Knowledge” and we assume that Relational Knowledge is both a query and a tool for structuring reticular organisation.

2.2 Matrix of organized action

We postulate that networks are structured progressively through four mechanisms highlighted by sociology which are actually mechanisms for the stabilization of organized collective action (Friedberg, 1993) :

1. The formalizing and codification mechanism of the rules that shape the action
2. The finalized mechanism (or integration)
3. The internalization mechanism (or awareness)
4. The delegation mechanism. It clarifies the rules of key actors who play the role of an organised regulatory action

These mechanisms are built on the principles of stabilized regulatory organizations (or rules, Reynaud, 1998).

We are going to develop a grid of organized collective action, which is a theoretical framework related on what we have observed on the ground (see Part III for the methodology). First, health professionals belonging to a healthcare network vary between two representations of what the network could ultimately be:

- The professional bureaucracy, enhancing the hierarchy, the division of labour based on professions and the importance of a sense of stability and permanence in the *modus operandi*
- The reticular organization (Livian, 1998), valuing non-hierarchical cooperation between players, learning and innovation.

The difference between these two models provides two opposing conceptions of the organization in the structuring process (see also Giddens 1987)¹. Both models are "*poles of attraction to which professionals are attracted to different times and in different circumstances*" (D'Amour et al. 1999: 70).

We therefore consider that the network will be a hybridized form, mixing these two models, and hence a form of two hybridized relational models.

2.3 Relational knowledge as a tool for the construction of a professional network for actors

Knowledge is one of the oldest concepts that has been studied. Yet its mobilization to reflect the success (or failure) of organizations has only recently been linked to the "*Resource Based View*" approach. It has highlighted the strategic nature of knowledge because of the competitive advantage provided for the organization (Kogut and Zander, 1992). This is the economic value of knowledge being measured. However, nothing is stated about knowledge that might be useful for the construction of the groups or/and the organization.

Knowledge may also be approached according to its nature: either tacit or explicit knowledge (Polanyi, 1962). Although some literature analyzes knowledge management on the basis of this

¹ The theory considers organizations according to the work of Mintzberg (1982) - that organizations need to be sustained and stabilize their relations to become more structured. For Mintzberg professional bureaucracy becomes a model for fixed and rigid organizations. Reticular organization is the opposite of this model capitalizing on the flexibility and versatility of relations to make the organization responsive. Recent organizations studies indicate that these models are present at different times in the organization, although one of them is dominant and structure the organization. Our field helps us to understand the way in which this model is dominant. Very little is said, however, about the analysis models to understand the constitution of this model

characteristic (for e.g. Nonaka and Takeuchi, 1995), we prefer to follow the work of Carlile (2002), and to adopt the epistemology of knowing. Knowledge is developed through practices (individual or collective), and the distinction between tacit and explicit becomes unnecessary.

Knowledge creation is a matter of individual and collective action in an organizational context: "*we will speak of knowledge in the organization and not the organization*" (Huber, 1991, Gomez, 2002).

According to Hatchuel (1996) knowledge can be defined as "*knowing what*" links "*of actors and a condition weighing on the knowledge of everyone*" (David et al. 2000: 33). Therefore we need to consider relational knowledge. The criticality of organizational relationship now rests on its ability to establish relationships (Pesqueux, 2002).

In this context, Relational Knowledge (RK) is critical for organizations to work properly. RK can be defined as the knowledge that can create, maintain (or destroy) a collective action. It is two-fold:

-Knowledge established during interaction (mutual Knowledge according to Orlikowski, 2002). This knowledge relates to shared identity of actors and / or to a process of socialization.

-It is also knowledge gained in the collective process in which the actor took part. "*Social knowledge*" (Kogut and Zander, 1996) includes rules, working habits related to the culture of a group, or a collective identity. This knowledge relates to the modus operandi of the group in the organization.

Research Questions

We submit that the structuring of organizations oscillates between several models according to the relational input of players. We are trying to understand how the mechanisms highlighted by Friedberg (1993) are based on a relational knowledge created by the actors (mutual understanding), or a social knowledge (knowledge about the modus operandi of the group in the organization) likely to understand the choice of any particular organizational model in the structuring of a health care network.

3. Research methodology and presentation of the research field

3.1 Presentation of the research field

The healthcare networks were set up with often militant steps aiming at the improvement of knowledge and practices, and which were framed little by little by many lawful texts, that the law of March 2002 unified. The very general objective of cooperation is between closed universes of competences. Other aims are also required (Béjean and Gadreau, 1997): seeking complementarities of resources, diffusing knowledge, improving quality of service, reducing costs. These reasons can be grouped into two logical categories: traceability and organization of a process, and improvement of the practices and knowledge. Actually, many networks use these two areas simultaneously. The health sector in France is experiencing profound changes, among which are the multiplication of specialities, and the difficulty in receiving full and multidisciplinary reimbursement of medical expenses for chronic illnesses. To respond to these problems new intermediary organisations have been created as health networks between hospitals and G.P. surgeries. Their goal is to create innovative models to forge links in different ways between different health professionals. The promoters are often private doctors who want their initiatives to be financed so that they can be perpetuated.

It is in this context that doctors of a medium-sized agglomeration wished to create "something" to be better able to diagnose and care Memory Complaints (Alzheimer, Parkinson...) of elderly people of over 65 year olds, and which would become the "*Réseau Pole Mémoire*" (RPM). The RPM is a voluntary response to dissatisfactions that certain professionals had been raising for a few years: not enough time to talk to the patient, lack of information on pathologies.

The structuring of the network was slow and not financed from 2001 to 2004 (the dates of our study), and can be divided into two phases. During the first phase of the growth of the network (October 2001 – October 2002), the meetings held by the members served to define the goals of the network, the legal aspects and the means of finance. But the refusal of finance in 2002 was a relief to some people. In effect they rejected anything to do with the authorities. There was tension during 2002 between the authorities and health professionals over the introduction of a €20 fee for a consultation with a GP. At the height of the crisis the first private health professional's strike (the only one to this day) took place. This led then to the second phase of the network (October 2002 to the end of 2004), during which new funding was requested to accelerate the estab-

ishment of the network. After a second refusal, some people seemed to be happy that they didn't have to carry out the demands of the rigid formal structure called for by the authorities. RPM was becoming a place of reconstruction of professional identity and culture.

The RPM consists of approximately 30 members and many of whom have known each other for a long time and have developed relational practices outside of this network: a neurologist, nominated chairman of the network, some therapists, some psychologists and welfare officers, general practitioners and gerontologists. The patients are not properly represented yet within the structure of the network.

3.2 Research methodology

We adopted a qualitative step of comprehension of the research field, which we followed and observed starting from a position of research - action (David et al, 2000). We adopted the method of the case study (Yin 1991) to examine Relational Knowledge from a longitudinal point of view and from its dynamic evolution at the same time. The case study was built according to the approach recommended by Yin (1991) and Miles and Huberman (1991) on the basis of secondary and primary data (interviews and observation). Within the framework of this article, we focused the study of Relational Knowledge and its impact on the construction of the network. Some actors played an important part: the neurologist chairman of the RPM, a therapist, specialized in the neuropsychological tests of detection and evaluation of the disorders report, some general practitioners, and a gerontologist. The principles of analysis of the data are as follows. We considered that the evolution of Relational Knowledge followed a life cycle in three separate sections: beginning, variation, crystallization.

4. Discussion: Relational knowledge in a health network

Our discussion highlights strategies for players revealed by the analysis of the knowledge and relational study organised by Friedberg (1993). Accordingly, the weight of so-called social knowledge (i.e. on the rules governing relations) is overriding and creates new relations with each other (thus changing relationships before RPM). Thus, we can better understand the relational strategies employed by those involved in the creation of a network of professional actors.

4.1 Analyzing the relations of the actors

We will see how the three categories of players mentioned above have mobilized relational knowledge to participate in the construction of the network.

The neurologist

The neurologist is a key player in the process of structuring: part of his specialty, and his institutional role (president of the association organizing the RPM Network). As a leader, he mobilized knowledge of "who makes what" based on his "professional culture". In doing so, culture, which tends to infuse the organization has changed. It affirms the central role of physicians (general practitioners or specialists) and tends to reduce the role of paramedics or therapists involved in the detection of memory complaints among their patients (except in specific cases of outpatient therapists).

The network has also enabled the strengthening of its vision of relationships: the neurologist is placed at the top of the hierarchy; he has to decide how to work within the system and how it should be organised. This knowledge has the advantage of being able to simplify a division of labor that categorizes who can do what around the project construction of the network. The neurologist is seen as the guarantor of cultural professional standards and reconfirms the success of the network on several occasions, as proof of the effectiveness thereof:

“We have seen recently an example with F (a psychologist) of a typical patient who had already used the network, who was referred to us by a G.P., Dr. C. who ... it was a patient where there were 5 weeks between the time of the complaint to the doctor and the beginning of the treatment, because she used the procedure we wanted” (Extract from meeting, May 2003).

Knowledge Relational coming from one's own culture is becoming an instrument of control (and not of delegation) to sustain the vision of the network. At the end of our study period (March 2002-December 2003), its logic of work division strengthened.

It was a way of structuring the collective action towards the finalization (of a culture here) and the rejection of the explanation of the rules (including their delegations). It is interesting to note that the informal structure of the bureaucratic Hospital (primate neurologists and physicians on the hospital administration), becomes the official structure here. It therefore oscillates between the legacy of a professional bureaucracy and flexibility of informal relational characteristics of reticular organizations.

Table A – The neurologist strategy

| Method of construction of the collective action | Bureaucracy | Network |
|---|---|---------|
| Formalization | Weak none centred around the professional culture Reinforcement of the weight of the neurologist | |
| Delegation | | |
| Finalization | | |
| Interiorization | | |

The speech therapist

The speech therapist immediately accepts the authority of the neurologist and is particularly careful (Goffman 1973) when it appears that the established order is being challenged: “actually, I don’t know” has been heard in several meetings

They also often agree with the opinion of a neurologist: *"it is also true" I agree* "(rallying to the majority). This division of labor advocated by the neurologist is even more widely accepted when the therapist is recognized as an expert by the neurologist. Indeed, therapists are not trained in dementia related diagnostic tests during their academic degree courses..

It is only in the context of a hospital that one of the therapists would be able to expand their competency in the diagnosis of Alzheimer disease. In such a cultural context, the network is recognition by practitioners of the therapist’s skills. The neurologist and the therapist discuss as equals:

- “ - Speech therapist: the clock test, it’s a representation of the face of a clock presented to someone who is asked to allocate the figures inside it and to write one time in particular
- Dr. X: it’s a grading out of 7 and at what point ...?
- Speech therapist: normally it should be 7/7
- Dr. X: ah yes, so we succeed, or not. (...)
- The neurologist: it’s a very efficient test” Extract from meeting, November 2002)

Table B – The therapist strategy

| Method of construction of the collective action | Bureaucracy | Network |
|---|---|---------|
| Formalization | Weak (acceptance of the hospital model) | |
| Delegation | Weak (even if the technical skill is recognized) | |
| Finalization | Other actors (mainly doctors) recognize the role of the neurologist | |
| Interiorization | Interiorization of its identity and its desire | |

General Practitioners

General Practitioners (GPs) interviewed between 2002 and 2003 emphasize the solitary nature of their profession, which is a problem when they have to find a social-health solution for their patients. Joining the RPM is a way of expanding the social network of correspondents. There is a double phenomenon:

- Trained in the same cultural context as the neurologist, they will immediately accept it and become *de facto* "allies" in the neurologist's vision of the network (identity for itself, acceptance of discrimination);
- The network is a chance to learn how to position oneself in relation to other medical professions. When the network sets up its first training in diagnosing memory disorders, general practitioners discover these tests. They also discover the know-how working with therapists. In an interview, a doctor says "*I did not know what they (therapists) did. I did not know they were doing it.*"

Doctors are professionals who have undergone perhaps the most significant variations in the relationship. However, even if the network led to a better mutual understanding, it would not substantially alter the concept of hierarchy within the profession.

Table C – The GP’s strategy

| Method of construction of the collective action | Bureaucracy | Network |
|---|---|---------|
| Formalization | Acceptance of the primacy of the neurologist | |
| Delegation | Weak delegation (just what is necessary to be coordinated around the patient) | |
| Finalization | Weak changes (except standardization of the tests) | |
| Interiorization | Coexistence of several visions of the RPM network | |

Case of one gerontologist

A gerontologist means a general practitioner who extended his initial training with an additional diploma in gerontology (how to care for elderly patients).

The gerontologist would push for the creation of an intermediate level between the neurologist and a general practitioner to develop greater power and obtain professional recognition by the neurologist. He tried this manoeuvre twice (in November 2002 and April 2003). He did not succeed. He probably used the same kind of argument as neurologists, which enables the rank to be placed higher than generalists and to mark its difference (technical and scientific argumentation). How are we to explain his failure and the absence of renegotiation in this network? The failure of the gerontologist is due to two reasons: First, it threatens the division of labor through the creation of an unplanned function (draft); secondly, it threatens the cooperation of a group belonging to the founder of the network, because of his lack of knowledge of the relations within the group. This might not be accepted by the group of the founder, who has been returning regularly since November 2002, which was formed around the sole representative of the legitimate biographical identity for others: the neurologist.

Finally, the model has become more complex and the integration of new players at the core of the network becomes more problematic.

Table D –The gerontologist’s strategy

| Method of construction of the collective action | Bureaucracy | Network |
|---|---|---------|
| Formalization | <p>Strong Formalization and taking the arguments of the neurologist again</p> <p>Self attribution</p> <p>Failure of the finalization</p> <p><i>Interiorization carried out (acceptance of recognition of its professional competence) but not recognized by all the members of the network = > failure in the co-operation</i></p> | |
| Delegation | | |
| Finalization | | |
| Interiorization | | |

4.2 Adoption of a common organizational vision of a little formalized professional bureaucracy

First, we observed a complementarity between the rules of division of labour (coming from professional practitioners) and the cooperation between players. This culture has clearly crystallized in the structure of RPM, which has gradually evolved. This culture is composed of two main elements; the neurologist rule, and rejection of formalism (informal), advocated by doctors in their practice. Therefore, after the rejection of formalization and an over-powerful network (March-July 2002), the division of labour was formed on two levels:

- Individual work: the network benefits from a mutual knowledge (expanding the social network) or new skills and resources among general practitioners in particular.
- Coordination between players who only slightly redefine relative to each other (adjustment premium compared to optimization or more profound changes).

Description of level 1 of the division of labour

Relational Knowledge has mainly resulted in the structuring of the network around a poor reticular organisation model.

The maintenance of this culture as a consensus (negotiated rule) probably began in November 2003, a relational rule (Rule structured) that has been questioned very little (April, 2003). The development practices took place through the collective production of knowledge (standardization of the relationship in the role and the expectation of roles between the neurologist and doctors on how to conduct diagnostics), and tools (for diagnosing the elderly in particular). The neurologist organizes the path of the patient in accordance with his own applications rather than vice versa. There is consensus on this vision and in this sense formalized discussions between him and the general patient cases during meetings of the coordination cell, facilitating cooperation.. This probably contributes to a sense of progress in the care of patients by members of the hard core of the network. The creation of a culture of working together avoids some redundant practices resulting in a feeling of comfort as explained in a speech:

"You no longer need to spend two hours on the phone to explain who you are" (excerpt from interview, June 2003).

However, those who dare to transgress the modes of cooperation that have been established as social norm are rejected (see the case of the gerontologist).

Description of level 2 of the division of labour

There was difficulty in forming the second level.. Health professionals had difficulty imagining and designing structures, tools etc. and supporting the informal coordination. There was thus a challenge to go beyond that logic to produce a classic professional bureaucracy. Two tracks can explain this different but complementary nature:

- The first question leads to the production of action from this relational knowledge.
- The second questions the very idea of coordination based on the idea that the players have of the network. One described the network (at interview) as a super structure that can only optimize patient care, another as a forum for consultation and collective production. The idea that the network only exists for the flow of information appears to be dominant.

4.3 Synthesis

The strength of the network might also be its weakness. The professional culture has enabled its development but will be insufficient to ensure the cohesion of the network (and articulate the visions and dissonance thereof). In the absence of greater formalisation, for example, social net-

works might impede the way the network is run. The maintenance of the network is based on the strict observance of its internal professional hierarchy, based on a constant reminder of this standard at each meeting. For example, the neurologist reminded a GP in November 2003 that he could not move directly without going through the neuro-psychologist. He is the only one who can prescribe the medication. The division of labour resulting from the professional culture would be threatened. The hierarchy is strictly observed among health professionals.

But this weakness in the formalization poses the problem of a network that is not well accepted by the players. The production network certainly alters the practices of doctors in the exercise of their duties in their surgeries, or in consultation (level 1), but not yet at the level of collective practices. Innovation in the coordination remains weak.

The same goes for the common goals that are shared in the only requirement to define them in a very restrictive way and in a very general way (Weick, 1979).

Table E

| | |
|---|--|
| Method of construction of the collective action | Bureaucracy > Network |
| Formalization | Structure = Culture |
| Delegation | Weak delegation centered in an organizational perspective based on the professional competency |
| Finalization | Integration for the various actors according to a process of exclusion in the event of non cooperation |
| Interiorization | Mode of structuring which does not allow a strong Interiorization |

5. Conclusion

Finally, Relational knowledge appears to have a dual purpose. From a methodological point of view, it is a tool for mapping the path taken by the network in its development; in particular it gives meaning to the relations and roles of players during this process. It is in this sense different from the approaches developed by the research undertaken by sociometrics networks, which do not include dynamic perspective in their analysis.

We are then opposed to Dyer and Singh (1998) or Persais (2001) considering that relational knowledge can only emerge on the outskirts of organizations.

Second, the primary role of RK in the organization is a theoretical point of view. It helps to better understand how an organised form is structured. We reject the static model based on a rational actor (Friedberg, 1993) in favour of an actor with multiple dimensions that vary over time. Nevertheless, the four structuring mechanisms function properly considering the context of the French health care system. Can RK explain the structuring of health organization in other countries?

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