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## Exploring the dynamics of slack in extreme contexts: A practice-based view

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# Exploring the dynamics of slack in extreme contexts: A practice-based view

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**Abstract**

Organizations that operate in extreme contexts have to develop resilience to ensure the reliability of their operations. While the organizational literature underlines the crucial role of slack when facing unanticipated events, a structural approach to slack says little about the concrete ways in which organizational actors produce and use this slack. Adopting a practice-based perspective during a 14-month ethnographic study in a French critical care unit, we study the slack practices, which consist in gathering, arranging and rearranging resources from both inside and outside the medical unit. This permanent process is captured in a dynamic model connecting situations, their evolutions and slack practices. Our research highlights the importance of situational slack production practices to ensure resilience. We also argue that these micro-practices are constitutive of the context in which actors are evolving. Finally, we discuss why these slack practices, although essential for ensuring resilience, can be endangered by the New Public Management context.

**Keywords:** ethnographic research, slack, practices, resources, extreme context, critical care unit, new public management, organizational resilience

## Introduction

Extreme contexts create unique contingencies, constraints and causation (Hällgren et al., 2018; Hannah et al., 2009). How organizations confront these contexts to ensure reliability and resilience has become a hot topic in a world impacted by environmental, technological and social disruptions.<sup>1</sup> Over the last thirty years, the academic literature has explored numerous practices and mechanisms that lead to resilience in groups or organizations, particularly in the context of high reliability organizations (HRO) or at times of crisis (e.g. Bourrier, 2005; Powley, 2009; Roberts et al., 2004; Sutcliffe and Vogus, 2003). Thus, the resilient organization has to design technological and human systems that are able to deal with shocks and to manage critical situations as quickly as possible once deviations emerge (Vogus and Sutcliffe, 2007).

This article focuses specifically on the role of slack in managing extreme contexts and ensuring resilience. Slack can be defined as ‘the potentially utilizable resources that can be diverted or redeployed for the achievement of organizational goals’ (George, 2005: 661). In extreme contexts, slack can prevent negative situations or can help to manage adverse situations when negative events have occurred (e.g. Bourgeois, 1981; Meyer, 1982; Perrow, 1984; Schulman, 1993; Sutcliffe and Vogus, 2003). Slack is therefore ‘one possible explanation for organizational resilience’ (Vogus and Sutcliffe, 2007: 3420). However, while slack is often evoked at the organizational and structural levels as an important mechanism for ensuring resilience and consequently reliability, few studies focus on the micro-level to capture slack in action (Daniel et al., 2004), especially during extreme events. Hence, our research question in this article is: “How does slack contribute to resilience in extreme contexts?”. For this purpose, we adopt a practice perspective, in which the site or the situation

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<sup>1</sup> This article originates from a PhD thesis begun years before the Covid-19 pandemic.

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3 is a nexus of material arrangements and human practices, to study slack in action. We focus  
4 particularly on the resources implied, produced and used<sup>2</sup> by actors to perform their activities  
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6 as the material underpinnings of practices are of prime importance (Feldman and Worline,  
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8 2011; Nicolini, 2009; Schakel et al., 2016).  
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11  
12 Carrying out a 14-month ethnographic empirical study in a French Critical Care Unit (CCU),  
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14 we reveal what we refer to as ‘slack practices’, i.e. the practices that are employed to produce  
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16 and use excess resources when operating in risky and emergency contexts. These contexts  
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18 refer, respectively, to situations which potentially or actually endanger the core activity of an  
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20 organization (Hällgren et al., 2018). From our empirical study, we develop a model  
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22 connecting risky and emergency contexts with the micro-dynamics of the production and use  
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24 of slack by actors according to the situation. When the context is risky, the slack accumulated  
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26 in the unit is sufficient to maintain resilience. However, the context can shift to one of  
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28 emergency and may require the production of situational slack to cope with unexpected use.  
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30 Beyond depicting these general dynamics, the main contributions of our study are threefold.  
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32 First, our research highlights the situational slack production practices and the importance of  
33  
34 absorbed slack for a HRO to ensure reliability. Second, the micro-practices not only depend  
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36 on contexts but are also constitutive of these contexts, underlining the theoretical flaw of  
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38 reifying the concept of context. Finally, we point out the invisibility of these practices at the  
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40 organizational level and the unfolding danger of the New Public Management context, which  
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42 primarily targets cost efficiency.  
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53  
54 <sup>2</sup> We opt for the word ‘use’ and not ‘consumption’ as for us ‘consumption’ denotes actors  
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56 having a passive role. ‘Use’ – as the resourcing view claims – refers to a creative human  
57  
58 activity.  
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### **The role of slack in extreme contexts**

Slack was initially defined as ‘[The] difference between total resources and total necessary payments [...]. Slack consists in payments to members of the coalition in excess of what is required to maintain the organization’ (Cyert and March, 1963: 36). In other words, slack is the difference between the resources available to the organization and the combination of demands for these resources (Bourgeois and Singh, 1983: 45). Bourgeois (1981) extended the concept of slack to the capacity of an organization to adapt to its environment. He defined it as ‘[...] that cushion of actual or potential resources which allows an organization to adapt successfully to internal pressures for adjustment or to external pressures for change in policy, as well as to initiate changes in strategy with respect to the external environment’ (Bourgeois, 1981: 30). This slack comprises different types of excess resources – e.g. a surplus of finance, personnel, supplies or material – which are available or made available, and which can be combined over time in an organization (Marlin and Geiger, 2015; Paeleman and Vanacker, 2015). For instance, in manufacturing operations, firms can meet unexpected variations in demand by selecting from different resource options to obtain volume flexibility with minimal disruption (Jack and Raturi, 2002, 2003).

These surplus resources have two distinct organizational roles. They promote change and innovation by loosening internal controls and creating funds that can be directed to projects with uncertain outcomes (George, 2005; Herold et al., 2006; Nohria and Gulati, 1996, 1997; Singh, 1986; Slappendel, 1996; Zajac et al., 1991), or they can prevent disruption by absorbing internal or external shocks (Meyer, 1982; Pfeffer and Salancik, 1978; Schulman, 1993; Sgourev and van Lent, 2017). This latter role is particularly important in extreme contexts characterized by the conjunction of potential or actual events that may disrupt organizational routines and have intolerable consequences. Based on the definition of extreme contexts by Hannah et al. (2009), Hällgren et al. (2018) distinguish risky contexts,

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2  
3 characterized by events that might occur and affect the core activity of an organization  
4 (potential disruption), from emergency contexts, where disrupting events actually occur.<sup>3</sup> In  
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6 these contexts, slack resources can absorb shocks by preventing or by recovering from the  
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8 occurrence of events, i.e. by being resilient by maintaining a positive adjustment under  
9  
10 challenging conditions (Sutcliffe and Vogus, 2003: 95). The normal accident theory (NAT)  
11  
12 (Perrow, 1984) and HRO literatures offer typical examples of how organizations facing  
13  
14 potential dramatic risks use slack to prevent the occurrence of catastrophic events, as their  
15  
16 failure could have disastrous consequences (Casler, 2014; Roberts, 1990; Roberts et al.,  
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18 2004). For instance, studying the Diablo Canyon nuclear power plant, Schulman (1993)  
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20 observed that in addition to slack in resources – constituted by redundancy of equipment,  
21  
22 supplies or personnel relative to current demand – conceptual slack, i.e. producing potentially  
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24 divergent interpretations, was also important for ensuring reliability.

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26 While slack can prevent the occurrence of disrupting or adverse events through an  
27  
28 anticipatory approach, it can also absorb shocks when disrupting events occur, i.e. when the  
29  
30 extreme context becomes one of emergency (Hällgren et al., 2018). For instance, studying an  
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32 unexpected doctors' strike in San Francisco's hospitals, Meyer (1982) observed that jolts had  
33  
34 a variety of impacts and were partly influenced by the hospitals' levels of slack. Some  
35  
36 hospitals absorbed the strike by opting to deplete their financial reserves, while others laid off  
37  
38 employees. Depending on their strategies and ideologies, surplus financial reserves or human  
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40 slack resources helped to absorb the effects of the strike.

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42 Although slack can be considered as critical for ensuring the resilience of organizations –  
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44 either by preventing dramatic events or by managing them once they occur – the literature  
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54 <sup>3</sup> While Hällgren et al. (2018) envisaged a third category – the disruptive context –  
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56 disconnected from the core activity of an organization, we do not discuss it within the scope  
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58 of this article.  
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3 only provides a general view about its relationship with resilience. How organizations  
4 produce and use slack before and during unforeseen events remains largely unexplored  
5  
6 (Vogus and Sutcliffe, 2007). With the exception of Schulman's (1993) detailed study about  
7  
8 redundancy, few works explain how slack intervenes concretely in the resilience process  
9  
10 whereas 'it is not merely the stocks of resources that determine resilience, but also the  
11  
12 deployment of the resources that exist' (Vogus and Sutcliffe, 2007: 3421). As we explain  
13  
14 below, we chose to study how slack participates in resilience in extreme contexts through the  
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16 practice theoretical lens, as suggested by Hällgren et al. (2018: 144–145).  
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### 22 **A practice perspective on slack**

23  
24 A small group of studies on slack suggest that slack resources are managed intentionally by  
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26 individuals and organizations to achieve their goals and, eventually, to ensure resilience.  
27  
28 They show that: surplus personnel can be used to offset the adverse effects of unskilled labor  
29  
30 (Sgourev and van Lent, 2017); excess production capacity enables organizations to be  
31  
32 flexible without incurring significant penalties (Jack and Raturi, 2002, 2003); excess sales  
33  
34 can be managed to create a 'sales surprise' to improve the valuation of firms by investors  
35  
36 (Manikas and Patel, 2016); and managers can create slack in the budgeting process by  
37  
38 negotiating achievable targets (Merchant, 1985). Although these studies do not refer to  
39  
40 extreme contexts, they illustrate the agency of individuals both in the production and use of  
41  
42 slack resources to achieve individual or organizational purposes. However, due to their  
43  
44 methodology, empirical groundings and theoretical approach, these studies do not examine  
45  
46 the production and use of slack as processes in the making and in situ, as the practice  
47  
48 perspective would require (Schakel et al., 2016: 392). Similarly, the NAT (e.g. Perrow, 1984)  
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50 and HRO literatures (e.g. Schulman, 1993) remain at the structural and organizational levels  
51  
52 of analysis (Barton and Sutcliffe, 2009). They emphasize the 'being' – stock of resources,  
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54 loose coupling structures or redundancy of functions – rather than the 'becoming' (Hernes,  
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3 2008), ignoring issues of time, process, uniqueness or context (Tsoukas, 2017). Moreover,  
4 these studies postulate that resources have innate features and qualities, while authors such as  
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6 Feldman (2004) and Feldman and Worline (2011) claim that resources are always creatively  
7  
8 connected to practices in organizations and are potential resources until somebody uses them  
9  
10 (Feldman and Orlikowski, 2011: 1246). For these authors, 'resourcing theory points to a  
11  
12 definition of resources focusing on how organizational members take up and use assets as  
13  
14 they pursue activities in line with what they wish to make happen in the world' (Feldman and  
15  
16 Worline, 2011: 630).

17  
18 For these reasons, we study slack in situ by adopting a practice perspective. Despite its  
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20 numerous and diverse philosophical roots and voices (Reckwitz, 2002; Schatzki, 2001, 2005),  
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22 practice research shares common characteristics and converges around several crucial points  
23  
24 about social life in general and organizational life in particular (Feldman and Orlikowski,  
25  
26 2011; Feldman and Worline, 2016; Gherardi, 2012; Nicolini, 2013; Nicolini and Monteiro,  
27  
28 2017; Sandberg and Dall'Alba, 2009). Practice researchers share 'site ontologies', taking  
29  
30 practice as a unit of analysis and as the fundamental building block of social reality, studying  
31  
32 ordinary actions and rejecting traditional dualisms or disjunctions (Tsoukas, 2017) between  
33  
34 structure and actors (Schatzki, 2001, 2005), human and non-human, or actions guided first by  
35  
36 interest (*homo oeconomicus*) or by norms (*homo sociologicus*) (Reckwitz, 2002).

37  
38 Practices produce the organizational reality and phenomena through their interconnection  
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40 (Feldman and Orlikowski, 2011). For this research, we focus on the human interactions with  
41  
42 resources in work activities and take a situational approach which addresses the local  
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44 accomplishment and reproduction of practices (Nicolini and Monteiro, 2017: 121). Viewing  
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46 slack from this practice perspective has several consequences and suggests a number of  
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48 differences from the current literature on slack.  
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3 First, as ‘practice is understood as something that people do in “real” or everyday life’  
4 (Miettinen et al., 2009: 1312), we depart from the slack literature which has traditionally  
5 searched for acontextual stable relationships between slack and other phenomena such as  
6 innovation, bankruptcy, risk-taking, absorption of critical events and so on at the  
7 organizational level. The practice perspective considers the mundane activities in working  
8 situations to be important, taking a micro-view of the production and use of slack. To our  
9 knowledge, only Sgourev and van Lent (2017: 1294) have developed the view of slack as a  
10 human resource management practice which consists in using extra human resources to  
11 compensate for skill shortages in carrying out organizational processes. However, we stray  
12 from their focus by considering simultaneously the use and production of situational slack  
13 during action.  
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28 Second, despite their repetitive dimension, practices enable the creativity and change required  
29 to adapt and act in constantly changing circumstances (Orlikowski, 1996; Tsoukas and Chia,  
30 2002). As argued by Nicolini and Monteiro (2017: 114) ‘performing a practice always  
31 requires adapting to new circumstances, as its accomplishment is neither mindless repetition  
32 nor complete invention’. This is especially important in extreme contexts where situations  
33 can evolve rapidly and unexpectedly. For instance, Faraj and Xiao (2006) observed new  
34 practices, such as epistemic contestation, joint sensemaking and cross-boundary intervention,  
35 in a trauma center when a patient’s reaction to treatment deviated from the plans and their  
36 health was at immediate risk. This conjunction of routines, change and novelty in situated  
37 actions emerges from the dynamic of different interactions (Gherardi, 2012). Consequently,  
38 the concept of site invites us to unpack the familiar idea that context matters (Nicolini, 2011)  
39 when observing the ‘world in the making’ in a simultaneously creative and routinized way.  
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55 Third, the ontology of the practice-based approach considers entwinement or entanglement as  
56 the basic form of being in the world (Hernes, 2008; Sandberg and Dall’Alba, 2009),  
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3 underlining the radical inseparability of humans and the socio-material world they live in  
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5 (Sandberg and Tsoukas, 2011: 343). While practices are considered in situ, they consequently  
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7 bring to the fore the material and technological entanglement in practice to perform activities  
8  
9 based on a relational ontology (Feldman and Worline, 2011; Hernes, 2008; Orlikowski, 2010;  
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11 Schakel et al., 2016). This invites the researcher to pay attention to mundane objects,  
12  
13 technologies and resources that are processed or ‘how they [resources] are brought into use’  
14  
15 (Feldman and Worline, 2011: 631).  
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18  
19 Finally, practice research studies organizations less as entities and more as entangled social  
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21 processes for organizing, i.e. open-ended and pervasive processes of organizing and changing  
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23 through permanent enactment and mutual constitution (Feldman and Orlikowski, 2011;  
24  
25 Feldman and Worline, 2011; Hernes, 2008; Tsoukas and Chia, 2002). As social ordering  
26  
27 structures emerge from situated (inter)actions and relationships, ‘practice approaches are  
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29 fundamentally processual and tend to see the world as an ongoing routinized and recurrent  
30  
31 accomplishment’ (Nicolini, 2013: 3). Thus, instead of considering slack as a fixed stock of  
32  
33 surplus resources, the practice view invites us to consider slack practices as processes that  
34  
35 unfold over time. Because the elements of a practice are not fixed and ‘follow a trajectory of  
36  
37 becoming’ (Gherardi, 2012; Tsoukas and Chia, 2002), a processual view can illuminate the  
38  
39 mechanisms that connect slack and resilience (Vogus and Sutcliffe, 2007). This processual  
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41 approach requires a qualitative commitment to produce processual, fine-grained observations  
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43 to understand the practices as they happen in the workplace (Gherardi, 2012; Nicolini, 2013).  
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## 50 **Methods**

### 51 *Description of the Critical Care Unit*

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55 Extreme-context research includes a variety of environments, such as emergency or critical  
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57 care units in the healthcare sector, where the activity contains risk – actual or potential – for  
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3 individuals, teams or organizations (e.g. Faraj and Xiao, 2006; Roberts et al., 2005; Tamuz  
4 and Thomas, 2006). Our fieldwork takes place in a CCU linked to the Emergency Center of a  
5 French university hospital – one of the biggest in the country. The CCU is only one  
6 component of the hospital's Emergency Center, which is composed of several other medical  
7 units such as the Emergency Department and Pediatric Emergency Department. Inside the  
8 Emergency Center, the CCU looks after patients with critical conditions such as  
9 cardiopulmonary arrest, poly-traumatic injuries and strokes. With an average of one patient  
10 dying in the CCU every two days, death is inherent in the activity of this type of medical unit  
11 and the severity of the cases handled. However, given the severity of the medical cases  
12 admitted to the unit, the death of a patient is not necessarily the consequence of a failure in  
13 organizational resilience.

14  
15 The CCU has three missions: handling vital emergencies, post-surgery monitoring and  
16 intensive care management. Its general mission is to treat patients with life-threatening  
17 conditions, i.e. *'when your organs are no longer capable of maintaining a sufficient level of*  
18 *vital functions'* (Head of the CCU interview). The unit therefore has to manage patients in a  
19 medical emergency situation regardless of the available capacity, maintaining their vital  
20 functions until a medical specialty (traumatology, cardiology, neurosurgery, etc.) can treat  
21 them: *'That's why the CCU and the operating rooms are connected. Anyway, we are not the*  
22 *ones who will heal them; we are the ones who enable them to live until they are fixed'*  
23 (Physician interview).

24  
25 The same number of staff works in the CCU night and day, on normal working days and  
26 holidays. The staff includes nurses, assistant nurses, doctors and interns who specialize in  
27 intensive care anesthesiology. Taking account of leave and sickness days, there is a total staff  
28 of 40, who are organized into shifts to ensure a continuous service. Among this staff, the  
29 anesthesiology interns are unique as they are trainees and are assigned to the department for  
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3 six months. Overall, there are one doctor, one intern, four nurses and four assistant nurses 24  
4 hours a day in the CCU.  
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8 The CCU has three areas of activity. First, the Trauma Room (TR) (4 beds) is where patients  
9 with critical life-threatening conditions and injuries are assessed to stabilize them. This  
10 involves initial medical examination, clinical evaluation monitoring, etc. The other two areas  
11 (the Intensive Care Unit (ICU) and Post-Operation Recovery Room (PORR)) are both  
12 spatially connected to the TR. The ICU (8 beds) is responsible for patients whose conditions  
13 are too unstable to allow them to be transferred to a specialist unit while they require close  
14 monitoring. The PORR (6 beds) is dedicated to the Emergency Center's operating rooms and  
15 monitors patients after surgery. The nurses and assistant nurses are allocated to these different  
16 areas: one nurse and one assistant nurse work in the TR, two nurses and two assistant nurses  
17 work in the ICU, and one nurse and one assistant nurse work in the PORR. The doctors  
18 oversee both the CCU and the anesthetic function of the emergency operating rooms.  
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33 The CCU has two essential characteristics. First, like other emergency units in the  
34 Emergency Center, it is an entry point for unplanned patients. It admits around 3,000 patients  
35 per year who stay in the unit for a period ranging from a few minutes (for example if the  
36 patient is under surveillance before surgery) to 72 hours.<sup>4</sup> The unit accommodates up to 15  
37 patients per day. Similarly, there is an extremely high variance in the severity of cases,  
38 ranging from simple fractures to serious poly-trauma, and in the pathologies (neurosurgical,  
39 visceral, cardiac, etc.). Patients may also have sustained injuries or have become injured as a  
40 result of a wide range of circumstances, such as a car accident, a fall from a roof, gunshot  
41 wounds, as well as aneurysms, strokes and post-surgical complications. Second, the activity  
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54 <sup>4</sup> Administrative rules state that this type of ICU cannot hold a patient for more than 72 hours.  
55 After 72 hours, the patient must have access to a bed in another ward (or another hospital) or  
56 be able to leave the hospital.  
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3 takes place in a highly technological environment to deal with life-threatening events. This  
4 makes the CCU similar to a HRO (e.g. Madsen et al., 2006; Roberts et al., 2005), as it  
5 regularly has to manage unanticipated events with potentially dramatic consequences in a  
6 complex technological and organizational environment. Indeed, the CCU's operations require  
7 access to numerous and diverse technical resources both inside the unit (monitoring devices,  
8 life-support systems, specific technical devices, computers) and outside the unit. The latter  
9 resources (CT scanner, MRI scanner, X-ray, blood bank, etc.) are shared within the entire  
10 Emergency Center. They enable the CCU to be designated as a 'trauma center', i.e. an  
11 organization that can manage the whole trauma without transferring the patient to a specialist  
12 unit. The other resources required for care – whether technical or human – are available  
13 within the hospital and can be forwarded to the unit when necessary. These resources come to  
14 the patients rather than the patients going to the resources.

### 31 *Ethnographic approach and data collection*

32 As work should be understood as a 'situated activity' (Gherardi, 2012), we employ a specific  
33 piece of ethnographic fieldwork to capture the medical view from inside and 'the materially  
34 mediated doings and sayings ("practices")' (Nicolini and Monteiro, 2017). Several extreme-  
35 context research studies have conducted ethnography to capture complex and unpredictable  
36 activities (Bechky and Okhuysen, 2011; De Rond and Lok, 2016; Faraj and Xiao, 2006;  
37 Schakel et al., 2016). Indeed, the ethnographic approach enables the researcher to report on  
38 practices 'in the making' (Hernes, 2008) and, in our case, to study how slack contributes to  
39 organizational resilience in a medical unit (Dixon-Woods et al., 2012; Leslie et al., 2014).

40 Our fieldwork took the form of a 14-month ethnographic study conducted by one of the  
41 authors in a CCU where, as well as collecting data, the researcher lived with the group and  
42 was immersed in its everyday life as an 'active member' of the unit (Adler and Adler, 1987).  
43 He was acknowledged as a management researcher (with his own research agenda) and, at  
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3 the same time, helped the team to take care of patients. Given his lack of medical skills, his  
4 participation consisted in doing the ‘grunt work’ (Barley, 1990: 238), such as carrying  
5 patients on stretchers, helping with administrative tasks or fixing computer problems. As a  
6 researcher, he collaborated scientifically to better understand the operations of the unit to  
7 improve patient safety.<sup>5</sup>

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9  
10 Our ethnographic approach is based on the rigorous observation of a small group of people  
11 (the medical team) with whom we had personal interactions (Cunliffe, 2010). To understand  
12 the people’s work ‘from the native’s point of view’ (Miettinen et al., 2009), we explore  
13 situated understandings of managerial practices, how they are accomplished in particular  
14 places and times, and how they are brought together and/or made distinct from other  
15 activities, before considering and theorizing their possible effects (Korica et al., 2017). Our  
16 methodology combined participant observation and semi-structured and informal interviews  
17 during the observation period with the collection of secondary data (such as activity reports  
18 and procedure guidelines) to refine and validate our abductive analysis (Figure 1). These  
19 sources enabled us to retrace the life of the unit, its repeated practices in habitual situations,  
20 exercise of human agency and ‘daily doings’ (Korica et al., 2017).

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47 Observation methods require a specific approach for making rigorous observation (Barley,  
48 1990) and ‘choosing different angles for observation’ (Nicolini, 2009: 1398). As a CCU’s  
49 activity can be characterized by unpredictability, time pressure and sudden changes,  
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54 <sup>5</sup> For instance, this collaboration led to the presentation at the French Society of Anesthesia &  
55 Intensive Care Medicine Annual Meeting in 2016 of a co-authored paper which highlighted  
56 the contribution of HRO principles to improving patient safety.  
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3 observation should therefore include unplanned activity, density of actions in a short amount  
4 of time, multiple spaces used for the same patient and the team's movements between these  
5 spaces. Hence, the specificities of the CCU required a fixed, systematic and mobile system to  
6 monitor a situation or to follow an actor. Based on the characteristics of the activity and the  
7 observation approach developed by Journé (2005, 2012), we adopted an observation strategy  
8 combining four different tactics according to spatial and temporal variables (Table 1). This  
9 strategy enables us to capture the resilience of the unit, defined here as being successful in  
10 handling the flow of patients whatever their number and the severity of cases. Indeed, as  
11 Weick and Sutcliffe (2007: 40) recalled ' [...] there are constant outcomes and nothing to  
12 watch. That does not mean that nothing is happening'.

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28 <Insert Table 1 about here>  
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33 To meet the need for in-depth analysis, we validated our results using three strategies. First,  
34 our study involved team work where one researcher (*the insider*) debriefed the other (*the*  
35 *outsider*). Working in tandem has two main advantages: it validates the interpretations from  
36 two different viewpoints and avoids being too close to the ethnographic fieldwork –  
37 especially the emotional part of working in a CCU – in order to keep an analytical distance  
38 (Adler and Adler, 2012). Second, we used data triangulation (Eisenhardt, 1989) to ensure the  
39 validity of our findings. Beyond the fieldnotes, we also used other types of data, particularly  
40 interviews. We conducted semi-structured interviews during the second half of the fieldwork  
41 (from April to December 2015) in order to obtain a rich knowledge of the activity and shared  
42 experiences (Becker and Geer, 1957). Such interviews ensure that in our observation we are  
43 not 'looking at the field we are studying the wrong way' (Beaud and Weber, 2010) and that  
44 we grasp the meaning of the observed situations. After the fieldwork stage, we also presented  
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3 our results to the members of the CCU to confirm our interpretations. Finally, we created an  
4 analytical framework based on the concept of ‘management situations’ to isolate and analyze  
5 the situations and the associated practices (Girin, 2011). Each selected situation was  
6 characterized through seven dimensions: number of participants, work areas, time sequences,  
7 material resources used, actions taken, outcomes and accountability of these actions. We also  
8 added the CCU’s global activity for each situation in terms of stock and flow of patients.  
9  
10 Through the semi-structured and informal interviews, we were able to cross check our data to  
11 fill in possible gaps and confirm our understanding of the situations as the variety and the  
12 variability of cases make them difficult to describe given the technical nature and complexity  
13 of medicine. While the data were sometimes insufficient to reconstruct a situation entirely,  
14 we ultimately reconstructed 92 situations with sufficient details for analysis.

### 25 **Results: Critical care situations and slack practices**

26  
27 In the following sections, we unpack the data collected and present the main results of our  
28 empirical study. First, we analyze the activity of the medical unit through critical care  
29 situations. This leads us to determine three types of situations (risky, emergency, crisis)  
30 according to the intensity of the activity, the pressure on resources it generates and the origin  
31 of the slack required to ensure organizational resilience. Second, we categorize slack  
32 production practices and use this to address the pressure on resources in each type of  
33 situation. Finally, we present a dynamic model of slack practices to explain how these  
34 practices ensure resilience according to the situation encountered and its evolution.

#### 35 *Analyzing the activity through the lens of critical care situations*

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37 After comparing the 92 situations in our sample, we identified the following five  
38 characteristics of the CCU’s activity which put pressure on its resources: 1) its status as an  
39 emergency unit which is operational 24/7, accepting patients with failing vital conditions;  
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3 2) its treatment of patients with life-threatening emergencies, which means their health can  
4 changed unexpectedly; 3) the need for the CCU to handle patients promptly – particularly to  
5 assess the seriousness of their condition – without putting them on hold and managing them  
6 later; 4) the need for the CCU to deal with a highly variable number of admissions and to not  
7 turn them away even if it is full; and 5) dependence of the CCU’s levels of activity and  
8 occupancy on upstream flows (incoming patients from other hospitals or directly from  
9 accidents) and downstream flows (redirecting patients to other units after emergency care).  
10 Given the imperatives for action in this extreme context, our observations and the actors  
11 themselves identified the availability of resources as a key factor in ensuring resilience, and  
12 that having these resources in a timely manner can sometimes be a source of tension. We  
13 specifically observed how actors used what they called ‘*just in case resources*’ or ‘*resources*  
14 *at hand but not always used*’ to manage this tension. These ‘slack resources’ are available out  
15 of the situation – in the form of resources granted to the unit – or are sometimes produced as  
16 the situation unfolds.

17 Understanding all the activity of the CCU led us to categorize the care situations that the  
18 medical unit encounters. We analyzed each of the 92 situations we were able to characterize  
19 from our data and classified them according to their level of criticality based on three criteria:  
20 the condition of a new patient arriving in the unit (e.g. broken arm vs. gunshot wound with  
21 great blood loss); the evolution of the situation while caring for the patient (e.g. unruptured  
22 abdominal aortic aneurysm); and the care environment in the unit at that time (e.g. the  
23 occupancy rate, the condition of the patients already in the unit, the expected incoming  
24 patients). These analytical distinctions were validated during semi-structured and informal  
25 interviews with the team.

26 Following Journé and Raulet-Croset (2008), we grouped the situations that we analyzed into  
27 three types related to the resource pressures generated by the various situations (Table 2).  
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3 Then, we established a correspondence between the situations and the origins of slack used in  
4 these situations (cf. infra).  
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10 <Insert Table 2 about here>  
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16 Risky situations are those situations that are normal in their intensity and the number of  
17 patients. Here, the context is risky but is “normal” for this kind of medical unit. Emergency  
18 situations are more intense situations because of the number of patients in the unit or a  
19 sudden change in a patient’s condition. Although they create resource pressures, these  
20 situations are part of the unit’s expected activity and are kept under control by creating slack  
21 resources when the situation occurs (situational slack). Crisis situations are a specific type of  
22 emergency situation where the resilience of the organization is at risk of failure due to a lack  
23 of resources or time pressures for mobilizing, reconfiguring or generating the resources.  
24 These situations are very rare; only one occurrence was observed during our 14-month period  
25 in the CCU and such events are widely discussed by the team because of their potential  
26 consequences.  
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41 The peak levels of activity are generally able to be controlled using the available resources  
42 (human, material or spatial) negotiated with the hospital’s administrative staff, outside the  
43 timeframe of the situations we studied. However, the tension and the time pressure can  
44 intensify because of the variability in the causes of the patients conditions (traffic accidents,  
45 brawls, domestic accidents, etc.); the variability in the hospital activity (in-patient bed  
46 occupancy); the number of patients already in the CCU and the evolution of their condition;  
47 and potential transfers from other smaller hospitals for the most severe cases. These factors  
48 can offset or reinforce each other, explaining why risky situations may evolve towards  
49 emergency ones. The CCU’s activity therefore has a large potential for disturbance and new  
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3 resources may be required. Two kinds of events shift the risky situation to an emergency one.  
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5 The first is related to the qualitative variability in the condition of the patients, whether they  
6  
7 are new or already in the CCU. The other is related to the quantitative variability in the care  
8  
9 environment of the unit, driven by the variability in the elements listed above. By moving  
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11 from the potentiality to the realization of extreme events, the pressure on resources requires  
12  
13 rapid action that cannot be delayed to avoid risking patient safety.  
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### 17 *Slack practices in critical care situations*

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19 To cope with the pressure on resources caused by the different situations, we observe that the  
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21 medical unit actors employ various slack practices related to human and material resources,  
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23 spatial resources and a queuing system. With regard to human and material resources, the  
24  
25 medical unit has a significant level of slack granted officially by the administration which can  
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27 be mobilized to treat patients. Indeed, as indicated by several actors, the CCU, as part of a  
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29 large university hospital, has access to all the hospital's material, staff and specialist medical  
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31 resources. One doctor told us: *'Here, no one has ever told me there are budget restrictions.*  
32  
33 *That's the advantage of this unit. We have all the resources we need. No one has told me to*  
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35 *stop at 25 packed red blood cells. If I stop, it's for medical reasons. There is no more hope.*  
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37 *Never for financial reasons'* (Physician interview).  
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43 These resources can be referred to as 'official slack' (i.e. slack that is acknowledged and  
44  
45 approved by the hospital administration) and they enable the risky situations, i.e. the majority  
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47 of situations encountered, to be managed despite their variability. Many of the unit's  
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49 resources for dealing with unexpected workflow are available as a result of negotiations with  
50  
51 the hospital administration. These negotiations relate to the resources that are necessary  
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53 between the official requirements for the hospital to respect a minimal staffing level and the  
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55 medical requirements for the optimal care of patients. The Head of the CCU illustrated this,  
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57 saying: *'The official text says, "It's 1 nurse for every 2 patients". For intensive care there is*  
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3 *no official text, there are guidelines and recommendations for intensive care and continuing*  
4 *care. And that changes everything! You can go to see the hospital administration and tell*  
5 *them you want these. As there is no official text they'll say, "that's all very well but show me*  
6 *you need it"* (Head of CCU interview).  
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12 Beyond the budgetary negotiations, doctors – particularly the Head of the CCU – play a key  
13 role in protecting slack. This requires them to participate in the hospital decision-making  
14 process in order to avoid managerial drift that could affect the quality of care. Indeed, the  
15 team emphasized that there is a significant distance between the frontline workers, whether  
16 doctors or paramedic staff, and the hospital administration. Doctors must therefore dedicate  
17 time to attending a large number of meetings to ensure that the metrics used by the  
18 administration are consistent with the reality of the field, and to provide the administration  
19 with an understanding of the reality in terms of quality of care and patient safety. For  
20 example: *'In the performance committee, they keep talking about lean management. That's*  
21 *the new big thing. You realize that the numbers they have are false. They have no idea about*  
22 *the level of activity. When the metrics show there are 2,000 complete hospitalizations, for*  
23 *them it's just a number. They don't have a medical view and there are errors every time. [...]*  
24 *And it takes up a lot of time. [...]* The NPM [New Public Management] has transformed the  
25 hospital with a huge decrease in the power of doctors. Before, the Medical Establishment  
26 Commission had an important role; now, it feels like it's no longer useful. The steering  
27 committee or something like that, there are 5 or 6 of them, they decide more' (Head of the  
28 CCU interview).  
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51 In emergency situations, new slack practices are employed to reconfigure existing resources  
52 and gather new ones. The medical team redirects the initial destination of a resource to a  
53 different one. For human resources, this is achieved through team members standing close by  
54 and letting their colleagues know they are there 'just in case', saying, for example: *'Do you*  
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3 *want me to deal with the second arrival if he arrives too quickly?* or *'If you need me to, can I*  
4 *do the central line while you manage the other patient?'* Another doctor in the team can also  
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6 stay in the CCU to take a step back to get an overview of the activity and be ready in case his  
7  
8 colleague needs him for a patient. With regard to the material resources, the most illustrative  
9  
10 practice involves creating a fifth bed in the TR, where there are usually only four, so that  
11  
12 extra patients can be absorbed when the CCU is overloaded. This is made possible by  
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14 bringing a stretcher from the PORR, taking a mobile scope and a mobile respiratory device  
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16 from the inventory room, and placing two folding screens in the middle of the TR to create  
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18 this new bed.  
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24 In addition to using the resources already in the CCU, we observed two practices to produce  
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26 slack by bringing in extra human resources from outside the medical unit. First, the unit's  
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28 medical staff has a network of relationships that extends beyond official working hours and  
29  
30 places. Using their personal smartphones, on-duty doctors regularly communicate with off-  
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32 duty doctors to inform them of critical situations, and the off-duty doctors regularly inquire  
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34 about the situation in the unit. Here, calls, texts or instant messaging apps (*WhatsApp*) are  
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36 common and the usual mode of communication for permanently maintaining potential  
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38 reinforcing resources. There is therefore no great compartmentalization between the CCU's  
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40 on- and off-duty doctors. There is a network of doctors in the field and others who can be  
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42 called on to be prepared and, if necessary, to assist the unit. Second, when necessary, other  
43  
44 human resources are also brought in from within the hospital. For example, during a night  
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46 shift, an intern or a doctor can call an additional duty doctor from a unit with a lower variance  
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48 of activity than the CCU and who can therefore intervene or be pre-mobilized when the  
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50 situation requires. The CCU team members call this resource, *'The phone-a-friend'* joker – a  
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52 joke based on the TV show *'Who Wants to Be a Millionaire?'*.  
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3 Furthermore, the spatial layout of the CCU and of the Emergency Centre facilitates the  
4 reconfiguration of space resources because of the spatial proximity and interconnection of the  
5 activity areas. As one physician explained: *'I need a bed in the post-op recovery room, but no*  
6 *bed is available. OK, no problem, I will take this and that. The nurse in charge knows about*  
7 *it and everything is reconfigured. It's a constant process of reconfiguration for physicians,*  
8 *nurses and assistant nurses at the same time'* (Physician interview).  
9

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12 Reconfiguration also takes place beyond the CCU's own walls. As previously mentioned, the  
13 anesthetic area of the operating rooms in the Emergency Center is managed by the  
14 anesthesiologists in the same team (who work alternatively in the CCU and the operating rooms  
15 and consult in the whole Emergency Center). Like the official slack for human and material  
16 resources, the layout of the workspace is also subject to negotiation. The doctors fought to  
17 participate in the conception of the CCU to design the spatial organization of the unit. They  
18 requested a specific form of spatial organization that provided flexibility during emergency  
19 activity. They favored a design where the operating rooms were on one side and the ICU was  
20 on the other, which was contrary to that of rationalized organization based on the different  
21 types of pathology. A nurse argued that: *'[The Head of the CCU] fought for it [the specific*  
22 *layout of the unit] to be created. If she had not been there, it would not exist: the Trauma*  
23 *Room next to the ICU, 15 meters from the operating rooms, and 15 meters from the medical*  
24 *scans. She fought to make it that way'* (Nurse interview).  
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47 In emergency situations, this spatial layout enables dedicated spaces to be used for other  
48 purposes. Thus, the most stable patient can be moved from the TR to the PORR when all the  
49 TR bays are occupied. In this way, the PORR becomes a 'Light Trauma Room' for taking  
50 care of patients according to their level of severity. Linked to the human and material slack,  
51 the spatial layout makes the use of resources smoother.  
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3 The last category of slack practices concerns the ‘queuing system’, i.e. the practices for  
4 managing the flow of patients and the patients already in the CCU (‘stock’) to avoid  
5 overloading the CCU. The CCU’s mission is to take care of the sickest patients whatever  
6 their condition, and it cannot send patients elsewhere to create its own slack by diverting or  
7 putting the flow of patients on hold. Thus, a lack of resources, specifically a lack of space in  
8 the unit, is never an excuse to refuse a patient admittance. Medical criteria alone determine  
9 the admittance or the refusal of a patient. To manage these important tensions, the team  
10 creates slack by creating a vacant bed (TR) or room (ICU) as quickly as possible.  
11 Consequently, managing the flow and the stock of patients includes making room for a  
12 ‘potential new or unexpected patient’.  
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26 In emergency situations, overloading arises and challenges the ability of the CCU to deal  
27 with the ‘potential new or unexpected patient’. The team’s priority is to free up space and  
28 make it ready as quickly as possible to receive other potential patients. To do so, the CCU  
29 doctors can increase the turnover of patients from the TR to the ICU. The patient trajectory  
30 does not change but is accelerated. Doctors can also negotiate patient transfers (new transfers  
31 or speed up scheduled transfers) with doctors from the other hospital units. The doctors’  
32 relational network – based on their personal and professional relationships – facilitates these  
33 transfers. The higher the tension around transfers, the more the relational network and the  
34 ‘institutional weight’ of the doctor play an important role. This makes it more difficult for  
35 interns to negotiate such places than attending physicians, who have greater negotiating  
36 power. We repeatedly observed the head of the unit asking the intern or the doctor if he  
37 ‘needed help to make room’.  
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54 The CCU can use the slack produced in these ways completely, partially or even not at all.  
55 For example, while the creation of a fifth bed in the TR may be effective, it may not be used  
56 if patient transfers free up space a few hours later. Once the situation is managed and under  
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3 control, situational slack is disbanded if it has not been entirely used or has been used and no  
4 longer exists. Official slack is reconstituted as soon as possible (free bed in the TR or free  
5 room in the ICU). After an extreme event, the CCU returns to a nominal state of a potential  
6 extreme event characterizing a risky situation.  
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12 Following our analysis, we can classify these interconnected practices involved in the  
13 production and use of slack into four main categories (Table 3) according to the situation and  
14 the two temporalities of the local ‘here-and-now accomplishments’ and the ‘elsewhere-and-  
15 then’ of other practices (Nicolini, 2009). In risky situations, the official slack is sufficient and  
16 is used to absorb the flow of patients. In emergency situations, the CCU team generates a  
17 surplus of resources from inside and outside the unit.  
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36 In most situations, the CCU team benefits from its official slack and situational slack to  
37 manage the flow and patient’s condition. However, the slack can sometimes be completely  
38 used up even though the situation has not been fully managed. In such situations (referred to  
39 as ‘crisis situations’ in Table 2), there are risks of failure. The difficulty in overcoming such a  
40 situation and the subsequent tension in the medical unit then reach their climax. The medical  
41 unit tries to bounce back as fast as possible to recover equilibrium between the resources that  
42 are required and those that are available. The only such situation we observed related to the  
43 immediate need for a blood warming<sup>6</sup> device for an urgent and massive transfusion, but the  
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57 <sup>6</sup> Blood that is too cold and requires additional energy from the patient’s body, which – given  
58 its condition – presents a major risk: cardiac arrhythmia, hypothermia.  
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3 device was not ready to use. After the nurse had returned with the blood warmer and started  
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5 to install it, the patient was closely monitored to make sure it was safe.  
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### 8 9 *The dynamics of slack practices*

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11 The slack practices we identified and categorized unfold according to the situation and can be  
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13 connected dynamically and in a processual view to understand how the CCU manages the  
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15 flow of patients whatever the shocks caused by the number of patients and the severity of  
16  
17 cases. Official slack depends largely on negotiations about and defense of the unit. While  
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19 these practices occur at the hospital level following negotiations with the administration, they  
20  
21 largely influence the daily activity of the unit by giving it budgets, positions, space and  
22  
23 access to technical devices. Situational slack is different in that it produces extra resources or  
24  
25 reconfigures existing resources to deal with increasing qualitative or quantitative variability.  
26  
27 This production is added to the official slack absorbed in the unit and used during activity.  
28  
29 Organizational resilience therefore depends on the ability to mobilize excess resources in a  
30  
31 timely manner and according to the situation. An unpredictable situation (and its evolution)  
32  
33 requires almost immediate availability of unused resources – ready-to-use slack. Resilience  
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35 also requires rapidly finding a balance to get out of the crisis zone before organizational  
36  
37 failure takes place. The inability to manage a life-threatening emergency within the time  
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39 constraint is a rare and stressful event for team members. Even if the eventuality of death is  
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41 an integral part of the medical unit, such inability puts patient safety at risk, with potentially  
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43 fatal consequences.  
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50 Our approach to organizational slack led us to distinguish two roles of slack in organizational  
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52 resilience: absorbing shocks and recovering from shocks according to the requirements of the  
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54 situation (Table 4). In risky situations, official slack – available before the situation occurs –  
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56 acts as a buffer absorbing shocks from the activity of the CCU. In emergency situations, the  
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58 team actively produces situational slack and tries to recover from shocks. The analysis of  
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3 slack practices and situations led us to add specific circumstances that occur when a high use  
4 of slack is not counterbalanced by the production of sufficient slack quickly enough. In these  
5 circumstances there is a shortage of resources, which challenges the resilience and generates  
6 a crisis situation. If the medical team recovers from this shortage in due time, the situation  
7 becomes an emergency one, otherwise there is a failure of organizational resilience.  
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17 <Insert Table 4 about here>  
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20 Following our analysis, we propose a dynamic model of slack production and use according  
21 to the situation and its evolution. This model links how resilience is ensured or jeopardized  
22 according to the level of slack (Figure 2). We consider each patient's situation as a trajectory  
23 to investigate how a situation can change suddenly and unexpectedly. Indeed, a situation  
24 cannot be captured entirely by the concept of context, but rather evolves from one context to  
25 another, depending on whether the extreme event is potential or real. Slack practices are  
26 activated to ensure the resilience of the medical unit by producing slack in order to prevent  
27 the event from 'exceed[ing] the organization's capacity' (Hannah et al., 2009: 898). We  
28 therefore analyzed each situation synchronically and diachronically to understand their  
29 characteristics, the corresponding slack practices, and the tipping points explaining the  
30 evolution of a situation. These tipping points unfold through the shift from one management  
31 mode of slack to another (Bouty and Drucker-Godard, 2019; Schakel et al., 2016).  
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47 In risky situations, official slack is available following negotiation with the administrative  
48 staff. Here, the role of the doctors is to negotiate and protect the slack. Tensions can appear in  
49 an unexpected situation or if a situation becomes unstable, resulting in the occurrence of an  
50 extreme event. Then, the medical unit situation shifts to an emergency one in which the  
51 available slack is used if necessary and some practices produce situational slack to maintain  
52 organizational resilience. If all the slack produced is used and there is still a lack of resources  
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3 to deal with the situation, then the unit shifts to a crisis management mode of slack. In this  
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5 specific situation, resilience is challenged, and the unit tries to bounce back to balance the  
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7 available and required resources to manage the situation. The unit gathers more human and  
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9 material resources as quickly as possible from within and outside the unit. If the additional  
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11 slack resources are sufficient to find a new balance, the unit returns to an emergency  
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13 management mode of slack. If there are not enough slack resources, then organizational  
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15 resilience may fail. According to the team, this, fortunately, is rarely observed in the unit due  
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17 to the relatively high level of absorbed slack and the ability of the medical team to produce  
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19 situational slack. As illustrated in Figure 2, the trajectories we described are not necessarily  
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21 linear and the tipping points lead to a shift from one mode of managing slack to another (e.g.  
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23 from risky to emergency or crisis mode). A risky situation can suddenly become a crisis  
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25 situation without going through an intermediate stage. In this case, the team must act  
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27 immediately and is under time pressure to gather the resources needed to deal with it. In the  
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29 figure, the most frequent tipping point is when a situation evolves from being risky to an  
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31 emergency due to a change in the patient's condition or the general situation in the unit. Once  
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33 the patient's condition is brought back under control, the situation becomes risky again.  
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35 However, the reverse relationship also exists. The team may be alerted to deal with a very  
36  
37 serious health condition and produces slack (emergency situation), but the actual condition  
38  
39 may turn out to be a risky situation and the unused situational slack is then disbanded.<sup>7</sup> The  
40  
41 two tipping points that lead to crisis situations are similar. The difference between the two is  
42  
43 the lack of time required to produce situational slack when moving from a risky situation to a  
44  
45 crisis situation. Tipping point 2 was observed only once when a serious situation worsened  
46  
47 due to a lack of resources. Tipping point 3 is indicated for theoretical reasons and because we  
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49 can imagine an unanticipated severe situation where there would be insufficient official slack.  
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59 <sup>7</sup> That is why we have drawn a double-headed arrow in Figure 2.  
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3 If such a situation were to occur, it is unlikely that there would be an immediate return to the  
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5 risky situation mode.  
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10 <Insert Figure 2 about here>  
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## 18 **Discussion**

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20 In this article, we adopted a practice perspective to provide insights on how organizational  
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22 actors manage excess resources (slack) in extreme contexts. Practice theories seek to revisit  
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24 traditional theories or concepts in organization theories or strategy to shed new light on  
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26 traditional phenomena (Feldman and Orlikowski, 2011; Korica et al., 2017; Lounsbury and  
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28 Beckman, 2015; Nicolini, 2009, 2013). By proposing the concept of slack practices and by  
29  
30 studying their dynamics, we hope to contribute to the HRO literature which has provided  
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32 insights into broad structural organizing principles – such as redundancy and loose coupling –  
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34 but to a lesser extent into the micro-level processes that produce reliability and resilience  
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36 (Weick et al., 1999). As Barton and Sutcliffe (2009: 1329) claim, ‘Yet, it is through micro-  
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38 level social processes that the organizational practices that contribute to safety are enacted’.  
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43 Our 14-month ethnographic study in a French CCU enabled us to observe and analyze the  
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45 role and deployment of slack in risky and emergency contexts (Hällgren et al., 2018), where  
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47 reliability is a crucial organizational goal. We focused on slack as an important mechanism of  
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49 organizational resilience, which, although often examined in the HRO literature at the  
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51 structural and organizational levels (Vogus and Sutcliffe, 2007), is understudied at the  
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53 situational level. Of course, the medical unit in our study – like the medical sector in general  
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55 (Carroll and Rudolph, 2006) – also employs other HRO mechanisms and practices to ensure  
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57 reliability. These include deference to and reliance on expertise and competence, importance  
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3 of routines, collective training and permanent learning from experience. We, therefore, do not  
4 suggest that slack is the sole necessary condition for maintaining a reliable production  
5 process. Instead, alongside other reliability mechanisms, we argue that it contributes  
6 importantly to resilience. To conclude, this study offers two main avenues for discussion.  
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13 *Theoretical implications: Slack practices, situations and contexts*  
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16 Our concept of slack practices insists not only on the use of slack resources according to the  
17 development of the situation but also on the production of these resources in action. While  
18 the literature on slack has traditionally downplayed the production side in favor of studying  
19 the organizational effects of *having* slack at the organizational level of analysis, situated  
20 observations encourage reasoning both in terms of stock and flow. According to the evolution  
21 of the situation, individuals not only use the slack they and their organization have produced  
22 ‘out there’ but also produce slack during action. This view of slack as resulting continuously  
23 from a stock and flows contrasts with the view of slack only as a stock in an entity-based  
24 paradigm (e.g. Feldman and Orlikowski, 2011; Hernes, 2008; Lindberg and Rantatalo, 2015).  
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26 In this article, we argue that slack practices depend on the context, as demonstrated in several  
27 studies on coordination that use the practice lens (e.g. Bouty and Drucker-Godard, 2019;  
28 Faraj and Xiao, 2006; Schakel et al., 2016). In a risky context, slack acts as a cushion to  
29 absorb potential shocks, such as the sudden arrival of several critical patients. In an  
30 anticipatory approach to resilience, organizational actors must expect the unexpected,  
31 deploying slack practices ‘out there’ (Nicolini, 2009), i.e. essentially by negotiating with the  
32 hospital’s administration. These negotiations about the excess resources absorbed in the unit  
33 concern staff, the configuration of space or equipment. Although we label this slack as  
34 ‘official’, to differentiate it from situational slack, it requires a high level of regular  
35 involvement in administrative and budgetary negotiations to obtain more resources than are  
36 required by the average level of activity. While this slack may appear as a given, it is only  
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3 obtained through sustained efforts by the medical staff outside the unit. These resources  
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5 constitute a potential stock that is recoverable, and which is deployed according to the  
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7 situation being faced. These slack practices do not depend on specific situations but are  
8  
9 aimed at fulfilling the unit's general mission.  
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12 Our observations show that this negotiated slack is generally sufficient and that the design of  
13  
14 the technological and human systems is adapted to the unit's mission. But, unlike Hällgren et  
15  
16 al. (2018), who tend to reify the context, we argue that these slack practices are constitutive  
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18 of the risky context as they enable the deviations in the activity to be kept under control. It is  
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20 *because* slack has been negotiated out of the flow of patients that the context remains risky  
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22 and does not always switch to an emergency context. By taking a practice perspective, we  
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24 avoid any reification of the context (i.e. risky or emergency *per se*) and consider it in relation  
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26 to the practices involved. From this perspective, and from the point of view of slack practices,  
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28 the context becomes one of emergency when the negotiated slack is found to be temporarily  
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30 insufficient. Indeed, contexts do not represent a stabilized state of the world. As we  
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32 demonstrated through our CCU observations, they can evolve from a risky to an emergency  
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34 context – eventually becoming a crisis situation – when potential disruptions *in the situations*  
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36 take effect, i.e. when the production of slack is overwhelmed by the requirements of the  
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38 situation. This can happen for qualitative or quantitative reasons which create tipping points  
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40 in the situations. Then, new slack practices occur to produce situational slack. We can sum up  
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42 our observations by arguing theoretically that the situation commands the context and,  
43  
44 consequently, that changing contexts are a recurrent and habitual characteristic of the activity  
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46 because situations evolve. These recurrent switches between contexts and situations  
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48 correspond to the complexity of the world (Tsoukas, 2017).  
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57 *Implications for practice: Why New Public Management endangers resilience*  
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3 A second point of discussion relates to the debate in the literature about the form, level and  
4 relationship of slack with performance. For some authors, unabsorbed or available slack  
5 (Bourgeois and Singh, 1983; Singh, 1986) (i.e. not ingrained or incorporated in the  
6 organizational working activities, typically cash and receivables) gives organizations a high  
7 level of discretion and may ultimately ensure adaptability at the organizational level. Due to  
8 the potential discretionary use of these resources (George, 2005), slack can initiate change in  
9 organizations (Zajac et al., 1991), including innovation (Herold et al., 2006; Nohria and  
10 Gulati, 1996, 1997; Singh, 1986; Slappendel, 1996), opportunity exploration (Argilés Bosch  
11 et al., 2016) and risk-taking (Bromiley, 1991; Nohria and Gulati, 1997; Singh, 1986). The  
12 context of our case – and of HROs more generally – is fundamentally different to the context  
13 traditionally studied in the literature on slack (i.e. mostly firms) and demonstrates that the  
14 flexibility attributed to unabsorbed slack does not hold true in extreme contexts. Indeed, the  
15 mission of the unit we observed is to save lives and requires reliability to be ensured in  
16 rapidly changing contexts. As we have seen, what partly guarantees this reliability is the  
17 absorbed slack, i.e. the resources absorbed in the daily practices of the professionals or the  
18 design of the organizational system (Bourgeois and Singh, 1983). But this slack generates, in  
19 parallel, excess costs. This means that the unit ensures the achievement of its mission by not  
20 being entirely concerned with efficiency. This raises the issue of the levels of slack in the  
21 context of French hospitals and many public sectors around the world.

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47 Because of its high discretionary dimension, slack can have ambivalent organizational  
48 effects. While some of the organizational literature considers slack to have positive effects,  
49 from an agency theory perspective it also gives organizations and individuals latitude to relax  
50 controls and to pursue risky projects with uncertain outcomes (George, 2005; March and  
51 Shapira, 1987; Nohria and Gulati, 1996; Williamson, 1963). This conception corresponds to  
52 the ‘contractualist’ view promoted by New Public Management (NPM) in the public sector  
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3 and its basic focus on efficiency (Lane, 2002). NPM puts greater emphasis on parsimony in  
4 the use of resources and encourages finding cheaper ways to deliver public services, doing  
5 more with less, and making standards of performance more explicit and measurable (e.g.  
6 Hood, 1995; Hood and Jackson, 1991). NPM and its efficiency logic raises serious issues for  
7 the public sector as it introduces and brings to the fore economic criteria in organizations  
8 whose performance criteria are not economic (Hollnagel et al., 2009). For example, a group  
9 of French military experts recently pointed out that ‘economic concern with defense, let’s say  
10 efficiency, is a recent idea. This idea contrasts with military concepts such as “available  
11 reserves”, “redundancy” and “higher-powered force”, which are necessary for operational  
12 efficacy and what is today called resilience (...)’ (La Tribune, 27/04/2020).<sup>8</sup> The potential  
13 deleterious or counterproductive effects of NPM, especially in hospitals have been  
14 highlighted by several studies (Simonet, 2014). The principles of NPM may contradict the  
15 ethos of public agents dedicated to the public good – such as health – demotivate them and  
16 reduce their commitment (Williams et al., 2012). The managerialism that accompanies NPM  
17 may lead to worry, anxiety and distress among employees (Chandler et al., 2002), and some  
18 reforms may lead to exactly the opposite of the intended outcomes, such as the ‘queue  
19 billion’ in Sweden, which induced bad practices (Hansson, 2014). While HROs must  
20 emphasize reliability over efficiency (Casler, 2014; Hood and Jackson, 1991; La Porte and  
21 Consolini, 1991; Roberts et al., 2004), the NPM focus on cost efficiency tends to suppress  
22 slack. As Karlene H. Roberts concludes, ‘when organizations are under scrutiny for cost  
23 control often the first two things to go are slack (which allows for redundancy) and training.  
24 Both contribute to reliability enhancement’ (Bourrier, 2005: 95).

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<sup>8</sup> Not to mention the recent Covid-19 pandemic which has illustrated perfectly how efficiency  
in the management of stock and supplies can reduce the reliability of the health system in  
many countries.

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3 In the general context of the diffusion of NPM across most OECD countries since the 1980s,  
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5 slack practices can help to protect the values and ethos of health staff by reliably maintaining  
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7 the core activity despite fluctuations. However, slack practices and their positive impacts rest  
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9 on what is largely invisible activity. This invisibility is first due to the situational processes of  
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11 production and use, which are not reported to hospital management. Second, as we  
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13 underlined above, some of the slack is disbanded after it has been used – without reporting –  
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15 which contributes to the invisibility of these practices. While NPM demands accountability  
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17 and standardization, some of the real work is informal and does not correspond to these  
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19 requirements. We believe that the invisibility of the practices that make an important  
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21 contribution to the core activity may lead to the administrative and political representatives  
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23 being blind to the daily efforts made by individuals. Stretching the daily workload cannot be  
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25 infinite, as exemplified by the 2016 French General Commission of Social Affairs' Report,  
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27 which alarmingly estimated that 45% of French interns displayed burnout symptoms that  
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29 eventually led to depression or suicide (Desailly-Chanson et al., 2016).  
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35 With regard to the partial invisibility of the situated work, using a practice lens helps to avoid  
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37 looking at NPM from an exclusively structurally oriented point of view that ignores the 'work  
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39 on the shop floor' (Almklov and Antonsen, 2014). As Almklov and Antonsen (2014)  
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41 theorized, the NPM view of work contrasts with a more realistic and operational view, which  
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43 may explain why it can lead to disaster (Hood and Jackson, 1991). Whereas NPM promotes  
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45 visible output, measurable performance, the fragmentation of work into specific tasks or  
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47 management of repetitive and expected tasks, the practice perspective and an operational  
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49 view of core work processes focus on invisible outcomes, management of the unexpected,  
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51 continuous operations and reliability. We could add that NPM tends to focus on average  
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53 levels of organizational systems, whereas reliability requires being prepared for a high degree  
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55 of variability. These two contrasting views of work explain why slack practices may be in  
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3 danger in an institutional context that promotes NPM and where these practices are vital for  
4 ensuring the mission of a public organization in which reliability is the main criterion for  
5 saving lives. In this context, protecting and negotiating slack depends on the ability of actors  
6 to justify what may appear to be wasted and unproductive resources and non-visible  
7 processes (Casler, 2014: 240).  
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12 The role of strong leadership at the head of such organizations and the 'coalition-forming  
13 activities' in an organization (Bourgeois and Singh, 1983) therefore appear to be crucial for  
14 decoupling – at least partially – the tendency towards managerialism and the 'real' work  
15 activity (Doolin, 2001). Although we have not explored these specific issues, it could be  
16 important to study more deeply how actors negotiate slack within the hospital as well as  
17 outside the hospital because the hospital's administrative hierarchy is itself under the NPM  
18 rules of administrative supervision. In this general context, various power relationships  
19 constitute an alternative hypothesis for obtaining more slack resources. As Cyert and March  
20 (1963) asserted, slack is distributed differentially within organizations, suggesting that some  
21 actors may obtain a greater share of the slack than others according to their power.  
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## Biographies

Geoffrey Leuridan is Assistant Professor of Management and Strategy at IMT Atlantique, France. He is a member of the RESOH (Research in Human and Organizational Safety) Chair. His research focuses on organizational resilience in extreme contexts and human & organizational factors of industrial safety. [Email: geoffrey.leuridan@imt-atlantique.fr]

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**Table 1 – The dynamic observation strategy of the CCU**

Observation tactic	Observation position	Length	Objectives	Occurrences (approximate)
Systematic	<b>Fixed</b> (e.g. Trauma Room)	<b>Long</b> (day shift; 24h shift)	Observing the daily activities and the regularities in the organization	<b>90–100</b>
Random	<b>Fixed</b> (e.g. transferring a patient)	<b>Short</b> (10–30 minutes)	Providing detailed data about sequences of activities	<b>500–600</b>
Planned	<b>Mobile</b> (e.g. following an intern)	<b>Long</b> (0.5–1 day shift)	Shadowing (Czarniawska, 2004): understanding subjective interpretations of situations and the tasks performed by actors	<b>50–60</b>
Opportunist	<b>Mobile</b> (e.g. cardiac arrest management)	<b>Variable</b> (depending on the situation occurring)	Grasping unforeseen problems and its management by the actors	<b>120–130</b>

**Table 2 – Type and number of situations studied**

Extreme context	Type of situation	Frequency	Empirical examples	Origins of slack
Risky	Risky	80	- Scooter accident with tibia + wrist fractures - Fall down stairs, hip fracture, respiratory disorder - Pedestrian knocked over by a car, loss of consciousness	- Out of the situation
Emergency	Emergency	11	- Two children simultaneously hit by a car - Fall from 2 <sup>nd</sup> -floor reception onto concrete floor, cardiorespiratory arrest during transportation - Motorcycle crash, high velocity with cranial trauma and serious thorax injuries	- Out of the situation - Situational
	Crisis	1	- Cannot do a quick blood transfusion	- Out of the situation - Situational ( <i>Shortage</i> )

**Table 3 – Slack practices according to the type of situations**

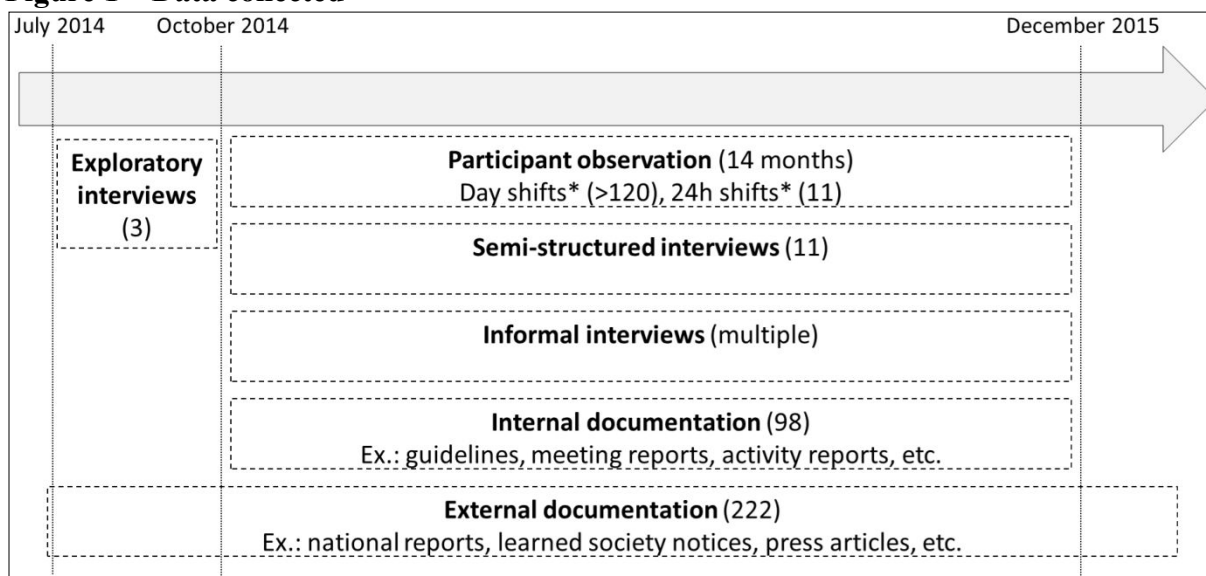
	<b>In the unit</b>	<b>Outside the unit</b>
<b>Risky situation</b>	<p><b>Queuing system</b> Managing flow/stock of patients to make room vacant ASAP</p> <p><b>Use of official slack</b></p> <p><b>Reconstituting official slack</b> Free bed in the TR or free room in the ICU</p>	<p><b>Human and material resources</b> Negotiating excess resources (annual budgetary meetings with the administration)</p> <p>Protecting excess resources (periodic performance committees)</p> <p><b>Spatial resources</b> Participating in the spatial layout design of the medical unit</p>
<b>Emergency situation</b>	<p><b>Human and material resources</b> Mobilizing colleagues (nurses, doctors) in the unit Repurposing existing material resources (5th slot)</p> <p><b>Spatial resources</b> Repurposing existing spatial resources (PORR slot becomes a 'Light Trauma Room slot')</p> <p><b>Queuing system</b> Accelerating turnover to free up TR slots</p> <p><b>Use of situational slack</b> <b>Disbanding situational slack</b> Resources to create a 5th TR slot return to their nominal use Nurse or doctor returns to original position Light Trauma Room slot in the PORR returns to a standard PORR slot</p>	<p><b>Human and material resources</b> Using interpersonal network to call colleagues (phone-a-friend, WhatsApp)</p> <p><b>Queuing system</b> Negotiating to accelerate patient transfers elsewhere</p>

**Table 4 – Role of slack in organizational resilience**

<b>Type of situation</b>	<b>Production and use of slack</b>	<b>Role of slack in organizational resilience</b>	<b>Origins of slack</b>	<b>#Situations analyzed</b>
Risky	$So \geq Sr$	Absorbing	Out of the situation	80
Emergency	$So + Ss \geq Sr$	Recovering	Out of the situation Situational	11
Crisis	$So + Ss < Sr$ ( <i>resource shortage</i> )	Recovering	Out of the situation Situational	1

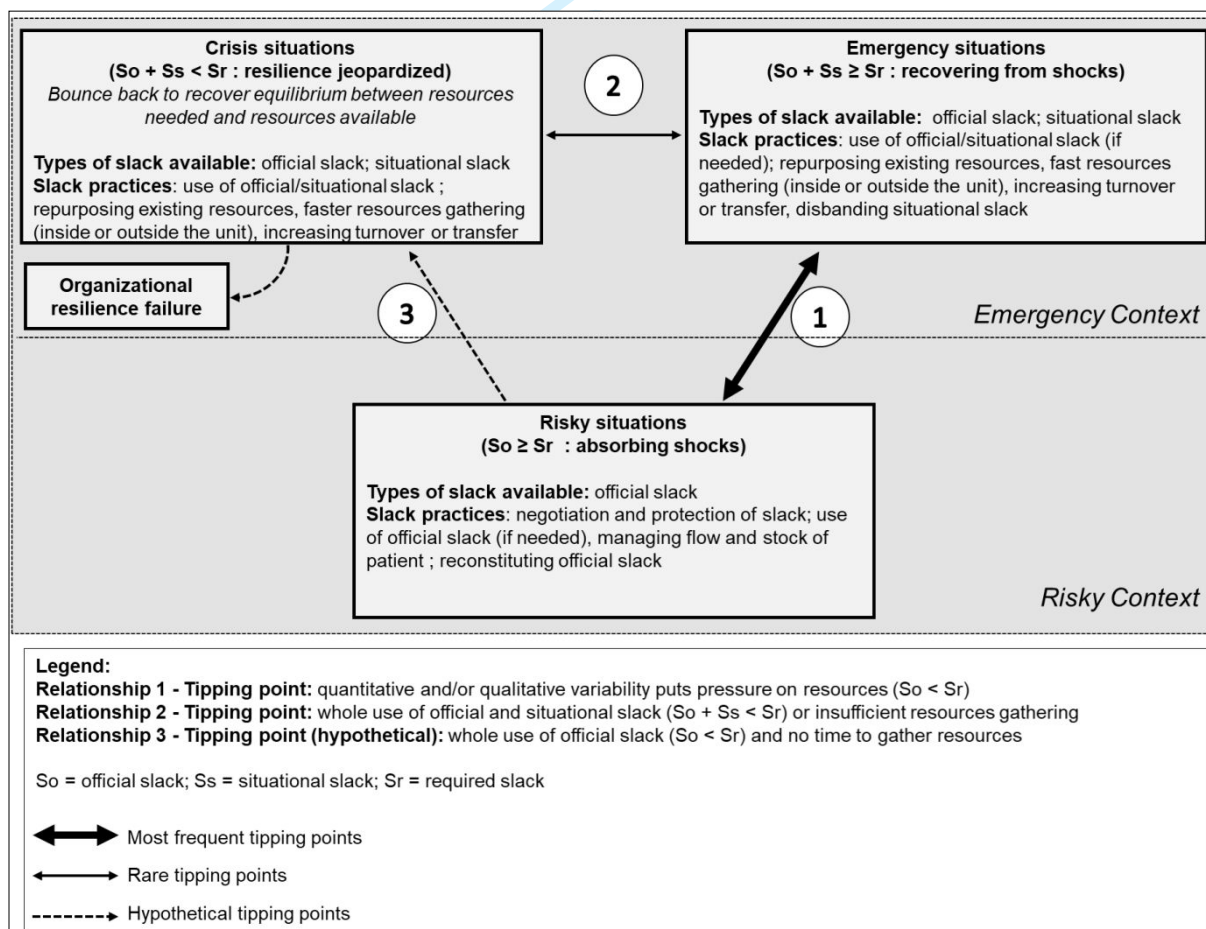
Legend: So: official slack; Ss: situational slack; Sr: required slack

**Figure 1 – Data collected**



\*A day shift refers to being in the CCU from 7:30 am to 5:30 pm; a 24h shift refers to being in the CCU for 24 hours.

**Figure 2 – Dynamics of production and use of slack according to the situation**





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