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Collectifs sociaux : une forme partielle d'organisation favorable à l'innovation sociale

Colectivos sociales: Una forma parcial de organización que apoya la innovación social

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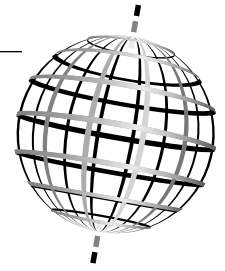
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Résumé de l'article

Nous mobilisons la littérature sur l'Organisation et les Pratiques pour analyser les mécanismes permettant à un Collectif social d'introduire une innovation en santé. Le cas montre comment ce Collectif acquiert des caractéristiques d'une Organisation Partielle par : 1) la résolution d'incidents critique; 2) un programme d'action qui transcende la participation des acteurs; 3) des pratiques complémentaires d'inclusion et d'exclusion de membres pour développer l'identité collective et la masse critique; 4) des pratiques de réification pour être reconnu Acteur; 5) un secrétariat qui théorise l'innovation et développe une relation étroite avec un acteur extérieur en raison de son expertise et de ses ressources.

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Collectifs sociaux : Une forme partielle d'organisation favorable à l'innovation sociale

Colectivos sociales: Una forma parcial de organización que apoya la innovación social

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ABSTRACT

We mobilize the organizational and practice-based literature to determine the mechanisms enabling a social collective to introduce innovation in public rescue. The case highlights how this collective acquired characteristics of a partial organization by: (1) emergent characteristics reacting to critical incidents, (2) an overarching agenda supporting actors participation, (3) complementarity of exclusion and inclusion membership practices to enforce collective identity and reach a critical mass, (4) recognition of collective actorhood through reification practices, (5) the role of a secretariat through theorizing and developing close but discrete relationships with an external actor with critical expertise and resources.

Keywords: Social collective, social innovation, partial organization, organizational, participation, reification

RÉSUMÉ

Nous mobilisons la littérature sur l'Organisation et les Pratiques pour analyser les mécanismes permettant à un Collectif social d'introduire une innovation en santé. Le cas montre comment ce Collectif acquiert des caractéristiques d'une Organisation Partielle par : 1) la résolution d'incidents critique; 2) un programme d'action qui transcende la participation des acteurs; 3) des pratiques complémentaires d'inclusion et d'exclusion de membres pour développer l'identité collective et la masse critique; 4) des pratiques de réification pour être reconnu Acteur; 5) un secrétariat qui théorise l'innovation et développe une relation étroite avec un acteur extérieur en raison de son expertise et de ses ressources.

Mots-Clés : Collectif social, innovation sociale, organisation partielle, organisationnalité, participation, réification

RESUMEN

Mobilizamos la literatura sobre la Organización y las Prácticas para analizar los mecanismos que permiten a un Colectivo social introducir una innovación en la esfera de la salud. Este caso muestra como este colectivo puede adquirir las características de una organización parcial para: 1) La resolución de incidentes críticos, 2) un programa de acciones que trascenda la participación de actores, 3) prácticas complementarias de inclusión y de exclusión de miembros para desarrollar la identidad colectiva y la masa crítica, 4) prácticas de reificación para que sea reconocida como actor, 5) un secretariado para teorizar la innovación y desarrollar una relación estrecha con un actor exterior debido a su pericia y a sus recursos.

Palabras Clave: Colectivo social, innovación social, organización parcial, organizacionalidad, participación, reificación

In a context marked by social and technological changes as well as uncertainty, social innovation is becoming a central issue for public and private actors looking for new development opportunities. Such innovation increasingly occurs through the joint efforts of a wide community of actors with varied competencies and expertise who cooperate in a dense network of collaboration (Cohendet *et al.*, 2008) to favor a greater common good through renewed social practices (Klaus & Hees, 2010). Such cooperation in heterogeneously creative communities is deemed to improve the success of innovation and especially the fit with users' needs (Håkansson & Waluszewski, 2007). Innovation then relies on the capacity to integrate the varied expertise and resources of actors who do not pursue the same goals and belong to different entities. Hence, coordination beyond organizational boundaries becomes a salient issue (Cohendet *et al.*, 2008).

In this context, the development of communities has raised increasing interest in industry and the academy as alternative modes of knowledge development and exchange within and across organizations (Amin & Cohendet, 2004). The literature on the practice-based perspective of knowledge focuses on such communities, described as autonomous groups founded on the voluntary membership of their agents based on shared values, norms, common cognitive interests, or common practice (Wenger, 1998; Cohendet *et al.*, 2006). Among the various forms of communities, Paraponaris and Rohr (2015) recently highlight the specific role played by social collectives (Cohendet *et al.*, 2006, 2008) to defend a common cause of social progress. A social collective is defined as a "truly communitarian form of a community" (Simon, 2009, p. 41), which emphasizes altruism, public action, and the adoption of innovative practices by the

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largest number to transform society. Because of their cause and values, collectives seem well positioned to support social innovation, but they face the challenges of being recognized and legitimized by civil society. Their rather informal character as well as the heterogeneity of their members raise questions about their organizationality (Dobusch & Schoeneborn, 2015) and their capacity to use the traditional managerial mechanisms of organizations (hierarchical control) to enforce social change. Granjou and Peerbaye (2011) stress that collectives are uncertain, temporary and unstable associations of elements that require a relentless effort to emerge and sustain over time. The functioning patterns used by collectives to introduce social innovation as well as the processes generating their emergence are, however, under-researched (Paraponaris & Rohr, 2015). As pointed out by Simon (2009, p. 49): “*it is important to more carefully document how [...] collectives are being constituted and to better understand their functioning patterns.*” This article intends to fill this research gap by analyzing how a social collective emerges and sets its organizational mechanisms to serve its social cause. It focuses on the following research questions: “What are the functioning patterns adopted by social collectives to successfully introduce social innovation? How do they emerge?”

To answer these questions, we developed a conceptual framework derived from the practice-based theory of knowledge and from the literature on partial forms of organizing. The latter stream of literature enables us to understand in what respect a social collective can be considered a (partial) organization by defining the key constituting elements of “organizationality” (Ahrne & Brunsson, 2011; Dobusch & Schoeneborn, 2015). This literature adds to the notions of common goals, shared identity and collective membership already highlighted by practice-based theory of knowledge, the concepts of collective actorhood, and interconnected decision-making, which come across as central to enforce the capacity of collective members to enforce change for society. After having presented this literature as well as our conceptual and methodological framework, this article describes the emergence and characteristics of a collective that succeeded in promoting the adoption of care practices in the field of cardiac arrest in southwest France in a context dominated by cure practices. The analysis reviews the progressive development of the founding principles and organizational design of the collective in reaction to various critical incidents. The paper highlights key insights to existing literature.

Theoretical Background

This section reviews the main constructs informing the functioning practices and managerial levers developed by communities and social collectives. It first covers the insights drawn from the practice-based perspective of knowledge highlighting the characteristics of collectives and the practices used by their members to manage cooperation dynamics. It then reviews the managerial levers and organizational design of social collectives drawn from this perspective and from the literature on partial forms of organizing.

SOCIAL COLLECTIVES AS COMMUNITIES SUPPORTING SOCIAL INNOVATION

The practice-based theory of knowledge considers innovation and learning as a social activity, that is, the output of interaction between members forming a community (Brown & Duguid, 1991; Lave, 1988; Wenger, 1998). In this vision, each community member learns by practicing and exchanging with others. Learning is therefore situated in its social context (Lave, 1988) and seen as a collective process requiring exchange and practice (Wenger, 1998). The properties of such communities emphasize their social dimension: the voluntary commitment to construction, exchange, and sharing of a repertoire of common cognitive resources; a common identity built on practice and repeated exchange; the respect of specific social norms (Cohendet *et al.*, 2008). Communities are generally described as rather informal, self-emerging groups, making them difficult to delineate (Bootz & Lievre, 2015), and mostly relying on self-organizing mechanisms that contrast with functional hierarchies (Paraponaris & Rohr, 2015). As specific forms of communities, social collectives exhibit similar structural characteristics but differ in their main goal. Whereas members of communities cooperate to acquire expertise, members of collectives collaborate because they share specific values reflecting the dynamics of civil society (Paraponaris & Rohr, 2015). Collectives emphasize public action and the adoption of innovative practices by the largest number to transform society, promoting “*a society opened to new values, broader interests and open access to knowledge*” (Paraponaris *et al.*, 2013, p. 10). To gather expertise and innovate, collectives rely on two complementary processes:

- *Participation.* Membership to a collective implies the commitment to engage in and contribute to its practice through joint activities (Wenger, 1998). The active participation of members to this “joint enterprise” enables them to constantly update ideas (Simon, 2009), sustain the common cause, and create a sense of shared identity.
- *Reification.* Collective members shape their experience and materialize their practice in a shared repertoire of resources consisting of objects, tools, artifacts, stories, and ways of addressing recurring problems (Wenger, 1998). The products of reification act as “boundary objects” because they cross boundaries of different communities and enter different practices.

Initially focused on communities made of individuals, the practice-based perspective progressively extended its focus to communities existing within organizations, such as communities of practice, craft task, epistemic-creative, and virtual communities (Amin & Roberts, 2008). Organization is then seen as a bundle of communities (Cohendet & Diani, 2003; Brown & Duguid, 1991). This literature considers that communities are self-organized; however, recent contributions highlight hybrid management mechanisms mixing self-organization and “control” (Agterberg *et al.*, 2010; Bootz & Lievre, 2015) and suggests the progressive development of a collective organization by community members. These contributions, however, are focused on internal communities existing within the same organization. The practice-based literature still fails at providing a precise understanding of the functioning modes and management mechanisms of inter-organizational forms of communities and collectives.

THE ORGANIZATIONAL DESIGN OF SOCIAL COLLECTIVES

As early as 1986, Perrow suggested in his famous book *Complex Organizations* that we live in a society of organizations whose characteristics challenge traditional organizational mechanisms based on hierarchy and formal inclusion. Other literature has addressed the various forms of organizations from different perspectives: meta-organizations (Ahrne & Brunsson, 2011), fluid social collectives (Dobusch & Schoeneborn, 2015), and boundaryless organizations (Ashkenas *et al.*, 2002). Based on Ahrne and Brunsson (2011), we refer in this article to partial organizations to describe organizations that exhibit only part of the characteristics of formal organizations such as less formal membership, more informal processes of decision-making as well as more complex forms of organizing. We review two recent contributions focusing on these characteristics. We first refer to the works of King *et al.* (2010), highlighting external attribution and intentionality as the two fundamental qualities of any organized form, and second to the work of Dobusch and Schoeneborn (2015) on the organizationality of social collectives considered as “*the degree to which a social collective displays the three characteristics of an organization: (1) interconnected instances of decision making, (2) organizational actorhood (external attribution) and (3) identity*” (Ibid., p. 1008).

Intentionality. This constitutes a distinctive quality of organizations. As stated by King *et al.* (2010, p. 3), “*organizations are usefully understood as social actors capable of behaving in a purposeful and intentional manner.*” Intentionality posits that the actions of an organization are driven by *goals and intentions* that guide the decision making and behavior of its members. In the case of collectives, these intentions correspond to the defense of a common cause for social progress (Paraponaris *et al.*, 2013). Despite their heterogeneity, the members of social collectives share common system-level goals (King *et al.*, 2010; Gulati *et al.*, 2012) derived from their common cause. Their collective action aims at influencing outside the boundaries of their own organization.

Collective identity and membership. The notion of identity is central to the community literature (Cohendet *et al.*, 2008) and to the literature on organizationality (Dobusch & Schoeneborn, 2015). For Schreyögg and Sydow (2010), any kind of organization, from the most stable to the most incomplete, requires some forms of identity and boundary that legitimize its existence, distinguish it from others, and bind it together. Identity describes the essence of an organization and gives its internal and external stakeholders a reference point for what it is or does and what it is not. By demarcating its boundaries, it provides a basis for members’ identification with the collective. Identity creates expectations about appropriate behavior (King *et al.*, 2010) and influences its membership by shaping whom it is attracting and whom it is selecting (criteria for membership). For Gulati *et al.* (2012), boundary issues include questions related to who chooses members and criteria for membership. King *et al.* (2010) highlight that the identity of a collective derives from its members’ common practice and repeated exchange, whereas organizations play a more active role in shaping their identity: “*organizations imprint their identities on members*” (Ibid., p. 298). Dobusch and Schoeneborn (2015) demonstrate the importance of practices of exclusive membership negotiation to effectively communicate their organizationality of a collective and demarcate its boundary. For

them, the identity of a collective relies on identity claims made by some actors and the attribution of these claims (or not) to the collective. By contesting the membership of an actor, the collective communicates that such claims are not made on their behalf.

External attribution (organizational actorhood). A social group acquires the status of an organization through a process of external attribution whereby other actors recognize it as a social actor, that is, as capable of acting. According to King *et al.* (2010), external attribution constitutes the second distinctive quality of an organization and posits that it is society that grants an organization its status of social actor through holding it accountable for its actions. For Dobusch and Schoeneborn (2015), social collectives manage to reinstate organizational actorhood, through communicative processes combining attribution and appropriation in which a “*certain practice is executed on behalf of, or at least attributed to, the organization*” (Ibid, p. 1012). For these authors, these processes rely on the preparation and performance of identity claims defined as speech acts that address what an organization is or does.

Inter-connected decision making. Decision making is a pivotal function of the organization (King *et al.*, 2010; Dobusch & Schoeneborn, 2015) that attempts to create a specific order that differs from established institutions or networks. Hence, organizations are viewed as “*the result of intervention of individuals or organizations which can and do make decisions not only about their own, but also about the behavior and distinction of others*” (Ahrne & Brunsson, 2011, p. 90). The goals of the organization drive its decision-making process and shape important decisions in terms of membership, hierarchical structure, or control over its members (Ahrne & Brunsson, 2011). However, the sovereignty of the organization (King *et al.*, 2010), that is, its control over members, can be difficult to exert in the absence of formal authority arising from contractual relationships, such as in the case of informal collectives. Sources of authority then rely more on expertise, reputation, gate-keeping privileges, or control over key resources (Gulati *et al.*, 2012).

The previous section highlights that the literature on organization studies has only recently addressed new forms of organizing such as social collectives. More research is needed to identify the reasons driving social collectives to become organizations and to choose a higher or lesser degree of organization (Ahrne & Brunsson, 2011). Moreover, the insightful conclusions provided by Dobusch and Schoeneborn (2015) are empirically grounded in the analysis of a social collective made of individuals. We therefore lack empirical work analyzing the way inter-organizational collectives instate organizationality.

Method

CASE SELECTION AND DESCRIPTION

The case describes how a social collective emerged to support the diffusion of social innovation linked to the adoption of care practices in the field of cardiac arrest in a rural region of southwest France. This social collective aimed to promote new practices to increase survival rates with lay citizen use of AEDs (automated external defibrillators). To defend their cause, the collective developed an innovating activity consisting of simultaneously installing AEDs and organizing local information events. The

novelty consisted of connecting an existing product (AEDs) with the new domain of civil society use (Mokyr, 2000). Its implementation involved a set of heterogeneous actors coming from the public and private arenas (mayors, firefighters, financial sponsors, product providers). This collective represents an exemplary case (Yin, 2003) because it involves a social cause challenging the dominant “cure” practices of institutions (mayors, doctors, paramedics) of calling rescue brigades and sending victims to hospitals. The case questions the main belief that installing rescue equipment (AEDs) is sufficient to generate effective use by lay citizens and illustrates the need to integrate the context of its use (Håkansson & Waluszewski, 2007). The emergence of this social collective enabled to design a supportive context encouraging care versus cure. Over a limited time frame (13 months), the collective effectively supported the use of AEDs by lay citizens thanks to various practices toward local stakeholders.

METHODOLOGICAL APPROACH: A PRACTICE-BASED INQUIRY

We conducted a practice-based inquiry to analyze how the characteristics of this collective supported the successful introduction of social innovation (Orlikowski, 1996). In this approach, social innovations are enacted by the actions of organizational members, who improvise adjustments (tacit or more explicit) in practices to cope with the local situations and contingencies they are facing or with the “*unintended consequences they encounter*” (Orlikowski, 1996, p. 4). Consecutively, we first reviewed the emergence of the social collective studied and its progressive development as a specific form of organization (criteria of organizationality). Second, we recorded the practices developed by its members to achieve social transformation and cope with critical incidents (Burns *et al.*, 2000).

Data collection: A critical incident technique

We used a qualitative, case-study strategy (Yin, 2003) to organize our data collection in consideration of the exploratory nature of our research objective and the importance of grounding our analysis in a thick description of the practices developed by the actors. We mobilized complementary methods to collect data. We began by analyzing secondary sources (documents, press articles, websites of key players, research articles on AEDs, legal texts) to increase our familiarity with the field and its actors. Next, we conducted semi-structured interviews with key players: MA (mayors association), SDIS (fire and emergency rescue brigade), mayors, managers of local institutions, TRAIN (training association of firefighters), and Laerdal (product supplier). These interviews enabled us to complement our secondary database with documents provided by interviewees (letters sent by MA to mayors, memos, press releases, and calls for tenders). In the 15 interviews conducted with 12 different actors, we adopted a retrospective approach to reconstruct the emergence and evolution of the innovation during the 2008–2010 period. We also observed some users during two different AED information sessions and interviewed them to collect their opinions about the event. We recorded and transcribed all primary data.

Among our research results, we identified the relevance of mobilizing a critical-incident technique (Roos, 2002) to structure our analysis, because it is particularly useful in situations involving innovation (Nissen *et al.*, 2014). This technique enables us to highlight key episodes of decision making and to identify “*a significant or critical behavior or factor that contributes to the success or failure of some human event*” (Burns *et al.*, 2000, p. 179). In our case, we identified seven episodes, including five critical incidents referred to CI thereafter (Figure 1), and analyzed the practices of collective members to cope with them. In line with our conceptual framework, each episode marks a significant

FIGURE 1
Time line of key episodes and critical incidents

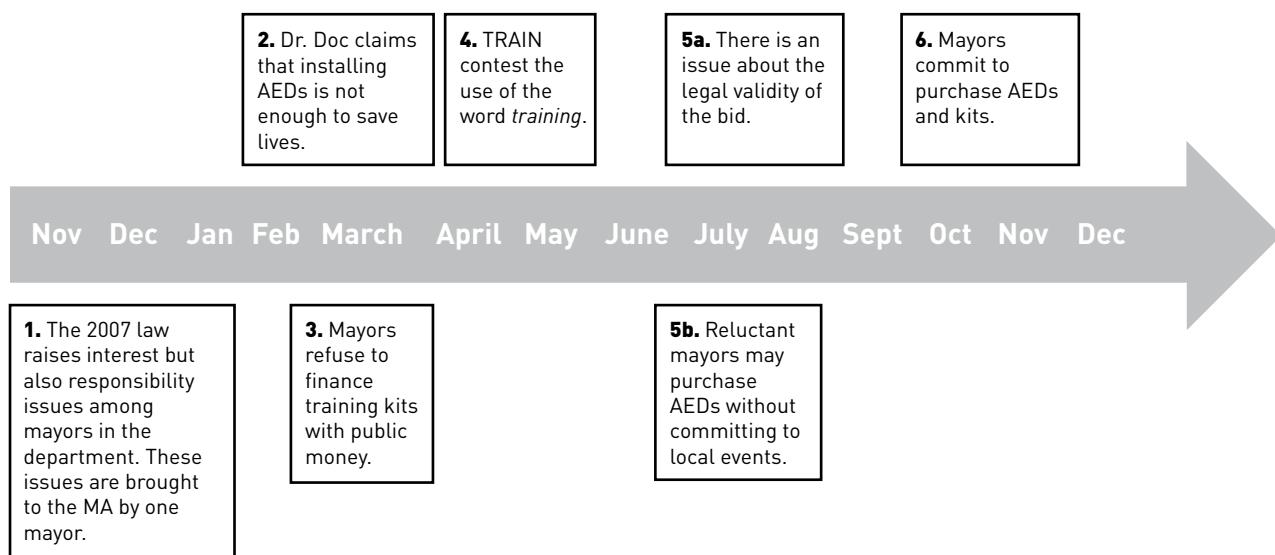


TABLE 1
Analytical grid

Common goals	Practices developed by the collective to set a common vision, goals, or intentions that are specific to the collective and are partially independent from the individual goals of its members
Interconnected decision making	Practices and mechanisms developed by collective members to make decisions on behalf of the collective: <ul style="list-style-type: none"> – Nature and identity of decision makers – Sources of authority of decision makers (expertise, reputation, status, gatekeeping privileges, control over key resources)
Identity claims membership	Speech acts (talks, conversations, texts) that define the collective as a specific group Criteria and decision process for integrating members: <ul style="list-style-type: none"> – Who chooses members – Criteria for membership – Attributes of members: internal resources, network resources
Collective actorhood	Practices developed to obtain external attribution from the collective main stakeholders and primary audience (to legitimize their action)
Boundary practices	Collective practices developed to cooperate with internal and external actors to defend the cause and connect AEDs with end users Participation – The engagement of the collective members in the activities required to defend their cause; the capacity of some members to develop cooperative relationships with external actors to promote their cause, based on their legitimacy Reification – The shared repertoire of resources (objects, tools, artifacts, stories, or ways of addressing recurring problems) that materialize and represent the common practice of collective members

evolution in the emergence of the collective, its shaping into an organizational form, and the successful enactment of its cause.

Data analysis: Analytical framework

We articulated our analytical framework using the main constructs defined in the literature review (see Table 1).

Because of our focus on practices and changes, we used qualitative techniques to analyze data (Miles & Huberman, 1994; Eisenhardt, 1989) and followed Langley's (1999) recommendations by taking multiple approaches to the analysis. We elaborated the chronology of the case by identifying the main critical incidents, phases, and actors involved in each phase and synthesized the interpretation that actors gave to events and behaviors, leading to the development of a thick description (Balogun & Johnson, 2004). This narrative reflected primary and secondary data to enhance the level of validity (Eisenhardt, 1989). We validated the narrative and our interpretations with three key informants.

CASE STUDY: EMERGENCE AND STRUCTURING OF THE SOCIAL COLLECTIVE

1. November-January: The 2007 law raises responsibility issues among local mayors (CI1)

AEDs enable the restoration of a normal heartbeat by applying a brief electric shock to victims of cardiac arrest. In 2007, French law authorized any citizen to use such a device (which was previously restricted to doctors and paramedics). Several countries adopted similar practices over the last 20 years with a significant impact on survival rates.

Informed of this law, the mayor of a small city in southwest France considered buying and installing some AEDs in his area. Worried about the efficiency of such equipment and his responsibility in case of victim death, he brought the subject to a meeting of the Mayors Association – MA – a not-for-profit association

including all 331 mayors of the region. Most mayors reacted in favor of the project because of the aging population and its “medical desertification” (80% of communities are remote from rescue facilities). However, the mayors voiced several questions and requested more information (efficiency, easiness and safety of use by lay citizens) from medical experts before purchasing the devices: “*They were very preoccupied by this problem of responsibility as today, when something goes wrong, the mayor is always the one in charge!*” (Mr. Mayor, President of MA). Mr. Mayor then contacted Dr. Doc, the chief doctor from the local fire and rescue brigade (SDIS) and considered to be a reference person in terms of public safety; he has 30 years of medical practice, has a recognized dedication to public safety, and is experienced in training and holds a senior position in SDIS. Dr. Doc rapidly accepted providing support to the MA because he felt personally concerned by the cause. He first contacted the French Federation of Cardiology – FFC – to frame a formal presentation related to AEDs and their use based on scientific data. The FFC provided a leaflet detailing the number of cardiac arrest victims in France (60,000), the ability of AEDs to decrease early deaths, and the importance of training people to their use. “*Being trained to life-saving practices is a citizen act ... Each French person should be initiated to first rescue practices, in the same way as we learn to write or to drive*”. This leaflet resonated with Dr. Doc's conviction drawn from scientific publications and his recent discussions with Laerdal's sales manager, Mr. Sales (historical supplier of training manikins). Mr. Sales presented their “MiniAnne kit,” developed to reduce the fear of citizens in using AEDs: a self-training solution informing citizens how to practice CPR (cardio-pulmonary resuscitation) and provide AED assistance. The MiniAnne kit looked a bit like a toy box (see Figure 2): it came in a colorful pack including a 30-minute instructional DVD, an inflatable manikin, a fake phone, paper sensors, and a fake AED screen.

FIGURE 2
The MiniAnne kit



Dr. Doc was convinced of the efficiency of this user-friendly device for the MA's project because it is *"practical and not theoretical. We don't want people to understand but to act. As firefighters, we do not teach theoretical knowledge but a methodology to reproduce practices."*

2. February–March: Dr. Doc claims that AED installation is insufficient (CI2)

Dr. Doc convinced Mr. Mayor to present the project of combining "AED installation and training" to mayors during the next MA meeting. He accepted because he considered Dr. Doc to be *"a man skilled in the art"* but set one condition: Laerdal should not be involved to avoid risks of confusion between private and public interests. Because of his knowledge of the political convictions of local mayors, he was concerned that the presence of a private firm, belonging to a foreign multinational, would generate useless criticisms. Dr. Doc and Mr. Mayor carefully orchestrated their speech to mayors about the presence of firefighters in the sessions to be reassuring for the local population. First, they made a key analogy to convey their message: *"We should avoid repeating the same mistake as with fire extinguishers. There is fire, and no one knows how to use them!"* Second, they stressed the lay positioning and benevolent side of this "community" project: *"I prepared a slide show where there was a grandpa who was staying on his knees, close to a small, 5-year-old girl with her mum who was putting the electrodes on her teddy bear"* (Dr. Doc). Dr. Doc also circulated the leaflet of the FFC in the assembly. This idea of training made sense to the mayors, who saw the benefit of reinforcing proximity to their citizens: *"What made the project so special is that beyond access to equipment, it also gave a little social value. The idea of training has been a trigger and enabled [us] to legitimize the operation ..."* (one mayor). Soon after, Mr. Mayor sent a letter to all mayors to confirm this "collective initiative" and asked them to get in touch with SDIS to obtain free advice on the number of pieces of equipment and their choice of location for installation.

3. March–June: Mayors refuse to finance training kits (CI3)

Although most mayors replied that they agreed to purchase AEDs, many declared reluctance to purchase training kits. Based on the sample kits supplied by Laerdal, they claimed that the kits were too expensive for a simple "30-minute DVD" (40€ each) and not as useful as AEDs. Some of them refused to *"enrich a private firm with public money"* claiming that private manufacturers have a commercial interest in freely distributing the kits to each citizen at the end of the training events: *"Of course, because the more persons trained, the more kits they can sell. Some of us said no"* (one mayor). To solve the sensitive issue about the public imprint of the project, Dr. Doc suggested that the TRAIN, an association of firefighters training citizens in life-saving actions and with identical hierarchy as SDIS, be involved in practically organizing training sessions. Mr. Mayor also offered to look for sponsors to finance the kits. Three local banks and insurance companies accepted as long as their logos and identity were placed on the kits. Laerdal agreed to remove its logo from the kits' package.

4. April–May. The TRAIN contests referring to training (CI4)

Dr. Doc then tried to enroll the TRAIN but faced strong opposition: the TRAIN perceived the training sessions as a direct competition to their own trainings, which led to the delivery of first-aid certifications. They claimed that using a defibrillator remained a technical practice requiring *"serious expert training,"* whereas the training kit *"is in fact a simple toy."* As firefighters and qualified CPR trainers, the TRAIN has links to several local actors and a positive image among the population; their opposition was seen as a threat to jeopardizing the project. To overcome this resistance, Dr. Doc offered to advertise their own trainings at the end of each session and to pay its trainers, and Mr. Mayor offered to refer to them as "information sessions" instead of training sessions. Once these issues were addressed, Mr. Mayor, Dr. Doc, and the TRAIN decided to communicate about a pleasant and lively opportunity to be informed on how to resuscitate people and to locate the sessions in a public, non-medical environment (town hall, gym) over a short time frame (30 minutes practice and 15 minutes discussion). They adopted the motto suggested by Laerdal: "30 minutes to help save lives."

5. July: The persistent reluctance of some mayors toward local events (CI5)

In addition to the AED purchase, Mr. Mayor worried that some mayors would still refuse to organize local events. He thus recommended launching a "public order grouping" combining AEDs and kits. Such a collective public purchase was unique and considered to be "pioneering." To ensure its legal validity and reduce potential criticism (Laerdal having a quasi-monopoly on the kits), Mr. Mayor hired two lawyers from the management center of territorial public offices to write specifications. They designed two work packages – one for AEDs and one for training kits – to enlarge the number of competitors. The approval of this plan marked the official launch of the common project and the first public decision of the collective.

6. October: Final confirmation of equipment orders

The contract for the supply of AEDs was given to a private French manufacturer (the largest budget) and the contract for the supply of kits was given to Laerdal (October, 2009). Soon

after, Mr. Mayor formally invited the mayors to confirm their orders. On November 6, Mr. Mayor held a local press conference in which he publicly announced the project. The associated press release detailed its nature, its planning, as well as the identity of each collective member with his or her differentiated role (see Box 1): MA as “the project holder”; SDIS, TRAIN, and the management center of territorial public offices as “technical partners”; and the three sponsors as “financial partners.” The local press relayed this information in several articles.

BOX 1 Identity and roles of the members of the social collective
<p>The Mayors Association – MA – representing the 331 communities of the region. Among them, 214 communities joined the collective.</p> <p>Technical partners</p> <p>SDIS – Regional fire and rescue brigade. Mission: to provide technical assistance to communities for choosing where to locate AEDs and to the MA to analyze competitive offers</p> <p>TRAIN – Regional union of firefighters. Mission: to inform voluntary people about the use of AEDS with the goal of training a minimum of 5% of the population of participating communities</p> <p>The management center of territorial public offices. Mission: to provide legal assistance for the creation of a public order grouping, the development of specifications for the public bid, and the analysis of competitive offers</p> <p>Financial partners</p> <p>Insurance company XX – amount of sponsorship: 75 K€</p> <p>Regional bank 1 – amount of sponsorship: 75 K€</p> <p>Regional bank 2 – amount of sponsorship: 75 K€</p>

Soon after, the first information sessions were organized and announced locally. Informed by the press and through word-of-mouth, some citizens complained that their community did not participate and put pressure on reluctant mayors to organize sessions. Therefore, some mayors decided to join the project later on. As summarized by a volunteering mayor: *“Honestly, the fashion effect among mayors has enrolled more cities than we initially thought. The interest when you participate is that you can communicate that we take care of you!”*

7. October–November: Ensuring the success of local events (preparation and staging)

During the first events, Dr. Doc noticed some organizational problems (inappropriate location, lack of sound, too-small screen) and prepared “a memo detailing key information for training with no worries” with the input of Laerdal and the TRAIN: *“such training needs to be perfectly orchestrated. It is like a well-run show... a single grain of sand and it’s over!”* (Dr. Doc). The TRAIN organized the logistics with local mayors. Within the MA, mayors discussed the target population to invite and gave priority to people in frequent contact with citizens (highest capacity to act in case of cardiac arrest). They used a snowballing technique to rally citizens: mayors asked municipal staff members, shop tenants, and presidents of local associations to attend and in turn to rally their customers, members, or network. This approach proved successful, as illustrated by one mayor: *“I had more demands for attendance than available kits.”*

As a result, out of 331 cities 70% have been successfully equipped with AEDs (293 installed), 41 information sessions organized, and 3,500 people trained. During one local event, the Red Cross attempted to become an official partner of the sessions and to show a promotional DVD about their activity. Dr. Doc blocked this initiative and forced them to remain in a low-key position and to behave “*just as any other participant.*” He was afraid of the TRAIN’s reaction (potential withdrawal) because the Red Cross also offered CPR trainings. During the sessions, participants collectively performed lifesaving practices on the manikin provided in the kit and then asked questions and shared their feelings with fellow citizens afterward over a free drink. Each citizen was asked to inform his or her personal network about the offered kit. The collective practice, the convivial atmosphere, as well as the variety of people involved (various ages and social classes) generated positive emotions of belonging to a benevolent community that helped reduce fears linked to the equipment, as described in these quotes: *“Now, I’m sure I will continue the experience with my relatives”* (a participant). *“It was a real success. We could show that we were doing something for the citizens”*; *“People developed a sense of solidarity and usefulness”* (Mr. Mayor); *“Training is not enough to engage citizens in action. They have to be committed and to feel involved. It was something that struck them”* (a colleague of Dr. Doc, SDIS). One year after the end of the sessions, Dr. Doc reported three cases of AED use by citizens.

Analysis

Our analysis highlights two main chronological phases: First, the resolution of the five critical incidents raised by actors when asked to engage in AED set-up, thanks to the progressive structuration of the collective as a partial organization (setting its common goal, its identity, and decision-making processes; defining who is entitled to membership and who coordinates action with external networks); second, the joint activities developed by this collective organization to defend their innovative cause for society and connect AEDs to lay citizens.

PHASE 1: THE EMERGENCE OF A COLLECTIVE ORGANIZATION IN RESPONSE TO CRITICAL INCIDENTS

The analysis of the case unveils that various critical incidents fostered the emergence of the collective and progressively pushed it to develop the dimensions of an organization.

Critical incident 1: The rise of the innovative cause. Originally, the collective was founded at the initiative of two actors responding to the 2007 law: Mr. Mayor and Dr. Doc, a technical expert. These founding members identified the interest of moving from cure to care practices to respond to the major concern of local citizens about medical desertification and the aging population. The rise of the collective thus responded to the new action possibilities authorized by the law (CI-1), which resonated and made sense to local society.

Critical incident 2: Framing the goals of the collective. From there, the founding members had the task to rally key actors to their cause, but they faced several critical incidents in this process. The case shows how the various solutions found to overcome these challenges progressively framed the definition

of the cause and the way to defend it (goals). To obtain the scientific caution and technical support of the SDIS, Mr. Mayor and the MA accepted extending the cause to training (CI-2). The goal of the collective became “AED installation plus training.” To help rally the mayors to the cause, Dr. Doc presented a set of slides showing trans-generational support and distributed the FFC leaflet stating that “*being trained to life-saving practices is a citizen act...*” This communicative practice anchored the identity of the collective in citizenship and was consistent with mayors’ values.

Critical incident 3: Setting the collective identity and criteria for membership. But this extended goal generated a new incident (CI-3). While the SDIS pushed training kits, mayors refused to purchase them. This new incident pushed Mr. Mayor to look for sponsors but also raised the sensitive issue of setting criteria for membership based on the declared values and goals of potential fellow members (at this stage mayors still needed to confirm their participation and hence commitment to the cause). Mr. Mayor faced the delicate situation of having to exclude Laerdal from membership, asking them to take their logo off their kits while accepting regional banks and insurance companies as members to defend the cause. As president of the MA, representing the concerns and interests of “his fellow members,” Mr. Mayor was legitimate to take this action on behalf of the social collective. This constrained decision had the advantage of officially positioning its cause and shared identity in a benevolent and non-merchant activity. Private sponsors could become members (because they were not involved in commercial activities in this project), but positioned as “financial partners” by Mr. Mayor to avoid any risk of confusion.

Critical incident 4: Reframing the common goal. To help anchor this benevolent and non-merchant identity and to benefit from the logistical resources of the TRAIN locally, the collective needed to convince them to actively participate and hence to become members (participation). But the TRAIN did not agree with the common goal framed as training citizens that could position the collective action as competing with its own activity. The solution found consisted of new communicative practices using the word “information” instead of “training” and the use of a simple motto that could meet the individual and sometimes conflicting goals of each member: “30 minutes to help saves lives.” The short time frame associated with the event positioned the collective action as non-competing with the TRAIN’s programs. This collective decision also informed the way the cause could be reified (for instance the choice of events location in public, nonmedical environment).

Critical incident 5: Commitment to practice and the first public collective decision. At this stage, the collective exhibited the key elements of organizationality as described by Dobusch and Schoeneborn (2015): existence of common goals, collective identity, criteria for membership (boundary work), collective decision making, and collective actorhood. These characteristics have progressively emerged and evolved from a group of individuals sharing a common cause to a form of organization able to proactively defend social progress for society, and to solve critical incidents to pursue their goals. We enrich this framework with the importance of reaching a critical mass of involved actors (Parapanaris *et al.*, 2013) to legitimize its action toward the

citizens. The solution consisted of developing a collective bid that could be considered to be a *reification practice*, enabling its founding members to push mayors to officially communicate about their *participation*. From there on, mayors had to choose clearly whether they accepted becoming members by formally ordering AEDs and training kits. Second, this bid supporting the choice of related suppliers, officially marking the first public decision of the collective (*collective decision making*). Third, this choice enabled the social collective to communicate its existence and innovative collective action to the press. The articles published in local newspapers publicly attributed the installation of AEDs and the organization of informational events to the social collective and positioned the members as pioneers (*collective actorhood*). They also unveiled their list of members and informed the goals and identity of the collective. This organizational structure supported the capacity of the social collective to act and enforce social progress toward the citizens. But its structure was not definitely set and its list of members continued to evolve as the collective started communicating to lay citizens.

PHASE 2: DEFENDING SOCIAL PROGRESS TOWARD LAY CITIZENS: FROM CURE TO CARE

To succeed in promoting the adoption of AEDs by civil society, the social collective heavily relied on the organization of local events that had been carefully staged and orchestrated. We analyze these events as a form of reification enabling the collective cause to materialize. The interest in such a reification practices was twofold: (1) it supported collective actorhood by legitimizing the collective cause toward external stakeholders and (2) it fostered the desire of lay citizens to use AEDs and promote care practices toward their relatives and friends. First, these events came across as local shows in which citizens performed life-saving practices in a friendly environment where key actors of civil society were represented and staged. Because of this high media power, events captured the attention of several external stakeholders placed at the heart of civil society (e.g., the press, local associations, and shop tenants) inciting them to publicly relay the collective action, hence generating positive word-of-mouth and external attribution. These events also engaged some local citizens to put pressure on some reluctant mayors to join the cause and participate in the collective action. They thus enabled the collective to be recognized as a social actor capable of mobilizing citizens on a legitimate social cause. As summarized by one mayor: “*The idea of training has been a trigger and enabled to legitimize the operation ...*”

Second, the events staged carefully selected objects (AEDs, kits) and human displays (firefighters, mayors, citizens of various ages and origins) in the same location (at the “*heart of the local community*”) at the same time to convey a feeling of user-friendliness, security, and benevolence. The staging of the MiniAnne kit at the center of the event and the collective practice demonstrated that using AEDs is easy (even a child can do it), is not risky, and is efficient at saving lives (as testified by the presence of firefighters who supervised the event). The gift of the kit to citizens anchored the cause in a benevolent activity. The events reified the link between rescue and civil society, crossing the boundary between them, and therefore performing and cementing the idea of care. The events can thus be considered to be

boundary objects (Wenger, 1998), enabling the social collective to engage in direct interaction with civil society and generate their participation. During the events, participating citizens could share their experience, questions, and intentions about future practice. Many of them declared they were no longer scared of using AEDs and would incite their personal network to learn to do the same. This collective practice produced structure (what to do, where, when) and attached meaning to the collective action for citizens. Thanks to their careful orchestration, the events directly supported the legitimacy of innovative care practices for society (Suchman, 1995).

Discussion and Key Findings

Our research work shows that the social collective studied developed the characteristics of organizationality to introduce its social innovation successfully but used specific functioning mechanisms as compared to more classic forms of organization. As a general contribution, we acknowledge that these mechanisms have been shaped through a step-by-step process whereby actors succeeded in overcoming critical incidents and participated in elaborating solutions. We discuss these organizational mechanisms with an effort at highlighting their contribution to existing knowledge from practice-based literature and the literature on partial organizations.

FROM COMMON GOALS TO AN OVERARCHING AGENDA

The collective studied emerged thanks to the publication of a new law that favored a new type of practice (care) as compared to the established cure practices. The identification of this trigger event reinforces previous work advancing that collectives emerge in reaction to an external change in society (Ahrne & Brunsson, 2011) and question existing practices (Simon, 2009). The defense and generalization of innovative practices favoring social progress (Paraponaris *et al.*, 2013) form their main “reason why” (Simon, 2009), which is called “joint enterprise” in the community literature (Wenger, 1998). The existence of common goals has also been acknowledged as a distinctive feature of partial forms of organizations enabling members to guide their decisions and align their behavior (Gulati *et al.*, 2012). In contrast to most social collectives previously analyzed in the literature, the collective studied in this article was made up of several existing organizations that continued to pursue their own and sometimes conflicting goals. Sustaining and managing different goals even came across as a prerequisite for the active participation of the collective’s members and key stakeholders. We believe that the alignment of collective members does not stem from a shared goal but rather from the combination of an overarching agenda resting on two pillars: a shared social cause and a shared belief on how to defend it. Although it was not difficult to obtain the alignment of mayors and firefighters for the cause of reducing the number of victims of cardiac arrest, it was more difficult to obtain their alignment on a precise agenda and set of actions to defend this cause. It is only when they all acknowledged their common belief that installing AEDs was insufficient to lead to lay citizen use that they developed an original activity (practice-in-use events) that aligned with their individual goals. This shared belief formed a common ground that provided them concrete guidance on what, where, and how questions. We therefore

suggest replacing the notion of common goals addressed in the organizational literature by that of an overarching agenda. Based on Weaver *et al.* (1981), we define this overarching agenda as a set of issues that are the subject of decision-making and debate within a given collective at any one time.

MEMBERSHIP NEGOTIATION: THE TRADE-OFF BETWEEN BOUNDARY DEMARCATION AND CRITICAL MASS

The literature on organizationality states the importance of exclusive membership negotiation practices for social collectives to enforce their identity and demarcate their boundary (Dobusch & Schoeneborn, 2015). Although our case supports this recent finding (exclusion of Laerdal to perform the public and non-business anchorage of the collective), it highlights that membership negotiation is a complex task that not only informs identity but also answers the need to reach a critical mass (Paraponaris *et al.*, 2013). Reaching this critical mass is required to legitimize the action of the social collective for society and gather sufficient resources to defend its cause: it is key to ensuring the successful introduction of the collective’s social innovation. The founding members thus had to make a trade-off. On the one hand, they were pushed to restrict membership to public actors to enforce the values of their dominant target members, that is, the mayors (because of their refusal to deal with private actors in a merchant positioning). On the other hand, they needed to include new members from the public and private arenas to augment their idiosyncratic resources (network of qualified trainers, logistical organization, financial support, legal and medical legitimacy toward lay citizens). To manage this trade-off, the group distinguished the project holder (MA with its participating cities) from the technical partners (SDIS, TRAIN, legal center) and the financial partners. This internal typology of roles can be interpreted as communicating about the existence of different statuses and an informal hierarchy within the collective. Hence, the MA is clearly positioned as the most central member being at the origin of the action; the firefighters (TRAIN, SDIS) holding the second-most important role, and the private sponsors positioned last as pure fund providers, thus conveying the message that they have less authority. Hence, our case highlights the complementarity of membership negotiation practices to enforce the organizationality of social collectives: although practices of exclusive membership “perform the identity” of the collective (Bartel & Dutton, 2001, p. 125), practices of inclusive membership help reach its critical mass and sustain its capacity to act.

ORGANIZATIONAL ACTORHOOD THROUGH REIFICATION OF COLLECTIVE PRACTICES

Social collectives achieve organizational actorhood through the performance of identity claims (Dobusch & Schoeneborn, 2015). Our case sheds a different light on this important dimension of organizationality: It is mostly thanks to the reification of its collective agenda in the form of societal events that the collective obtained external attribution for this innovative activity and instated organizational actorhood. From there on, members of the social collective agreed to contribute collectively to the practice of commonly organizing local events. These events formed a concrete anchor materializing their cause toward external stakeholders (press, sports association, shop tenants) and end users; it

generated interest in the cause toward civil society and to connect the AEDs (product innovation) with its target users (Håkansson & Waluszewski, 2007). These events reifying the cause thus served as boundary objects (Wenger, 1998) and proved key to the success of the innovative practice. Our case confirms Dobusch and Schoeneborn's (2015) work on the importance of binding identity claims to physical objects, sites, or human individuals to enforce organizational actorhood of partial organizational arrangements, and to instate the collective actorhood. But we complete the contributions of these authors by advocating that the reification process goes beyond identity claims and concerns the collective agenda. We also contribute to the practice-based literature by highlighting the importance of external attribution mechanisms, whereby the collective's capacity to act is recognized and legitimized by external stakeholders. Because of their social cause and desire to benefit to society, such mechanisms may be more important in collectives than in other forms of knowing communities that mostly defend their own regime of competence.

MANAGEMENT MECHANISMS: THE ROLE OF AN INFORMAL SECRETARIAT

Our case highlights the key role played by two actors in coordinating the decision-making processes of the social collective and its activities. They formed an informal management team in charge of preparing major decisions (who is entitled to membership), coordinating relationships within and outside the collective, communicating on behalf of the social collective, and defining rules for allocating resources (e.g., the number of sponsored kits attributed to each community). Because of the inter-organizational structure of the social collective studied in our research, we can make a parallel between the roles played by this management team and the notion of a "secretariat" (Gadille *et al.*, 2013; Ahrne & Brunsson, 2011) found in partial organization studies. The secretariat constitutes a permanent structure, formally appointed by the members of such organizations to ensure their continuity and efficiency. The secretariat role is to define soft regulations (considered more efficient than formal directives), decision-making processes, and to ensure social coordination among its members (Gadille *et al.*, 2013). Its legitimacy relies on its expertise, which acts as a substitute to hierarchical authority (Ahrne & Brunsson, 2004). In our case, the secretariat was emergent rather than appointed: its two founding members naturally emerged as legitimate members of this secretariat, for several reasons.

The first one relates to expertise: Mr. Mayor as president of MA and Dr. Doc as chief doctor of SDIS were recognized for the complementary of their expertise, thus confirming existing literature (Ahrne & Brunsson, 2004) stating that acceptance of a secretariat derives from the acknowledgment of its expertise. The second explanation relates to the ability of the secretariat to frame the need for change and to demonstrate the benefit of social innovation. Thanks to this theorization work (Munir, 2005), the secretariat can efficiently sustain the innovation journey despite critical incidents. This theorization work proved important to envisioning events as critical incidents and hence identifying the need to find solutions. This finding enriches the work of Nissen *et al.* (2014), who observe how progress can be jeopardized by the lack of understanding of events as critical incidents. The

third explanation lies in the secretariat capacity to mobilize its relational network and manage the collective's links with external actors owning critical resources for the success of their innovation. This secretariat thus formed a boundary structure managing the links between the collective and its external stakeholders. Based on Wenger (1998) and the practice-based theory of knowledge, we can refer to secretariat members as brokers insofar as they have close ties or belong to multiple groups and can therefore introduce more easily "*elements of one practice into another*" (Ibid, p. 105). The role and ability of the members of the secretariat thus increased the efficiency of the collective and constituted its strength.

Concerning the boundary practices of the secretariat members, our case reveals an interesting finding regarding the way they manage the paradoxical relationship with Laerdal: although Laerdal could not become a full member of the collective because of its business status, it owned key resources for the success of the innovation. To handle this paradox, secretariat members maintained close but discreet relationships with Laerdal. This mechanism enabled the secretariat to obtain Laerdal's advice and benefit from their experience to help them make decisions. This role of external "eminence grise" (braintruster) is close to the notion of peripheral participant proposed by Wenger (1988), who connects with community members by offering peripheral experiences that contribute to developing new practices. According to Wenger, the periphery is a very fertile area for change because of its specific location: "*partly outside and thus in contact with other views, and partly inside and so perturbations are likely to propagate*" (p. 118). Wenger characterizes peripheral participants as "*people who are not on a trajectory to become full members*" of the community (p. 117). Similarly, external eminence grises are not full members of the collective but actively influence its decisions through close ties with its secretariat. This role is kept discreet and remains ignored by most members of the collective.

Our research thus contributes to existing literature on the functioning patterns of social collectives by revealing an original form of secretariat mixing informal membership and more formal processes of decision making and playing a brokering role between internal members and external stakeholders. This secretariat enables the efficient management of the collective's boundaries by protecting and enforcing its identity through exclusive membership practices while benefiting from the critical resources of key external actors through privileged yet informal relationships.

Conclusion and Further Research

Our research highlights that a social collective can fruitfully sustain the development and introduction of social innovations by acquiring the characteristics of a partial organization supporting the participation of important stakeholders (critical mass) and the external legitimization of their cause (reification). This form of organization enabled the collective to create a protected space to "escape" the dominance of existing cure practices. Our research thus enriches the literature on favorable spaces for innovation (Cohendet *et al.*, 2008), which protects actors from dominant routines and ways of thinking through the delineation of their boundaries. Although this literature analyzed a preexisting

creative space, we focused on the emergence and functioning mechanisms of such spaces.

A first insight of our research is that the organizational design of social collectives is emergent and shaped by the critical incidents faced by its members when promoting their innovation. The second insight relates to the dimensions of the organizationality of social collectives. We have identified four sets of organizational dimensions that support the participation of key actors and the reification of the innovation: 1) framing an agenda overarching the individual goals of its members and embedding a shared social cause and a shared belief about how to defend it; 2) the complementarity of exclusion and inclusion membership practices (Dobusch & Schoeneborn, 2015) to create the identity of the collective and to reach a critical mass; 3) the recognition of collective actorhood, thanks to reification practices (Wenger, 1998). Concerning reification, our research highlights the importance of going beyond simple materialization through objects to also include human bodies carrying a high symbolic power (e.g., firefighters) as well as artifacts having a high media power (e.g., social events). The staging of such media artifacts favors public broadcasting of the cause and raises the interest and participation of key stakeholders; 4) the emergence of a secretariat coordinating the key decisions of the collective and acting on behalf of its members. Its acceptance relies on the expertise of its members as well as their innovative and relational ability to theorize innovation and critical events (Munir, 2005). We highlighted the original role played by an “external eminence grise” (peripheral participant) owning key resources for the success of the innovation, formally maintained outside the boundaries of the collective but influencing the decisions of its secretariat.

To conclude, we first acknowledge one research limit related to the temporal scope of analysis. Although we conclude our research with societal events, we could not investigate whether the organizational characteristics of the collective have persisted after these events or could have produced other innovative practices. Based on our case study, we identify two main research avenues. First, further work could explore if our findings are relevant and applicable to other forms of collectives and knowing communities, such as creative collectives (Simon, 2009), creative territories (Cohendet *et al.*, 2008), or communities of practices (Wenger, 1998). Second, further research could analyze the issue addressed by O’Mahony and Lakhani (2011) on the role of collectives for formal organizations. It could investigate whether collectives favor or hinder the accomplishment of the specific goals of its organizational members (meta-organizations) and the nature of value that it brings to them.

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