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From Stabilization Knowledge to Possibility Knowledge in Organizational Learning

Our categorizations of knowledge tend to be based on formal characteristics of knowing. Polanyi's (1967) distinction between tacit and explicit knowledge is a case in point, as is also Bruner's (1986) distinction between narrative and paradigmatic forms of knowing. For dealing with the learning challenges organizations are facing, I find it more useful to look at knowledge from the point of view of its *uses*. I suggest that knowledge used and generated in work activity may be divided into two broad types, namely *stabilization knowledge* and *possibility knowledge*.¹

Stabilization knowledge is constructed to freeze and simplify a constantly shifting or otherwise bewildering reality. It is used to turn the problematic into a closed phenomenon that can be registered and pushed around rather than transformed. It commonly takes the shape of fixed and bounded categories, but also narratives may be used to stabilize. Stabilizing categories often become stigmatic stamps on objects, both human beings and things.

Stabilization is not evil. It is necessary for our survival in a complex world, and it takes hard work. 'Stabilization is not just a process of standing back in order to let the object quieten; it also involves reaching out and bashing the object into shape, so that it will be stable enough to register. (. . .) The stuff of objects is by nature unruly. It is a collaborative achievement for them to hold, or be held, still enough to be brought into focus' (Smith, 1998: 300).

Possibility knowledge, on the other hand, emerges when objects are represented in fields with the help of which one can depict meanings in movement and transformation. One traces transitions of positions in a field, which destabilizes knowledge, puts it in movement and opens up possibilities. In this sense, possibility knowledge is agentic knowledge, the instrumentality of agency at work.

A good example of stabilization knowledge is the notion of 'heartsink patients', initially coined by the physician O'Dowd (1988). The notion refers to patients who are frequent attenders or otherwise troublesome for the practitioner—they give the 'doctor and staff a feeling of "heartsink" every time they consult' (O'Dowd, 1988:

528). The notion became popular among British medical practitioners and has sparked a number of studies and controversies (e.g. Mathers et al., 1995; Butler and Evans, 1999; Rosendal et al., 2005). Various studies have found very little in common across patients their doctors categorize as 'heartsink'. It is a garbage-can category that makes it easier to deal with the troublesome reality of diverse problematic cases. Of course it is also potentially a stigmatic stamp. Mizrahi (1986) reported similar categorizations in a hospital in the United States. Berkenkotter and Ravotas (1997) analyzed the use of stabilizing categories in the practices of psychotherapists. Mehan and his colleagues analyzed similar phenomena in the categorization of handicapped students (Mehan et al., 1986). In a recent study of a commercial bank, we found that the asset managers spoke of problematic clients as 'unproductive mass' and 'black hole' (Engeström et al., 2005).

For 20 years, my research teams have conducted intervention studies on work with 'demanding' or 'difficult' patients and clients in health care and social welfare settings, as well as in other organizations. In these settings, especially with chronic patients and long-term clients whose services are fragmented between multiple providers, a new type of longitudinal collaborative 'co-configuration' mode of production (Victor and Boynton, 1998) is badly needed. We call the new type of work involved in such production 'negotiated knotworking' (Engeström, 2005). To learn such a new mode of working, organizations need to destabilize their categorical knowledge of problematic patients or clients and turn it into possibility knowledge. They need to learn to turn rubbish into diamonds (Engeström and Blackler, 2005). How can this be done?

Here is a brief example from an intervention study we conducted at a public primary health care center in Finland in 2004–2005. The center was new, and its chief physician wanted to do something about the care of difficult patients. He suggested that the staff should aim at working with 'two pipelines', one for common one-problem patients, the other one for difficult patients, such as those with multiple chronic illnesses, addictions, multiple mediations, mental health problems, etc. Patients put into the second pipeline should be investigated, conceptualized, and new tools for their care should be developed. My research team began to follow patients identified by the practitioners as potentially difficult. We interviewed these patients, observed their consultations, and eventually brought them into so-called laboratory sessions with the staff, to discuss their needs and services. All these interactions were recorded (for a synthesis of findings, see Engeström, in press).

One of our initial findings was that the patient and the professional caregiver often saw the situation in radically different light. What was a 'heartsink case' for the practitioner may have been a first ray of hope for the patient.

GENERAL PRACTITIONER HT She is a red flag to me, and I'd rather hand her over to someone else, redirect her elsewhere, for example to the psychiatric clinic. But they won't take her, because she wants medicine but not therapy. She needs more and gets less, she is the last one I'd like to talk with.

PATIENT HT, this personal general practitioner of mine, she really cares for me. This is the first time I get this feeling that she not only renews my prescription but also demands that I come to consultation, and says it firmly. Now of course even more firmly, but it does help me!

To facilitate the formation of common ground between the practitioner and the patient, we developed and implemented two simple tools: care calendar and care map. The care calendar was a timeline drawn on a sheet of paper. On one side of the line, the practitioner marked key events in the care history of the patient, typically drawn from medical records. On the other side of the line, the patient marked key events in his or her experienced history of illness and health. The line was constructed in conversation, during a consultation. The care map was another sheet of paper on which the practitioner and the patient placed boxes to represent the different caregivers (clinics, specialties) involved in the patient's care. The parties filled each box, again both with official information (visits, diagnoses, treatments) and with the patient's experiences ('they didn't say anything about smoking'). The parties also marked contacts between the caregivers with arrows, and used graphic symbols to indicate ruptures in the flow of information.

The use of these simple tools had some striking consequences, especially when the patients began to draw on the tools in the laboratory sessions with the staff. Here is an example from such a session with a client who was initially considered very difficult in that she would cling to the practitioners and become dependent on their constant attention.

FAMILY GUIDANCE WORKER Well, I'd like to ask if it is useful to meet again in this combination, or shall we continue each one? So that we'll carry on with Vera in the Family Guidance Clinic, and . . .

PATIENT I think probably no. At least now I don't feel that this is necessary. Because *everyone* has now been in a couple of these meetings, and knows where we stand. So I can be in touch, tell you if something big and radical happens. And how each one of you can help if it is close to your profession. This sounds funny, but this is how I think. Or what do you think?

CHILD WELFARE SUPERVISOR Your idea sounds good to me, that you don't want to cling to us after all.

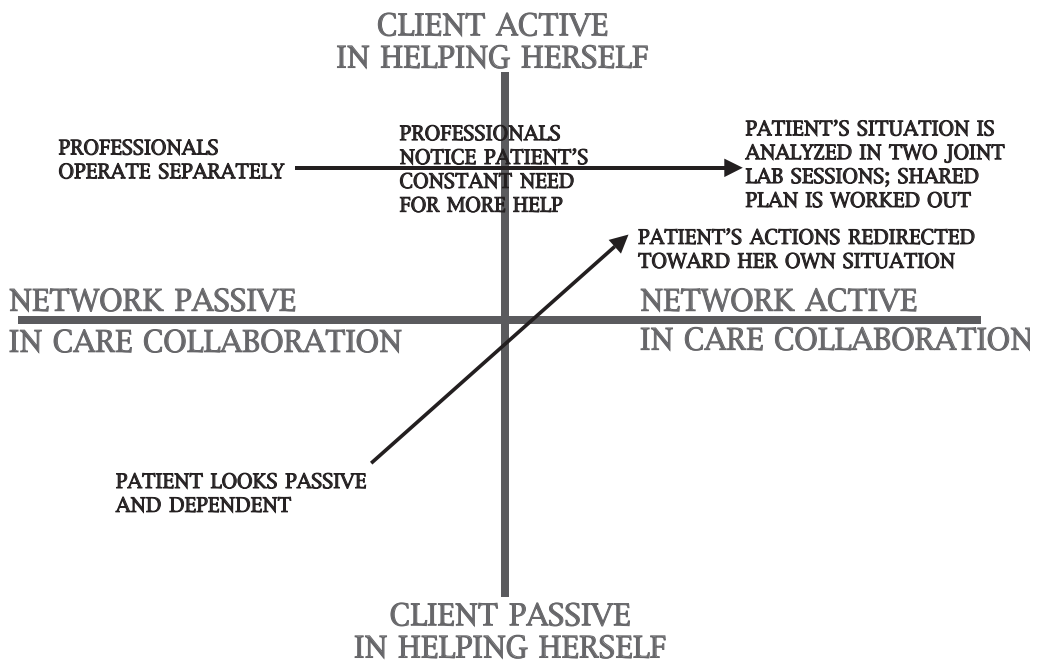
PATIENT Exactly. Because it helps me forward this way . . .

FAMILY GUIDANCE WORKER These are big issues, yes . . .

PATIENT About that model, if you want my comment, it seemed pretty utopian when you started making it. But now that I look at it, it kind of pulls me better into life. I mean, this is how it goes, or how it must go, normally. It's been a long time, about ten years, since I've been working, so I've lost touch with development. I have adapted, accepted things as they are. I haven't realized that there may be something else. I mean, normal work ja life and such. So that was a pretty good move. When you see it there in front of us, it makes things concrete. It sticks. It would be good to get a copy . . .

RESEARCHER Yeah, I'll take a photo and send it to you by e-mail. And a copy will be delivered home to you [the patient] . . .

It became clear to us that the construction of the patient is a two-dimensional achievement. On the one hand, the client or the patient herself may be active or passive in helping herself. On the other hand, the network of professional caregivers may be active or passive in collaborating and coordinating their efforts. With

Figure 1 Representation of a field of possibilities

these two dimensions, we put together a field in which we could depict the movement of the construction of the patient. Figure 1 depicts the movement of the patient cited above. The upper arrow represents the movement of the professionals as seen by the patient; the lower arrow represents the movement of the patient as seen by the professionals.

This kind of a representation puts inert stabilizing knowledge into movement. It shows significant transitions in the patient's and the caregivers' positions. It makes visible the emergence of possibility knowledge (on visibilization, see Engeström, 1999). And it does this by preserving and accentuating the multi-voicedness of the endeavour.

To achieve possibility knowledge, one needs a new instrumentality (Engeström, in press). In the health center case, the instrumentality consisted of (a) the practical-semiotic tools of the care calendar and the care map, (b) the dialogues and multilogues between the practitioners and the client and (c) the reflective meta-tool of the representation of the field of possibilities and transitions in the field. The field can be constructed by means of interacting dimensions of development. With the help of the field, you trace *transitions* of positions in the field. Tracing transitions destabilizes knowledge, puts it in movement, and opens up possibilities.

This of course opens the difficult questions of what is development, which dimensions are relevant and desirable. Perhaps we may start to deal with these questions by acknowledging that the first step of development often requires breaking away from a closed category whose inhabitants are doomed to stagnation and marginality (Engeström, 1996).

Note

1. The notion of possibility knowledge is not commonly used in the literature. Hargadon and Fanelli (2002) talk about ‘knowledge as possibility’ synonymously with ‘latent knowledge’. While relatively vague, their notion partly overlaps with mine.

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Q1: Please add Berkenkotter and Ravotas (1997) to ref. list.