

“The Killing Fields” of innovation

How to kill ideas

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ABSTRACT

This paper points to seemingly contradicted processes of framing innovation, idea generation and killing ideas. It reports from a yearlong innovation project, where health care professionals explored problems and tested ideas for solutions, regarding a future downsizing of the case hospital. Theories in various ways describe the opening and closing phases of innovation. Exploration and idea generation opens a field of interest, which is then closed by making choices of ideas to further explore in the next opening phase. These choices deliberately kill a lot of ideas. In the innovation project, however, substantial amounts of relevant ideas got killed during opening phases, where the purpose of activities was framed as idea generation. These ideas were either verbally or silently killed, and some in rather contradicted ways: The design and facilitation of brain storming processes lead to clustering of ideas, a design strategy which seemed to kill unique ideas. The reframing of innovation as a radical endeavor killed learning from others for being not innovative. The findings of this paper supplement theories of deliberate killing of ideas by suggesting *framing, design and facilitation of innovation* as more subtle ways of killing ideas during opening phases.

Key words: Health care, innovation, framing, design, facilitation

Introduction

This paper takes its departure in a field study of an innovation project in a Danish hospital. The fieldwork demonstrated seemingly contradictions between the *purpose* of innovation, the design and facilitation of idea generation and the killing of ideas. The Cambodian journalist Dith Pran originally coined the title analogy “The Killing Fields” after his escape from the communist Khmer Rouge regime to describe a number of sites in Cambodia, where large numbers of people were killed and buried.¹ With humble respect of this genocide, “The Killing Fields” in this paper refer to innovation processes, where different kinds of ideas are discarded for obvious or more subtle reasons. The processes of supporting or undermining innovation in public service organization are less studied aspect of innovation processes (Hartley, 2006: 34).

¹ en.wikipedia.org/wiki/Killing_Fields

The purpose of the innovation project was to adapt new and better practices from across professional and organizational boundaries in the health care sector, to experiment with ideas from other contexts than health care and to generate new ideas for solutions. The innovation project was designed and facilitated as continuing divergent and convergent phases. Divergent phases were designed to open a field of interest through exploration and idea generation. Convergent phases aimed at closing the field of interest by making choices of ideas to explore in the next opening phase and so forth. *Why then were substantial amounts of ideas killed during opening phases?*

This empirical wondering was the spark to analyze contradictions between innovation theories and practices in this paper. This approach to research is described by other researchers as using empirical *mysteries* as dialogue partner with theories and models in order to question, doubt and problematizing existing or dominant expectations and frameworks (Alvesson and Kärreman, 2007).

Initially, theories of innovation phases are reviewed in order to enable discussion of what kills ideas. Deliberate exnovation and individual and group dynamic explanations for killing ideas are supplemented by the concept of framing in order to address the often-contradicted problems and solutions in health care. The theory section is followed by an outline of the context and case, the field study and the methods for data collection and analyses. The analyses suggest that framing and design of innovation affects the killing of different types of ideas. The conclusion summarizes the findings and suggests implications for innovation research and facilitation.

Promoting or killing ideas

This section reviews theories on promoting and killing ideas throughout innovation research. The concept of *framing* is introduced as a theoretical and analytical approach to address the promotion or killing of ideas.

What promotes innovation?

Researchers and policy makers point to innovation as "... the key to meeting the challenges of the early 21st century, arising from technological advances, social change, globalization or global financial crisis" (Cropley and Cropley, 2012: 29). In a hospital setting, innovation can be defined as: "the process of turning ideas into reality, using a new concept, service, process or product to improve treatment, diagnosis, education, outreach, prevention and research, as well as enhancing quality, safety, outcomes, efficiency and cost" (Omachonu and Einspruch, 2010: 5). Innovation is thus given a central role in sustaining and transforming our societies. It has become the *king of words*, as graffiti states in Copenhagen, Denmark (Ingerslev and Elmholdt, 2012). Governments make reforms and strategies to stimulate innovation (Regeringen, 2007; Danske regioner, 2012; Kommunernes Landsforening, 2012), and since the 1880's, researchers have tried to break the code: "Can we learn how to innovate and not just wait for the muse to inspire us with a bright idea (Drucker, 1985: 34)?" The research ambition has been to understand innovation drivers and barriers. It has addressed how environments as private businesses or public institutions accordingly should be shaped to generate, sustain, and diffuse innovation (Greenhalgh, 2005;

Fagerberg, Mowery and Nelson, 2006). Researchers try to understand which organizational structures, financing, and cultures tend to create innovative organizations (Amabile, 1996).

Of particular interest to this study, researchers have addressed *phases* of innovation processes like the stage-gate model from idea to launch to market (Cooper, 2008). In a public health care context these phases could be conceptualized as: (1) *invention* - creativity plus ideas, (2) *implementation* - concrete change, and (3) *diffusion* - spread and adoption of ideas (Hartley, 2013). The quest to promote innovation by designing and facilitating innovation processes along these lines might seem straightforward. Nevertheless both Hartley (2013) and Moore (2005) argue that there is much more at stake in innovation than generating, implementing and spreading great ideas. According to Cropley & Cropley (2012) the question of what promotes innovation is tricky due to the contradictions, characterizing innovation. The next section unfolds the seemingly contradiction of killing ideas.

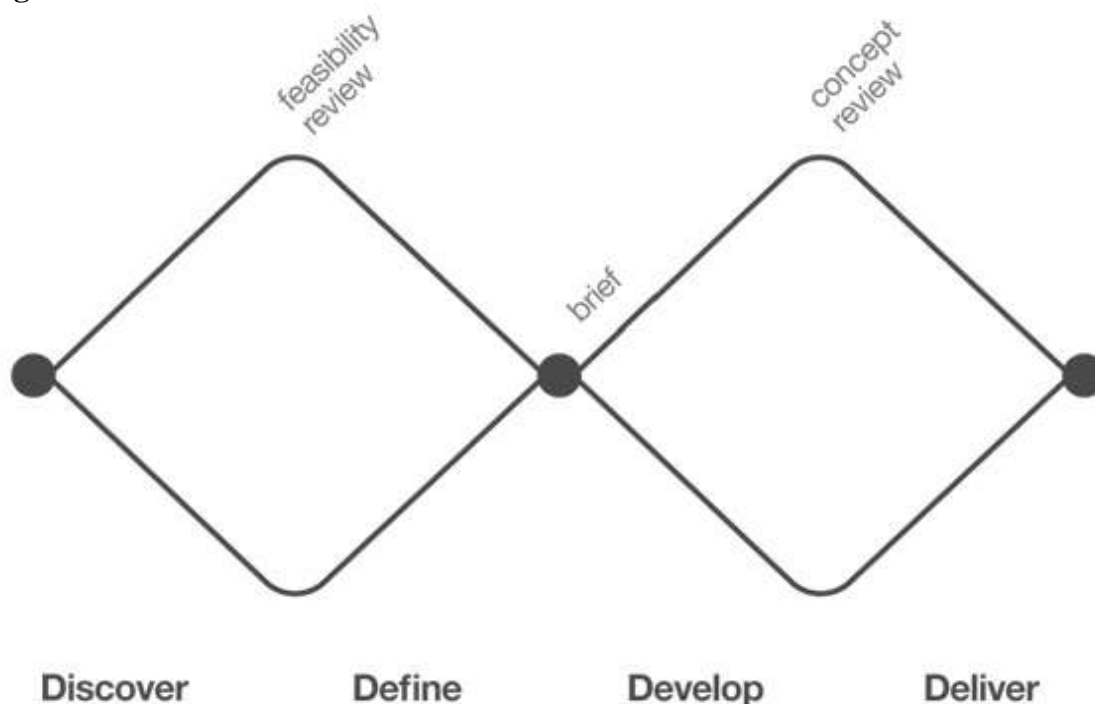
What kills ideas?

A widespread assumption is that organizations support dissemination and diffusion of their innovations and that managers engage with promising practices in search for ideas to learn from and adapt into their particular organizational setting (Hartley, 2013). However Moore's (2005: 47) study of public innovation demonstrates the opposite. Quoting Elmore (1997), Moore found that: "Indeed, a common fate of innovations in the public sector was to languish within a given organization until it could be killed by the organization that developed it". People did not support their own creative ideas through implementation or spread to other organizations. Likewise people did not adopt inventions from other organizations into their own organization. Instead subtly languishing slowly killed creative ideas. Accordingly Moore (2005) argues that ideas need help to survive and flourish within an organization and to spread to other parts of society.

Innovation literature describes various strategies for killing ideas. In the stage-gate innovation model, the purpose of the gates is to decide whether an idea should be recycled, continue to next stage or be killed (Cooper, 2008). The brainstorming technique in similar ways allows for creating many ideas, before categorizing the ideas to pursue and thus killing other ideas (Osborne, 1953). The *Double Diamond* innovation process (Figure 1) illustrates divergent and convergent phases of innovation, conceptualized as *discover*, *define*, *develop*, and *deliver* (British Design Council, 2007). *Discover* is an opening phase of exploration and creating knowledge of the problem and existing solutions. *Define* is a closing phase of analyzing and making sense of data from the *Discover* phase in order to define 'innovation questions'. Innovation questions should mobilize for action and stimulate imagination. *Develop* is an opening phase of generating ideas for solutions and *deliver* is a closing phase of choosing and conceptualizing ideas for testing. The divergent phases are thus described as opening the field of possible ideas and the convergent phases closes the field by analytical sense making and making choices.

Exnovation is a term coined by Kimberly (1981) as part of ending innovation processes, where existing but no longer relevant practices are discarded to create space for adopting different and fresh thinking. Exnovation also describes deliberate killing of an innovation, which fails to meet its initial promise (Hartley, 2013).

Figure 1: The Double Diamond Innovation Model



Source: British Design Council, 2007

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Stage-gate, brainstorming and exnovation are all *deliberate* strategies for killing ideas during the closing phases of innovation. Substantial amounts of ideas are created, but only a few turn out to be worth pursuing through implementation and spread. These strategies presume that the design for killing allow for the best ideas to survive. Other theories suggest that this is not always the case and employ individual and group dynamic explanations for killing ideas. Visholm (2012) suggests that competition, envy and fear of innovations, which threaten status quo, are also killing ideas along side of the deliberate rejection of bad ideas. This paper takes a different approach by studying how *framing* of innovation promotes or kills ideas.

Framing promotes or kills ideas

Innovation processes typically address problems, needs or possibilities (Bason, 2010). However problems in complex settings as health care do not present themselves as well formed problems, but as messy indeterminate situations (Schön, 1984; 1991). This applies to problematic situations in clinical practice and to problems regarding specialization and thus interdependency between organizations and professions in health care (Strauss et al., 1997; Akkerman and Bakker, 2011). Schön demonstrates how practitioners through the

active process of *framing* construct well-formed problems by choosing and naming their observations from messy indeterminate situations (Schön, 1991). Disciplinary backgrounds, organizational roles, past histories, interests, and political and economic perspectives make health care practitioners frame problematic situations in different and often contradicting ways. Problems, as the outset for innovation, are thus highly dependent on framing in terms of how people think of them. Contested framing and possible reframing of problems in this sense affects innovation processes, both in terms of framing the purpose and outset for innovation and the range of relevant outcomes. This paper seeks answers to the question: *Why are ideas killed during opening phases?* by analysing the relationship between framing and promoting and killing ideas in the case, described below.

Case and methodology

This section presents the case and methods for collecting and analyzing empirical materials.

Case

The context of the study is public health care in Denmark. The empirical material is based on a hospital innovation project. Due to governmental decisions of building new but smaller hospitals nationwide, the public health care sector is under dramatic change. The consequences of this downsizing could be a restructuring of tasks and workflow between hospitals, municipality-based primary care units, general practitioners and even patients (e.g. self-monitoring at home).

Table 1: The Four Themes of the Innovation Project

Theme 1	Theme 2	Theme 3	Theme 4
Boundary crossing leadership, coordination and collaboration between professions and organizations	New forms of shared leadership with fewer managers and square meters	Rethinking administrative and clinical service functions in line with the hospitals' core missions and task	Alternatives to hospitalization due to urgent need of reducing number of hospital beds

Source: Author

The innovation project was a yearlong process where health care professionals explored problems and tested ideas for solutions, regarding this downsizing. The process was designed and facilitated by six human resource consultants as a *Double Diamond* process with deliberate opening (*Discover and Develop*) and closing (*Define and Deliver*) phases (Figure 1). The projects' steering committee invited 38 employees from different departments and disciplines to participate in the innovation project in order to explore the consequences of the downsizing within 4 themes: 1) leadership across boundaries, 2) shared leadership, 3) administrative and service functions and 4) alternatives to hospitalization (Table 1). The employees were divided into seven groups, which explored the themes, problems, and ideas for solutions through workshops, meetings, and dialogues with stakeholders, experiments, and feedback.

The hospital management initially asked: “How can the hospital keep up current levels of productivity in terms of outpatient treatments and surgery in the new hospital buildings? In a five year perspective, we must concurrently reduce square meters, hospital beds and employees by about 40 per cent.” Initially the steering committee’s ambitions regarding the outcome of the innovation project were: “more nuanced and concrete solutions to identified problems that are ready to implement.”

Over time the purpose of the innovation project changed. Soon after the first workshop, leading hospital staff members referred to the innovation project as: “we are doing something radical in a radically new way.” This statement represents a shift in ambitions towards creating *radically* new solutions. In the *Define* phase, when the steering committee evaluated which ideas to pursue for testing and implementation, they talked about finding the *best* ideas. These were framed as “*ideas with a certain innovation height that are also wide and deep*”. *Innovation height* usually refers to a continuum from incremental, small step improvements to radical breakthrough inventions (Albury, 2005; Moore, 2005). As such, *innovation height* is not at one (radical) end of an innovation scale. Preceding the managers’ expression of radicalism, the human resource consultants stated: “the participants should fly in the opening *develop* phase, not letting themselves limit by what is known to be possible.” The steering committee at this point used the term *radical innovation* to express their ambitions for the innovation project. They demanded radically new ideas and wanted a sufficiently open design of the innovation processes to allow for wild ideas. “This is a playground!” the head of the steering committee announced. The steering committee often referred to a book on innovation with *Next practice* as an appealing phrase in the title (Jensen et al., 2008). In this book, the field of *radical innovation* is in opposition to the well-known (and boring?) *best practice*. Best practice included doing benchmarks and learning from others. The point taken from this book was that, if the hospital pursued best practices from other hospitals, it would always be second to someone. In other words: When you learn from others, they are ahead of you! The purpose of the innovation project thus changed from searching for *concrete* solutions to problems to searching for *radically new* solutions.

The analyses below address how this *reframing* of the purpose of the innovation project affects the process of generating and abandoning ideas for innovative solutions.

Methods for collecting and analyzing empirical materials

An explorative research strategy was chosen for collecting incidents of killing ideas throughout the innovation project, as it was not possible to predict where and when ideas emerged or whether they got killed. Ethnographical inspired methods as extensive observations and detailed field notes (Spradley, 1980) were used in order to collect ideas and trace whether they got killed or lived long enough to be tested in the *deliver* phase. Below the different design strategies, employed during the innovation project for generating ideas, are described and examples of ideas are provided for illustration.

Brainstorming sessions

One design strategy for idea generation was brainstorming sessions, which were reoccurring during opening phases of the innovation project. Brainstorming sessions were usually conducted in silence. The participants used Post It notes to write down ideas and

display them on blank walls. Closing phases followed brainstorming sessions, where the participants clustered ideas, which covered the same theme and created headlines for each cluster. These headlines and clusters were points of departure for the next opening phases. Human resource consultants asked questions at workshops like: “What should be our focus in order to succeed in the future hospital?” Participants provided answers like: “In the future we should evaluate managers’ ability to sustain productivity as well as their ability to facilitate innovation.” Participants also designed and facilitated brain-storming sessions with stakeholders. One of the groups working on better referrals asked general practitioners: “What needs do you have in order to conduct medical examinations and referrals in the future?” The general practitioners suggested “If we are to conduct medical examinations, we must be able to consult senior hospital physicians“.

Exploration and analyzes

The seven groups of participants used a different design strategy than brain storming for idea generation in between workshops. In group meetings they worked on their specific theme, problem, innovation question, and ideas for solutions. The groups used the *Discover* phase to explore *real world challenges* related to the four themes. They investigated already existing innovative practices in high performing clinical departments throughout the hospital to learn from their work processes. They visited waiting areas for outpatients and interviewed patients and medical secretaries. They even went to shopping malls and libraries to conduct “vox pops” about people needs regarding health care and to a local windmill factory to learn from their use of R&D project tools.

Define phase

The seven groups shared experiences from the discover phase with each other and tried to catch the essence of their learning with regards to specific aspects of the theme to pursue and ideas to test. The innovation questions should narrow the four rather broad themes of the innovation project into questions like: “How do we ensure free access to patient data, no matter where you are, what time it is, or what position you hold?” The participants used design tools as modeling and prototyping to support their ideation from these innovation questions. One group tried to reduce the number of inpatients at a surgery department. They were inspired by principles from day surgery and tested an idea of exchanging hospital beds with flight seats. This allowed outpatients to rest after procedures until they were discharged. Another group struggled to identify *complex patients* as these patients are in greater need for collaboration across professional and organizational boundaries. The group used LEGO bricks to build mock ups of an identification tool and discovered the language of red and green traffic lights. The color codes appeared useable on a schema in order to create a quick overview of the severity of patients’ complicating life circumstances as, for example, drug abuse and psychiatric diagnoses. During a day shift, nurses on duty in two wards tested the color-coded schema by checking the red or green boxes for each patient.

Approximately 1650 ideas on Post It notes from opening brainstorming sessions and conclusions of the groups’ *Define* phases constitute the empirical material. During the analytical process, these ideas were sorted into three empirical categories: 1) verbally expressed killing as “this idea is no good”, 2) silent killing as ignoring an idea and 3) ideas which are further pursued in the innovation project. Within these categories, the next analytical step was to search for clusters of ideas with common characteristics. The empirical

materials were subject for presentations and discussions with researcher colleagues in order to strengthen and refine categories and create headlines for clusters. Observations and field notes were used in order to create first draft descriptions of circumstances and tentative explanations of the two types of killing of ideas. Open extensive dialogue interviews with the seven groups of participants supplemented these descriptions in order to create fuller account of the events (Czarniawska, 2007). Inspired by the Critical Incident Technique (Flanagan, 1954) the interviews were used to probe for the participants' experiences of critical incidents in the process of generating and killing ideas. The observations, field notes, and interviews led to accounts of incidents of verbal or silent killings of ideas, analyzed in turn below.

Findings and analyses

Verbal killing of ideas

An example of verbal killing of ideas was a nurse participant, who argued for re-introducing hospital physicians with generalist skills. Her hope was that generalist physicians would be better able to detect and interpret patients' overall conditions. Specialists tend to focus on specific symptoms within a narrow area of expertise. Questions from several physician participants killed her idea:

“What should the training of these generalist physicians consist of? Who would hire such a person? What patient would feel safe in the hands of a generalist?”²

Three clusters of ideas were verbally killed during the opening phases of the innovation project. *Doublets* were ideas that addressed the same problem or theme, which is expected in brainstorming (Van de Ven, 2007; Cropley and Cropley, 2012). The process of clustering similar ideas under headlines killed a lot of Post It notes, but ideas tended to survive, if several participants had the same idea.

Another cluster of verbally killed ideas addressed *Contested Terrain*. These ideas typically related to ongoing initiatives like the idea to train generalist physicians. These problems received massive management attention and displayed high potential for conflicts. In various ways the hospital management expressed that in these terrains, they did not want un-controllable interference from the innovation project. On several occasions the steering committee verbally and deliberately killed ideas in *Contested Terrain*.

The third cluster of verbally killed ideas is *Copy and Paste*. The participants generated hundreds of ideas, which were killed as “*this is already working elsewhere*”. Verbal killing of *Copy and Paste* ideas is illustrated in the following vignette.

One group worked on a systematized collaboration and coordination between clinical departments regarding e.g. stroke patients. During the *Discover* phase, the group

² The idea of re-introducing physicians with generalist skills was killed in the innovation project, but is accepted nationwide. Now physicians are trained as acute specialists to act as a first entry point to the hospital for all acute patients. This is no matter which conditions they might suffer from, and specialties they need treatment from.

visited a unit that faced similar challenges concerning patients with lower back pains. After this visit, a physician participant announced:

The Centre of Lower Back Pain is already working hard and successfully to coordinate between specialists and departments. What really strikes me is that they are not using a specific person as a coordinator, as was our initial idea. They understand coordination as a work function to be handled! This is a great perspective! They are so far ahead of the rest of us. We shouldn't continue working on this idea of improving coordination across specialties and departments. We are approaching the same type of problems as the patients with lower back pain used to experience. The patients in our case only suffer from stroke.

After the visit to the Centre of Lower Back Pain, the group discarded the idea to renew coordination of processes for stroke patients. Other departments had already implemented similar functions. They did not find their own idea innovative at all. With this conclusion, the group instead invented the schema for scoring patients' complicating life circumstances in order to identify *complex patients* in need of coordination. The well-established coordination function at the Centre of Lower Back Pain was not explored any further during the innovation project and thus not adopted by other hospital departments.

Killing *Copy and Paste* ideas contradicts theories, which point to the ability to learn from others through creative imitation (Drucker, 1985) by adapting ideas from other contexts (Hartley and Benington, 2006; Moore and Hartley, 2008) as an important factor in public innovation. Killing *copy and paste* ideas is discussed after the findings and analyses of silent killing of ideas below.

Silent killing of ideas

An example of silent killing of ideas appeared at the very first gathering in the innovation project: a nurse participant expressed her idea of involving employees from local authorities as participants. She argued that a range of possible solutions to the hospitals' challenges involved home care or rehabilitation before and after hospitalization. Neither the steering committee, nor the human resource consultants or the other participants answered to this idea. It was not addressed in later sessions in the innovation project.

Three clusters of ideas were silently killed during the opening phases of the innovation project. *Abstractions* were abstract or complex ideas, often framed by the participants as questions or visions like: "How do we ensure common purpose and high quality standards for patients across the hospital?" These kinds of ideas might need further processing during the *Discover* and *Define* phases to crystallize in more concrete forms. Unfortunately, they did not make it that far as they disappeared.

Another cluster of silently killed ideas were ideas *out of sync* with the design of the Double Diamond innovation process. An example was the above idea of involving employees from the municipality. This silent killing might be a sign that the human resource consultants relied too heavily on the process design. Innovation models can appear linear even though, amongst many others, Van de Ven (1990) described innovation processes as chaotic, emergent and unpredictable. If the human resource consultants made sense of the process of

innovation in a linear manner and thus stuck to the plan of selecting participants from within the hospital, they by default killed ideas, which were generated through these iterative and perhaps contradictory processes. This might have caused them not to pay attention to the ongoing framing and reframing of ideas, regardless that the purpose of this phase of the innovation project was to *open up*.

The third cluster of silently killed ideas was *Soloists*, meaning unique ideas. When the participants clustered ideas in the closing *Define* phase, they on some occasions left out ideas, which were less represented on the Post It notes. Silently killing unique ideas seems contradictory to the purpose of innovation as creating something new. Killing *Soloists* can be ascribed to new ideas being uncomfortable with regards to status quo or to envy towards other participants' innovativeness. When approaching design and facilitation, *Soloists* seemed to end up as unimportant ideas by means of the design strategy of clustering.

Table 2: Types of ideas which are verbally or silently killed

Killing	Verbal	Silent
Type of ideas	Doublets (safe) Contested terrain Copy and paste	Abstractions Out of sync Soloists

Source: Author

The clusters of verbally and silently killed ideas are displayed in Table 2. The contradictory killing of *Copy and paste* ideas is a typical case, holding many empirical examples. The next section discusses circumstances, tentative explanations and consequences of these killings.

Discussion of killing copy and paste ideas

The circumstances of and tentative explanations for killing *copy and paste* ideas *already being done elsewhere* relate to an expression by the group, which tried to identify complex patients. The group evaluated their idea to improve coordination as: “not innovative at all” after visiting the Centre for Lower Back Pain. The evaluation of what is regarded as an innovative *outcome* must always be relative to what the *purpose* of the innovation project is. However this purpose is reframed throughout the innovation project.

Part of the initial framing of the purpose of the innovation project was to *spread best practices* and the ambitions regarding outcome of the innovation project were: “more nuanced and concrete solutions to identified problems that are ready to implement.” This purpose and ambition regarding outcome was substantially reframed during the innovation project from *concrete solutions to searching for radically new solutions*. This reframing affected the process of generating and killing ideas for innovative solutions in contradictory ways.

The reframing of innovation as radical affected how the participants over time perceived themselves as part of the innovation project and the problems and ideas they

worked on. In the *Discover* phase, when the purpose was framed as finding concrete solutions to problems and to spread best practices, the participants appreciated their privilege of being part of the innovation project. Several of them asked the head of the steering committee challenging questions with regards to the overall purpose and scope of the innovation project: “What is not up for innovation?” Other participants posed rather radical ideas such as quitting the hospitals’ traditional organizational structure related to the medical specialties. They suggested organizing according to patient pathways instead. The head of the steering committee rejected these types of ideas: the hospital management had decided to carry on the organizational structure into the future hospital.

After the first workshop, the radical reframing of the purpose of the innovation project began. Simultaneously several of the participants reflected upon how hard it was to think anew about the hospital they were part of. A charge nurse participant expressed her concern: “Everybody knows so much about the everyday work at the hospital. The challenge is to use that knowledge to innovate on an organizational level“. Some participants regretted they kept using knowledge from the existing hospital and felt at risk of ending up copying and pasting old structures and cultures into the new hospital. They even wondered if they were able to be creative after all these years working at the hospital.

The managers’ growing aspirations of creating radically new solutions to problems were setting an ambitious context for the groups’ work. At the same time these ambitions led participants to express feelings of inferiority, of not being innovative, wild and creative enough. The participants even began to judge their deep knowledge of hospital practices as barriers to innovation.

The reframing of innovation as radical thus negatively affected the participants’ sense of innovativeness. The vignette about the group that visited the Centre for Lower Back Pain, illustrates how the search for radically new solutions meant that the participants did not pursue ideas with great potential for innovating patient pathways, if these ideas were already at work elsewhere at the hospital. The framing of innovation as radical seemed to stop the groups from learning from practices in other specialist areas and testing these in new contexts. This is a contradictory situation in light of Hartley & Bennington’s (2006) claim that learning from others and combining this learning with practices in new settings is one of the most important aspects of public innovation. In addition to this advocacy for learning from others, Moore (2005) argues that many small changes can accumulate into significant change and Cropley & Cropley (2012) point out that, if innovations are to succeed in implementation and diffusion, they should not be too wild. These findings suggest nuances to conceptions of innovation as a radical endeavor in order to avoid killing good, but small ideas from other settings.

These theoretical claims could leave the impression that public innovation is only about small scale improvement and *copy and paste*. However Hartley & Bennington (2006) state that public innovation is not about adopting and scaling up, but about *craft and grow*—dynamically adapting innovations to a local context. An example of this was the standardization and systematic information procedures in day surgery, which inspired a cardiologist from an inpatient surgery department. He saw the potential to reduce the number of hospital beds in his own department, improve quality of care, and patients’ experiences by

adapting this information procedure to his patients. It seems contradictory not to change practices regarding inpatients due to the fact that these information procedures were already implemented with regards to outpatient treatments in other parts of the hospital building.

This theoretical framing of innovation as *accumulative through learning from others* was part of the initial purpose of the innovation project, as described in the case. Over time, the analyses demonstrated how this purpose in several ways was reframed as a matter of radical innovation: in texts, by human resource consultants who taught innovation models, and by the steering committee waiting for innovative solutions to complex challenges. The consequences of reframing innovation as radical were that learning from innovative practices in other contexts was killed.

Clagett (1967) coined the *not invented here* syndrome in order to describe internal resistance against external knowledge. The syndrome can occur when external knowledge conflicts with the prevalent routines and beliefs within an organization, so that employees respond with resistance. This often explains discarding learning across contexts. Another type of explanation of this killing learning across context could be the envious killing of other people's ideas (Visholm, 2012). It might sometimes be the case that people prefer to come up with good ideas themselves and devalue other people's ideas for not taking local context into account. However, the analyses and discussions of this paper tell a different story: A story about how framing learning from others as non-innovative kills ideas.

Conclusion

This paper has analyzed contradictory processes of framing innovation and the generating and killing of ideas. The analyses of "the killing fields" of innovation showed that opening and closing phases of innovation processes are far from deliberate and smooth. Killing ideas is not always deliberate exnovation in the closing phases, according to explicit premises like; *do ideas meet problems in building a new and smaller hospital?* Contradictory silent or verbal killing ideas also appear during opening phases, exemplified by killing of *Soloist* ideas through clustering of ideas and killing *Copy and Paste* ideas and thereby learning from others. These kinds of killings are not designed for in innovation models or through the human resource consultants' facilitation and are less obvious than the deliberate killings of ideas in the closing phases.

The reframing of innovation as radical affects the opening and closing phases of innovation processes in ways that challenge design and facilitation of innovation. The reframing introduces competition between ideas, which contradicts the opening principles of brainstorming, allowing for numerous ideas to surface and seeking to silence the critical voice of self and others (Osborne, 1953). The framing of innovation as a radical endeavor is a key to understand the killing of learning from others as a source of innovation and thus affects what is considered innovative solutions.

The main finding of this paper is that ideas are killed during opening phases of innovation processes as well as during closing phases of evaluating ideas. Killing ideas during opening phases is not designed for in innovation models, but is explained by contradicted reframing of problems, purpose of innovation and ideas. Killing ideas by

reframing and facilitation nuances theories, which explain the killing of ideas by closing phases on innovation, used in design models of innovation. Framing and facilitation also nuances explanations pointing to individual and group dynamic reasons for killing ideas. This finding suggests further research into the effects of framing and reframing problems, purpose and ideas for innovation processes. Knowledge of how framing closes idea generation in undesirable ways could be used to further advance facilitation of innovation processes with a specific attention to the killing fields of innovation.

About the author:

Karen Ingerslev, Ph.D. Scholar at Copenhagen Business School, Department of Operation Management (PEØ), Centre for Business Development and Management (CVL) and Cand. Psych. from Aarhus University, 2000. Karen's research on innovation in public hospitals is part of a government initiated research program SLIP "Strategic Leadership Research in the Public Sector". The research project is performed in collaboration with the Central Denmark Region and Aarhus University Hospital, where she is a former consultant and manager of Human Resource Development and currently employed as Head of Innovation. Current area of academic interest is the role of participatory citizenship in public sector innovation. Karen has co-founded the platform for participatory citizenship *Sager der Samler*. The author can be reached at email address: Kareinge@rm.dk

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