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Interpretation of multiple institutional logics on the ground: Actors' position, their agency and situational constraints in professionalized contexts

Abstract

Our study examines how interdependent actors in a professionalized context interpret the co-occurrence of a professional logic and a policy-driven logic. The empirical setting comprises two hospitals in the English National Health Service. Two issues stand out. First, our study shows that any logic is variegated and ambiguous, so policymakers and organizational managers cannot assume that they are easily blended. Second, it shows how Nurse Consultants exhibit agency in blending these two logics in pursuit of positional gain in professional and managerial organization. They can do so because of their ambiguous status level: in comparison to doctors, their status as nurses is low; within the nursing profession their status is high. Theoretically, by focusing upon interpretation of multiple institutional logics at the micro-level, our study renders visible agency of interpreting actors, interdependency of actors, their interpretation of institutional logics, situational context, and the effect of, and upon, social position of actors.

Key words: institutional logics; institutional complexity; healthcare; profession; social position

Introduction

There has been growing interest in 'institutional logics' (Friedland & Alford, 1991; Thornton et al., 2012) to investigate links between macro-level and micro-level phenomena. This reflects increasing recognition that organizational fields encompass institutional complexity characterized by multiple logics (Greenwood et al., 2011; Lounsbury & Boxenbaum, 2013). However, institutional logics literature, until recently, has tended to ignore 'how social actors translate logics into action as they engage in everyday organizational activities or how these micro-level activities help reproduce or transform organizational structures' (McPherson & Sauder, 2013: 166). McPherson and Sauder (2013) emphasize the meaning of logics are not fixed and take a more practice-based view of their interpretation and

enactment. Aligned with this, our study examines actors' interpretation of multiple logics on the ground to fully understand institutional change and maintenance, with a focus upon actors' social position and situational constraints that frame this.

In summary, we address the following interlinked research questions in a professionalized context: (1) How does social position shape actors' interpretation and enactment of multiple institutional logics on the ground? (2) How does actors' interpretation and enactment of multiple institutional logics shape their social position on the ground?

Our empirical case is set in hospitals within the English National Health Service (NHS), where hybrid nurse managers exhibit agency, shaped by their social position and situational constraints, in interpreting and enacting policy-prescribed guidelines for the delivery of clinical care. Such a healthcare setting is an excellent example of a well-established organizational field, where strong institutional forces push towards conformity and stability, which allows us to analyse re-composition of an organizational field (Reay & Hinings, 2005; 2009). At the same time, the multiple logics evident as an ordinary, everyday phenomenon in healthcare may prove less compatible than in other settings (Reay & Hinings, 2009; Ruef & Scott, 1998), and so our case may prove rather distinctive. We reflect upon transferability of analysis further in our conclusion.

Institutional complexity and institutional logics

The concept of institutional logics was introduced into organizational studies by Friedland and Alford (1991). They conceptualized society as consisting of multiple logics, each associated with 'a set of material practices and symbolic constructions' (Friedland & Alford,

1991: 248), which act as 'taken-for-granted social prescriptions' (Battilana & Dorado, 2010: 1420) or 'frames of reference that condition actors' choices for sensemaking, the vocabulary they use to motivate action, and their sense of self and identity' (Thornton et al., 2012: 2).

Organizational fields are characterized by institutional complexity, comprising multiple logics, as opposed to being dominated by a single logic (Greenwood et al., 2011). These multiple logics may be competitive, but their relationship may also be co-operative, orthogonal or blurred (Goodrick & Reay, 2011; Waldorff et al., 2013). Given the meaning of institutional logics is not fixed, then relationships between multiple logics might be subject to interpretation by individual institutional actors (McPherson & Sauder, 2013).

Institutional actors can engage in strategies that allow potentially competitive logics to co-exist (Purdy & Gray, 2009; Reay & Hinings, 2009), keeping apart people, practices, or audiences that follow contradictory or competing logics (Greenwood & Suddaby, 2006). However, this may prove challenging where people and practices are interdependent, for example in a healthcare setting, as detailed below. In this situation, institutional complexity is permanent and must be managed continuously (Greenwood et al., 2011; Zilber, 2011), commonly reliant on individual agents to strike an appropriate balance between logics (Battilana & Dorado, 2010). In both this situation, and less competitive situations, institutional actors enacting different logics need to recognize their interdependence and accommodate others' positions in relation to their own logic (Jarzabkowski et al., 2009). Where logics are co-operative or blurred, there may be benefit for an organization, so they capitalize on interdependence between logics and not just remedy problems arising from tensions between logics (Greenwood et al., 2011). In particular, actors may enact agency to (re-)interpret and blend logics over time (Glynn & Lounsbury, 2005; Thornton et al., 2005).

Indeed, it may be that strengthening one logic may even result in strengthening another logic (Reay, 2014). However, this is likely to prove challenging where institutional logics are ambiguous or contested.

Consequently, to fully understand institutional change, or maintenance, we need to examine the ways in which institutions are negotiated, interpreted, and enacted by individuals, as people and their practices interact on the ground (McPherson & Sauder, 2013). Following this line, whilst practice theorists, such as Bourdieu (1990), have been critical of dualisms of institutions and actions that still permeate institutional theory, a focus upon practice has been an important precursor to the institutional logics perspective since its inception (Friedland & Alford, 1991). Thus, recent academic commentary suggests there may be significant value examining everyday practice as a case of longstanding or routine institutional complexity, since such a focus transcends any assumption that certain institutional logics are necessarily compatible or contradictory (Jarzabkowski et al., 2013; Thornton et al., 2012).

As per introduction, a particularly relevant study from which our study derives is that of McPherson and Sauder (2013). McPherson and Sauder (2013) conceive of institutional logics as tools, which can be 'continuously combined, configured, and manipulated to serve the purposes of actors' (McPherson & Sauder, 2013: 168). Specifically, McPherson and Sauder (2013) show how actors exhibit agency in interpreting institutional logics to navigate institutional complexity, characterized by multiple institutional logics and where there are many interdependent actors. They show why logics are used and what structural constraints limit agency in use of logics. As Jarzabkowski et al. (2013), for example, highlight, power and politics relating to an institutional actor's position, determine how and when to work within

and between different logics. This may be particularly important for those actors whose status means they are located more peripherally within fields, and where logics are likely to prove ambiguous and contested. In the next section, we discuss the ambiguous and contested nature of institutional logics and institutional actors' social position within a healthcare setting, the latter which forms the empirical site of study.

Institutional logics within a healthcare setting

Healthcare represents a common setting for the study of multiple institutional logics, as evidenced in a plethora of studies that take an institutional logics perspective in examining the effect of field-level change upon healthcare organizations (Goodrick & Reay, 2011; Kitchener, 2002; Reay, 2014; Reay & Hinings, 2005; Scott et al., 2000). In general terms, within healthcare systems across the world, we can see the intrusion of a new business-like or managerial logic upon the previously dominant professional logic (Reay & Hinings, 2005), with healthcare settings an increasing site of contestation between multiple logics (Scott et al., 2000).

We recognize that ideal types of institutional logics are not descriptions of what happens in an organizational field, rather they represent formal analytical models by which to compare empirical observations across institutions (Thornton & Ocasio, 2008). Commonly, ideal types are derived from empirical study, rather than set up a priori (cf. Thornton, 2004). Thus, as detailed further in our description of how we analysed the data, we remain wary of pre-determining the multiple logics at play in a healthcare setting. Nevertheless, we frame the changes that have occurred in healthcare settings globally with a broad understanding of professional organization and intrusion of business-like changes at play, from which institutional complexity and logics derive.

Detailing this further, with respect to professional logic within a healthcare setting, we highlight this is nuanced and that likely multiple professional logics are enacted. Doctors exercise a high degree of autonomy and clinical judgement, and are expected to self-police professional practice. Thus they remain relatively free from external regulation (Abbott, 1988; Freidson, 1988) and may use 'mindlines', rather than standardized guidelines, when determining clinical interventions (Gabbay & Le May, 2004). Doctors cede their core work only reluctantly, using an armoury of techniques to defend their territory (Abbott, 1988; Freidson, 1988). However, professional logic is not monolithic. Nurses commonly align with more holistic care for the patient compared to doctors, and they accept greater hierarchy intra-professionally, compared to doctors, who tend more towards collegial organization (Currie et al., 2015). Consequently, managers with a nursing background are likely to be perceived within their profession as senior to their mainstream nursing colleagues, and able to effectively manage their professional peers (Currie et al., 2015), notwithstanding reports that they may struggle to adapt to their new hybrid management roles (Croft et al., 2015a, b). Meanwhile, general managers, even at executive levels of the organization, may struggle to assert influence over doctors, although they exert greater control over other, non-medical, professionals, such as nurses (Reay & Hinings, 2009; Waring & Currie, 2009).

Within such a hierarchy, the position of hybrid managers, who combine managerial and clinical responsibilities, is an interesting one. In part, to address a policy implementation gap, rather than controlling professionals through managers, policy intent has been to co-opt clinicians into management, enabling professional governance from a distance (Martin & Learmonth, 2012). Following which, hybrid managers, drawn from the ranks of doctors, nurses and other clinical professionals, are expected to proactively manage their colleagues

towards organizational aims (Ferlie & McGivern, 2013). Highlighting nuances of professional logic, compared to hybrid nurse managers, doctors moving into hybrid manager roles (Llewellyn, 2001) commonly enact a more representative, than managerially hierarchical, hybrid manager role. Derived from which, hybrid medical managers are viewed 'first amongst equals' and orientate towards professional interest, rather than strategic organizational interest (Spyridonidis et al., 2015; Waring & Currie, 2009), although policy has reduced doctors' power to pursue self-interest (McGivern et al., 2015). Thus the interaction of institutional logics may be less straightforward and more ambiguous and contested than policymakers assume, even where they try and co-opt different clinicians into hybrid managerial roles.

In considering intrusion of managerial logics, we cannot assume that ideal types of corporate and market logic can be disaggregated. Thornton et al. (2012) suggest market and corporate logic blend and blur, and combine to suppress professional logics in their empirical study. This seems the case in healthcare settings, particularly in the English NHS during our period of study (2009-2012), although to emphasize an earlier point, any such assertion about the presence of ideal type institutional logics requires empirical investigation (Thornton et al., 2012). During the period of study, the English NHS represents a setting shaped by sustained intrusion of market forces, performance management and increased regulatory control to which healthcare providers need to respond (Raynard et al., 2013), originally derived from 'New Public Management' (Ferlie et al., 1996; Hood, 1991). Recently, the intrusion of the managerial logic has been reflected in: more intensive performance management around waiting lists and waiting times for patients, which inform the panoply of 'league' tables, with sanctions for so-called 'failing' organizations (Lewis &

Appleby, 2006); and greater accommodation of non-traditional provider hospitals (Secretary of State for Health, 2006); greater influence given to commissioners to strategically plan and purchase healthcare over those organizations delivering healthcare (Ham, 2008). Given an implicit, if not explicit, aim of policymakers to break the monolith of the NHS into separate, more flexible, parts, by market means, as with other public-sector organizations in England (Currie et al., 2009a), organizational survival may be threatened. For example, following poor performance and/or financial deficit, hospitals may be taken over, sometimes by a private-sector organization, or closed down (Waring & Currie, 2013). Further, the period of our study can be characterized as one of financial parsimony across global healthcare systems, rather than, as had been the case until then, growth in funding (OECD, 2014). Reflecting this, in the English NHS, the chief executive called for efficiency savings of 20 per cent over five years (Nicholson, 2009), at the same time as there was increasing regulation around performance and quality. Given increasing central political and regulatory control, competition between logics was likely to be more pronounced (Nigam & Ocasio, 2010).

Our empirical tracer study of standardized national guidelines, which are increasingly evident globally (Dopson & Fitzgerald, 2005), reflects potential competition between logics, and their blurring and blending. On the one hand, their effect, although not their avowed aim, may be to assure quality and cost-effectiveness of clinical care, and regulate professional practice, in a way that dilutes professional autonomy and discretion in clinical decision-making (Dopson & Fitzgerald, 2005; Ritzer & Walczak, 1988). On the other hand, we suggest standardized care guidelines aim to offer evidence-based standards and remove individual variation, through asserting the primacy of clinical knowledge and targets over differing management objectives (Dopson & Fitzgerald, 2005), and so may buttress

professional logics. In short, policy intervention, specifically standardized guidelines, its aims and effects, is likely to prove complex and nuanced within any healthcare system, and so prove illuminating of our theoretical concern about institutional complexity, agency in enacting institutional logics, and actors' attempts to maintain or enhance their social position in the field in the face of institutional complexity.

Research design

We adopted a comparative case-study design (Yin, 2009), involving two similar size teaching hospitals. These two case studies were selected to show variation in quality and financial performance that may influence the enactment of institutional logics under consideration. The first case had a slight financial surplus prior to, and during, the study period (2009 from initial scoping and access interview with the Medical Director to 2012 when the final set of interviews were completed), and its service was judged by external regulators as high quality. Meanwhile the second case was selected because it had a significant financial deficit prior to, and during, the study period, with concerns raised by external regulators about the quality of its services.

The focal actor in our study was the Nurse Consultant, introduced into the English NHS in 2000 (DoH, 2000) to achieve better outcomes for patients by improving quality and services. Nurse consultants are middle-level hybrid managers, with clinical and managerial responsibility for quality of care delivered. The Nurse Consultant role is higher status than other senior nurses, such as clinical nurse specialists and nurse practitioners, although given its separation from mainstream nursing, there remains some ambiguity about the exact scope of the 's role (Kennedy et al., 2011). In our empirical cases, we analysed the role and changes in social position of Nurse Consultants and their interdependence with executive

managers, doctors and hybrid medical managers, as Nurse Consultants implemented standardized guidelines for clinical care. A focus upon Nurse Consultants is particularly relevant, since besides a limited number of studies of institutional change, such as Reay et al. (2006) who examined the institutionalization of 'small wins' by nurses, most studies of professionals' influence upon strategic or institutional change in healthcare focus upon the role of doctors (Currie et al., 2012; Iedema et al., 2004; Waring & Currie, 2009).

The standardized clinical guideline we selected as a tracer study was the implementation of the chronic heart failure (CHF) clinical guideline (NICE, 2003). Clinical guidelines in the English NHS come under the auspices of the National Institute for Health and Clinical Excellence (NICE), a government-mandated, but independent, body that provides national guidance and advice, based upon evidence about efficacy of health and social care and its cost-effectiveness (www.nice.org.uk). Henceforth, reflecting responses from interviewees, we refer to the CHF clinical guideline as the NICE guideline.

Regarding institutional complexity on the ground, there were three crucial dimensions of institutional change within the NICE guideline linked to multiple logics. First, implementation of the guideline was aimed at achieving better quality care, and so can be characterized as aligning with professional logics enacted by both doctors and nurses. Second, in relation to professional logic enacted by doctors, the NICE guideline prescribed a CHF service in which many of its dimensions moved from a hospital setting to a community setting. The advice was for the new service to be nurse led, potentially by the CHF Nurse Consultant, in particular to manage the transition of services from the hospital to the community. On the one hand, this potentially threatened hospital doctors, since their control of the service was diluted and they were likely to lose resource. On the other hand, the reconfiguration of the service might allow hospital doctors to give up the less specialist

clinical work to others, and so allow them to focus upon the specialist work that enhanced their status (Currie et al., 2009b). Meanwhile, third, in theory at least, the NICE guideline offered potential cost savings for hospital management and so reflected a more managerial logic. In short, the institutional logics underpinning it, and possible effects of the NICE guideline, were ambiguous and likely to be contested.

Data collection

Within our comparative cases, we used a qualitative, interpretive research design because interpretation of institutional logics constitutes a complex social process in which the causal dynamics of social interaction are not immediately evident. In both case studies, our access point for research was the Medical Director, an executive level hybrid medical manager, who was ultimately responsible for the implementation of standardized guidelines, although they ceded this to Nurse Consultants, as empirically detailed later. The Medical Director identified key informants, beyond the Nurse Consultant, whom they thought would be involved in the implementation of the guideline chosen for this research. To extend our sample of relevant interviewees beyond those identified by the Medical Director in our two hospital cases, we used the snowballing technique. This allowed us to further explore diverse and sometimes competing interpretations of institutional logics, specifically from frontline doctors, hybrid medical managers and executive managers. In total, 52 interviews were conducted.

46 semi-structured interviews were conducted by one of the authors (the other did not carry out fieldwork) with key informants, following implementation of local guidelines on the clinical frontline. This took place around the same time in each hospital, spread out over 12 months (2010 to 2011). Given our focus was upon changing social position of actors over time, we took the opportunity nine months following the end of our formal fieldwork

(2012), to re-interview six key informants to assess whether any gain in position of the Nurse Consultant had been sustained (see Table 1 for details).

-- Insert Table 1 about here --

Data from interviews were complemented by analysis of documentary evidence, such as the NICE guideline, meeting minutes, implementation protocols for NICE guidelines, reports and training manuals. In using multiple sources of evidence and interviewing a wide range of key informants, we aimed to enhance the credibility of our analysis, in particular to counter self-attribution by CHF Nurse Consultants regarding whether they enhanced their social position through enactment of institutional logics associated with implementation of standardized guidelines. We note that claims by CHF Nurse Consultants regarding their agency in interpreting institutional logics and subsequent enhancement of social position were supported by documentation and other interviewees. All interviews were transcribed verbatim, transcripts were anonymized and a code number was assigned for identification purposes.

Data analysis

Whilst only one of the authors engaged in fieldwork, both authors analysed interview transcripts and documentation, and discussed emerging themes, such as the ambiguity of, and contestation over, institutional logics. As evident in our literature review, the ideal types of institutional logics presented by commentators, such as Thornton et al. (2012), may not prove helpful in the field. For example, first, professional logics may be nuanced; i.e. doctors and nurses may hold different professional logics. Second, policy-driven reforms appear to blend and blur ideal type corporate and market logics in a way that makes such

categorization not meaningful. Given it is problematic to recognize ideal type institutional logics empirically (Jarzabkowski et al., 2009; Reay & Hinings 2005), data analysis was iterative, and we remained sensitive to ambiguity and contestation among multiple logics as they were interpreted on the ground throughout the analysis. Data analysis progressed in three stages, during which the level of analytical generalization was raised step by step (Mantere, 2008).

In the first step of the analysis, after transcribing each interview verbatim, transcripts were read closely, separately by each author, to identify interpretation of institutional logics and changing social position, but both remaining sensitive to limitations of ideal types of institutional logics. Within first-stage analysis, the following dimensions emerged: the institutional context of NICE guidelines implementation, comments on adapting the CHF NICE guideline to the local context; blending the dual responsibilities of implementing national priorities and catering for the specific needs of their own populations; and integrating other types of evidence to fit the local circumstances. The two authors discussed their first-order coding, particularly where there were differences in their analysis, following which they reached agreement about first-order codes. For example, during the early stages of our analysis we identified codes such as 'seeking information from institutional environment', 'raising an issue', 'agreement with institutional environment', 'disagreement with institutional environment' and 'negotiating professional/managerial interests'. We then decided to combine these into a more manageable code that we called 'struggling with conflict or ambiguity between competing national policies, (first column, Figure 1).

In the second stage of analysis, we focused upon relationships across first-order codes and the synthesis of codes into broader, more theoretical categories. Our intention was to move from a descriptive to an interpretive, more explanatory mode. For example,

comments on why NICE guidelines had to be adapted to the local context and how CHF Nurse Consultants strategically blend together multiple logics to minimize conflict within their local context led us to see that CHF Nurse Consultants were ‘experiencing difficulties in mediating responsibilities, agendas, boundaries and dominant institutional logics’ (second column, Figure 1). Particularly useful as we derived more theoretical codes at second and third stages of analysis, one author, who did not engage in fieldwork, had a critical distance from the data and was able to challenge and interrogate the interpretation of the other author, who was more embedded in the data (Mantere et al., 2012). At this point, whilst we agreed on our analysis of social position of Nurse Consultants, such agreement was not immediately forthcoming about the nuanced nature of interpretation of multiple logics, ambiguities around which departed from ideal types (Thornton et al., 2012), with evidence of contestation, as well as blurring and blending (Greenwood et al., 2011). Again, at the second stage, where there were differences in their analysis, the authors reached agreement about second-order codes.

The third step of the analysis involved categorization of the broader explanatory categories into aggregate theoretical categories, with consideration for how they linked to each other (Pratt et al., 2006). Three theoretical categories emerged strongly here: implementation was embedded in institutional fields; pursuit of positional gains; and the effect of, and upon, the social position of actors. Figure 1 summarizes the three stages of our analysis, which displays our first-order categories, broader explanatory categories and aggregate theoretical categories.

-- Insert Figure 1 here --

In the next section, we demonstrate how actors maintain or enhance their social position, as they interpreted institutional logics.

Findings

We present our findings structured around three themes – implementation embedded in institutional fields; pursuit of positional gains; and the effect of, and upon, social position of actors.

Implementation embedded in institutional fields

NICE guidelines could be implemented by hybrid medical managers, given their professional logic supported the use of evidence in developing and delivering better patient care. However, they ceded responsibility for implementation to hybrid nurse managers on the basis it was managerial work, which was mundane:

It will be a better use of my time not to be involved with the audit and monitoring of adherence to the NICE guideline. I was happy to have an advisory role within the service, discuss patients' needs and treatment requirements, and support the nurses. But the NICE guideline had to be championed and it is a heart failure nurse service in the community. So that needed to be championed by them. The audit of the service was also left to nurses.

(Lead Consultant Cardiologist, Hospital 2)

Not all managerial work was judged as mundane by hybrid medical managers. Where they anticipated their medical colleagues might be affected by organizational change they engaged with managerial activity much more, for example around the management of clinical divisions and the development of clinical pathways:

Meeting financial targets has been something I pay attention to since, if we control the money, we allow clinical leaders more freedom to run their own budget and use it to develop clinical pathways in the way they want.

(Medical Director, Hospital 1)

Interpretation of institutional logics, as guidelines were implemented, to mediate institutional complexity by CHF Nurse Consultants can be viewed as a response to conflict or ambiguity between competing national policies around professional and policy-driven managerial logics:

We end up with a lot of different policy frameworks. You try to make sense of how performance could be assessed and how we could monitor and evaluate it. A very good example is clinical governance and professional self-regulation, which don't align.
(CHF Nurse Consultant, Hospital 2)

It was deemed acceptable for doctors to deviate from NICE guidelines. Informants suggested doctors resisted guidelines where they perceived the drivers of change were managerial control from outside, rather than within, the profession:

Doctors have the right to prescribe differently. You can't enforce clinicians to implement guidance, because you need to allow that freedom to act in the best interest of patients.
(Director of Nursing, Hospital 2)

Thus doctors emphasized a professional logic to derive a more 'bottom-up' approach to development of new services. For guidelines to inform frontline service delivery required doctors to accept the credibility of the guidelines' authors:

They [hospital executive management] will tell you guidelines come from the rank and file people, who are in touch with the suffering population. The fact that NICE guidelines are produced by experienced colleagues is not important for them [frontline CHF doctors]. It has to do with the motivation of that person who produces a guideline, and of the hospital implementing guidelines. It is all to do with whether they [frontline CHF doctors] trust the persons producing and implementing the guideline.
(Doctor, Chair of Clinical Risk Committee, Hospital 1)

So even where guidelines were produced by teams of clinical professionals, doctors on the frontline may be sceptical of their value, where they perceive them insufficiently contextualized for frontline CHF care. Whilst early-phase implementation across both hospitals was controlled and staged by executive management, later the process became uncontrolled, subject to unpredictability of outcomes and generally proceeded in a non-linear way from the planning phase to adoption in everyday practice:

In the early stages of the process, there was more control. We had our dissemination and training plans well organized. But I think as it progressed, it has become diluted.

(Doctor, Chair of NICE Guideline Implementation Group, Hospital 1)

Building upon their understanding of the complexity of the institutional environment and local context, CHF Nurse Consultants struggled to interpret multiple logics on the ground, as the NICE guideline was implemented:

The government assumes, because the CHF guideline was written from a kind of scientific perspective, it will be implemented in practice, but the guidelines are not tailored to my local professional situation.

(CHF Nurse Consultant, Hospital 1)

CHF Nurse Consultants had to allow for professional logic and doctors' discretion, without ignoring the managerial logic more concerned with the 'healthy' operation of their organization:

It is important for me to facilitate clinical change, enhance patient safety, but without ignoring cost effectiveness that is implicit in the job of being clinical lead.

(CHF Nurse Consultant, Hospital 1)

I think there is an increasing level of regulation and performance management right across the NHS, which places great demands upon all of us. We have to focus on our local needs without ignoring national priorities. It is the conflict between local and national needs. And you have to take into account our clinicians' experience as well.

(CHF Nurse Consultant, Hospital 2)

Mediating between multiple logics was seen as a major challenge. CHF Nurse Consultants followed documentary guidance about implementing NICE guidelines, but did so very weakly, so that professional logic was sustained, with daily work routines left unaltered. In both hospital cases, CHF Nurse Consultants purposefully and flexibly interpreted and enacted professional and managerial logics so they blended into organizational practices they thought could offer more effective avenues for NICE guideline implementation:

I am looking at it from a clinical perspective [professional logic]. I am also thinking financially [managerial logic], but I am also thinking about how to provide the best care for those patients [professional logic, but also managerial logic aligns with this] that is cost effective [managerial logic].

(CHF Nurse Consultant, Hospital 1)

At the same time, executive managers invoked managerial logic as a rationale for implementation of NICE guidelines, in line with the overall organizational strategy to maintain fiscal balance:

Some guidelines are easier to implement than others, and those will be done. The ones that require particular financial investment will move to the back of the queue.

(Doctor, Chair of NICE implementation Group, Hospital 1)

CHF Nurse Consultants took on the role of facilitator, mediating between frontline staff, CHF senior doctors, some in hybrid middle manager roles themselves, and non-clinical executive management. In so doing, CHF Nurse Consultants attempted to strategically blend

multiple, sometimes ambiguous, and contested institutional logics to minimize conflict within their local context, and combine managerial and clinical practices, agendas and discourse. Their aim was to use logics flexibly to mediate between executive managers' and doctors' interests within their organizations. This was not without challenge for CHF Nurse Consultants who, sometimes, can be seen to move uneasily between professional and managerial logics, so they are blurred. Our findings suggest a potential risk of confusion arising from disparities in the way CHF Nurse Consultants framed and elaborated their various interpretations of multiple institutional logics:

It is important for us to demonstrate that we are NICE compliant [may represent managerial logic around organizational response to regulation, but might also represent professional logic of patient care based on best evidence]. However, it is reasonable to step outside the guidelines and use your judgement, particularly for doctors, who are trained to put everything else outside, apart from the one patient you are dealing with [professional logic]. At the same time, we have got to look at how we get the best value at the best quality and the best care for the population for a limited amount of money [managerial logic].

(CHF Nurse Consultant, Hospital 1)

Nevertheless, what is important for CHF Nurse Consultants, as they interpret logics, is not just implementation of NICE guidelines to take account of local context, but that others recognize and accept CHF Nurse Consultants as valuable strategic actors. We further discuss the enhancement of CHF Nurse Consultant's social position intra-professionally, inter-professionally, and within the organizational management hierarchy, in the next empirical section.

Pursuit of positional gains

The CHF Nurse Consultants positioned themselves as 'knowledge expert employees', who blended multiple institutional logics as they enacted their emerging managerial role.

Following professional logic, CHF Nurse Consultants recognized the need to seek legitimacy, with doctors in particular, for their expert role in acquisition and using evidence as they interpreted the institutional demands of implementing NICE guidelines:

Things change in medicine very quickly, which are not in the NICE guidelines published three years ago. It can mean that you are not following best practice, so it is always important to look for new knowledge and update our practice accordingly.

(CHF Nurse Consultant, Hospital 2)

CHF Nurse Consultants also imitated doctors, when they stressed their legitimacy to draw from their personal experience and tacit knowledge as they made clinical decisions:

Evidence comes from different things. I would not solely rely on guidelines on how to treat a patient. My evidence comes from personal experience.

(CHF Nurse Consultant, Hospital 1)

CHF Nurse Consultants argued that, because NICE guidelines were ‘abstractions from context, developed at a high level in the healthcare system’, their knowledge of context was necessary to accommodate operational issues on the ground:

They [NICE guidelines] are not good for looking at practicalities of our local context. We developed our local protocol guidelines, developed from other sources because the [NICE] guidelines are very good at setting up principles, but they do not provide the how-to-do.

(CHF Nurse Consultant, Hospital 1)

As well as emphasizing their expert and contextual knowledge, CHF Nurse Consultants remained keen to emphasize their managerial purpose, employed to enhance and maintain improvement in organizational outcomes. As CHF Nurse Consultants re-designed and modified the NICE guideline to reflect local circumstances, at the same time they monitored

clinical work, audited clinical performance and managed finances. Thus they enacted a managerial logic and exerted control and authority over implementation practices of their nursing peers and other professionals outside the medical cadre:

We planned financial resources, as well as deadlines to be devoted to implementation. We have a clinical risk manager and clinical facilitator reporting into me. These roles are also about audit, as well as trying to implement NICE.
(CHF Nurse Consultant, Hospital 1)

Executive managers supported the emerging managerial role enacted by CHF Nurse Consultants. Aligned with managerial logic, they described CHF Nurse Consultants well placed to control implementation of NICE guidelines:

I take my guidance from our CHF Nurse Consultants. I would not dream of saying I know better than them. They signpost which direction we should take in implementing the NICE guideline.
(Director of Nursing, Hospital 1)

They [CHF Nurse Consultants] are very influential within our organization. I am not too concerned if we are not NICE compliant, because we have to comply with best practices. We do this by having, in the case of CHF, our Nurse Consultants who are checking with our clinicians, how far they got implementing local guidelines, assessing non-compliance, process flows, cost effectiveness, new evidence and providing some information back to us.
(CEO, Hospital 2)

Whilst somewhat counter to the hierarchy encompassed within their professional logic, doctors also accepted expertise of CHF Nurse Consultants, because they perceived the latter made clinical judgements, based on the particular circumstances of their patients [professional logic], rather than for managerial reasons of control, cost or meeting targets [managerial logic]:

I feel that she [CHF Nurse Consultant] is working in the best interest of my patients and there is certain integrity between us. So I have trust in the way she is going about her work, from an integrity point of view and in her knowledge.

(Frontline CHF doctor, Hospital 1)

I trust [CHF Nurse Consultant] using her clinical judgement. She is acting in the interest of her patients and therefore she is not going to do just what the NICE guidelines are asking us.

(Frontline CHF doctor, Hospital 2)

Thus in interpreting institutional logics, as encompassed in clinical guidelines, CHF Nurse Consultants began to gain legitimacy with other higher status actors, frontline doctors, hybrid medical managers and executive managers, the latter seeing them as expert professionals and emergent managers. CHF Nurse Consultants invoke a managerial logic on occasions around evidence-based practice and control of professionals. Nevertheless their social position does determine the type of argument they make, as well as which logic they use to make it. Thus they continue to orientate towards professional logics, with a focus upon clinical judgement, patient care and the local population.

The effect of, and upon, social position of actors

Apparent in interviews with key informants nine months following the implementation of local guidelines, we found service reconfiguration and the social position of CHF Nurse Consultants sustained in the first hospital, but not in the second. In Hospital 1, the CHF Nurse Consultant sustained her position as an elite actor inter-professionally, intra-professionally and managerially.

The CHF Nurse Consultant was trusted to ensure best clinical and cost-effective practice within CHF and so produce the best outcomes for patients and the organization. Reflecting this, the CHF Nurse Consultant enhanced her position beyond that expected if we followed

professional logic enacted by doctors about clinical organization, where nurses remained overtly subordinate to doctors. She was free from external regulation and enjoyed autonomy beyond that which nurses traditionally experienced. Indeed, she might be characterized as behaving like her more powerful colleagues, doctors, in this respect:

We are not going back and checking, and this is because we assume that they [CHF Nurse Consultant] will carry on implementing best practices and will audit themselves all the time.
(CEO, Hospital 1)

Nevertheless, the interdependency of actors around professional logic was emphasized:

She [CHF Nurse Consultant] relies on the CHF doctors for support. They discuss treatment options and implementation plans. That is established. We pay our CHF doctors to do that. It is all formalized once a week [that] we are doing that.
(Medical Director, Hospital 1)

To highlight, the position of the CHF Nurse Consultant had been enhanced to some extent inter-professionally, albeit only in relation to general practitioners (GPs), who were of lower status compared to their hospital-based medical peers:

When the NICE guideline was published [2003], the Nurse Consultant post was to be the champion of that change. These days, I clinically lead the community CHF services. I actually do the service development, improve the clinical standards and educate not just nurses, but GPs.
(CHF Nurse Consultant, Hospital 1)

However, any aggrandisement of the CHF Nurse Consultant's position inter-professionally was one derived from the Medical Director's interest being served by service reconfiguration. In the case of the Medical Director, we see that a hybrid medical manager at executive level, did not necessarily represent their professional peers, but might indeed align with organizational interest:

I knew that if a GP was leading the service, he would devote a small amount of time to it and he would not be able to grow the service. I did not want a consultant cardiologist because he [sic] would go off and do other things and not focus on CHF in the community. In contrast, the Nurse Consultant is more reliable at following orders, and it is easier to influence her as opposed to GPs.
(Medical Director, Hospital 1)

Notwithstanding the above, nevertheless, in Hospital 1, frontline CHF doctors continued to transfer most of the CHF patients to the community team because this represented an opportunity to further develop the hospital cardiac department through increasing specialization:

If the cardiologists could offload the heart-failure patients to a specialist team in the community, it would increase their scope to develop their particular area as well.
(Frontline CHF nurse, Hospital 1)

Thus, in Hospital 1 at least, professional and managerial logics blurred and blended, as interpreted by different actors, including the CHF Nurse Consultant.

Aligning with the interest of hospital doctors and executive managers was a crucial aspect of the CHF Nurse Consultants interpretation of institutional logics in Hospital 1, which reinforced and sustained their influence. We note that both the new service and an enhanced role for the CHF Nurse Consultant in professional and managerial hierarchy endure. On revisiting the site informally, nine months later, following the end of our study, the CHF Nurse Consultant described:

Our service has been running successfully for a long time now [successful in terms of cost and clinical effectiveness, possible blending of professional and managerial logic]. We already do most of the things that NICE says and many more. The NICE guideline was a good place for us to start, but we have. We have been doing business cases year by year, developed our own guideline, gathered the evidence, treated the patients, done the trials, and you have seen what happens as a consequence [blending of managerial and professional logic].

(CHF Nurse Consultant, Hospital 1)

In contrast, such blurring and blending of professional and managerial logics was less evident in Hospital 2 over time, with greater contestation between logics in a way problematic for the organization to manage, and impacting on any positional gain for CHF Nurse Consultants. In the second hospital, local guidelines were not sustained. In large part, this was a consequence of performance and financial pressures faced by executive managers in Hospital 2, following which they enacted managerial logic in a particular way:

We are a challenged organization, particularly financially, with little stability in executive leadership. Now senior managers are more interested in managing the money, commissioning services rather than developing services. I can see how our community clinic has been challenged by that.

(Assistant Director of Nursing, Hospital 2)

It was emphasized that, because the organization was under-performing and had a financial deficit, any organizational change needed to be consistent with very strong managerial logic around quality and cost reduction:

Obviously the implementation of the CHF guideline is important, but we cannot ignore financial balance and other financial targets, which mean that we are given resources by the Department of Health to meet imposed priorities. And we don't exceed those resources, simply because my job would be under threat.

(Director of Finance, Hospital 2)

In the face of financial constraints, executive managers' priorities changed once the organization successfully passed a national audit on CHF NICE guideline compliance:

We passed a national audit of CHF and the hospital sees our service is complying with NICE and this is enough for them, but not for me. We can still improve the service, but it is not a top priority for the hospital.
(CHF Nurse Consultant, Hospital 2)

Evidence of a particular enactment of management logic was evident in the provision of financial incentives for GPs, which underpinned local implementation of the NICE guideline. To sustain the CHF nurse consultant-led community service required extra work by GPs. Consequently, CHF Nurse Consultants continually requested extra financial resources to incentivize GPs for their extra work, a request that executive management had previously supported. In the face of financially challenging circumstances, however, executive management now did not support their request. Consequently GPs refused to undertake extra work to support the new service:

GPs started to refer back to them [hospital doctors] and not to the community service [professional logic]. Community service referrals were going down and the hospital asked us to review our service. It appears that our service is not cost-effective anymore [managerial logic]. If the hospital board allowed us to provide some financial incentives I think we would be in a better place.

(CHF Nurse Consultant, Hospital 2)

At the same time, we note more powerful hospital doctors invoke a professional logic, which 'bites back' at the positional gain of the CHF Nurse Consultant. Frontline CHF doctors, represented by middle level, hybrid medical managers, clawed back services from the community in the face of the increasing resource constraints they faced because of the perilous financial position of Hospital 2. The CHF Nurse Consultant explained that, once CHF frontline doctors realized that resources were no longer available to develop the community

CHF service in accordance with their clinical interests, they deliberately disengaged from further efforts to sustain implementation of the NICE guideline and sought to maintain resource allocation to their clinical unit:

I struggled to sell the importance of cost effectiveness for primary care prevention of CHF to our hospital doctors to get them to support me. They were interested more in treatment and not terribly well disposed to any kind of prevention.

(CHF Nurse Consultant, Hospital 2)

Thus, highlighting the often ambiguous and contested nature of institutional logics, the initial strategic intention to invest in the implementation and sustainable uptake of the nurse-led community services, which the CHF Nurse Consultant managed, dissolved. The CHF Nurse Consultant in Hospital 2 enjoyed some early success in the re-organization of the community CHF clinics. However, later, it was not just that she could not develop service, but the community service that she managed, was discontinued. She further explained the reason for this:

I used to make recommendations for changes. People seemed to take notice. But after a point I felt increasingly powerless, really, because we didn't have the managers and hospital doctors on board with us. Inevitably, it was enough for our managers to comply with the basic recommendations of the NICE guideline [managerial logic]. This was not enough for me, so I am not involved in updating our local guidelines and disseminating them around. These days nobody is doing that.

(CHF Nurse Consultant, Hospital 2)

This caused some loss of her hard-gained status as an elite knowledge and managerial actor in the organization of CHF care provision. However, intra-professionally, the CHF Nurse Consultant retained significant clinical influence. She continued to specialize clinically within nursing, without disrupting traditional professional arrangements between nurses

and doctors; i.e. professional logic enacted by doctors was sustained. The CHF Nurse Consultant ceded clinical decision-making to doctors, at the same time she treated patients, and delegated to frontline CHF nurses any monitoring and feedback on progress towards adherence with agreed clinical outcomes, over which she retained oversight. At least, intra-professionally therefore, the CHF Nurse Consultant interpreted and actioned institutional logics to simultaneously change intra-professionally, and reproduce inter-professionally, power relations, establishing her role as dominant within nursing but remaining subordinate to hospital doctors.

Conclusion

Empirically, we explore how actors interpret multiple institutional logics in a public sector, professionalized organization, in a way that accommodates policy-driven managerial logic, itself ambiguous, and professional logic, itself variegated. Specifically, we consider two comparative cases of hospitals in the English NHS, where an emerging hybrid managerial cadre, CHF Nurse Consultants, implement standardized guidelines into frontline clinical practice.

In interpreting multiple institutional logics, CHF Nurse Consultants enhanced their social position in inter-professional and managerial hierarchy, and consolidated their elite intra-professional position (Battilana, 2011). However, over time, in Hospital 2, performance and financial pressures threaten survival of the organization, and so managerial logic was enacted by executive managers, to limit service change, rather than reconfigure service. In turn, this threatened the interest of powerful professionals, doctors, who, through their representatives, middle-level, hybrid medical managers, invoke their professional logic so that institutional arrangements are maintained in our empirical study regarding professional

relationships for delivery of healthcare (Currie et al., 2012). So, whilst multiple logics blended and blurred with little challenge in Hospital 1, in Hospital 2 the relationship between logics was more problematic for the organization. In Hospital 2, ambiguity in managerial logic is revealed in the way its enactment changed over time. In Hospital 2, in the later time period, managerial logic enacted by executive management and professional logic enacted by middle-level, hybrid medical managers and doctors, combine, to undermine the agency of, and positional gains made by CHF Nurse Consultants. Towards the end of our study, Nurse Consultants only sustain consolidation of their intra-professional position, as they stratify themselves further as elite actors within the nursing hierarchy, as an emergent managerial cadre (Lockett et al., 2015).

In the other case, Hospital 1, however, characterized by financial stability and high performance, professional logic remains in the background, not enacted by powerful actors. Thus, we see, in contrast to Hospital 2, co-existence of potentially competing logics is maintained over time (McPherson & Sauder, 2013). Relatedly, alongside consolidation of intra-professional position, positional gains by CHF Nurse Consultants are also sustained over the time period of our study. It may be, however, were performance and financial pressures to emerge in Hospital 1, then professional and managerial logics might also 'bite back' at positional gains. Notwithstanding this, Hospital 1 also reveals variegated interpretation of multiple logics by hybrid medical managers, as well as their nursing counterparts. On the one hand, those in middle-level hybrid medical manager positions, buffer intrusion upon professional logic enacted by doctors. On the other hand, the hybrid medical manager at executive level appears to interpret and enact managerial logic, more in organizational than medical interest (McGivern et al., 2015). Nevertheless, despite such

variegation, in the absence of the financial and performance pressures evident in Hospital 2, interpretation of multiple logics by different actors in Hospital 1 proves relatively unproblematic, albeit multiple logics are also revealed as ambiguous and subject to different interpretations in managerial and professional practice.

Theoretically, our study highlights the power and politics that pervade professionalized contexts, where institutional actors' social positions may vary (Greenwood et al., 2011; Pache & Santos, 2010). By focusing upon interpretation of multiple institutional logics at the micro-level (McPherson & Sauder, 2013; Thornton et al., 2012; Zilber, 2013), our study renders visible the agency of interpreting actors, interdependency of actors and institutional logics, and situational constraints that impact on the social position of actors. Given the availability of multiple logics, institutional actors exhibit agency in which institutional logics they enact, and how they interpret them, for social action and interaction (Friedland & Alford, 1991). Our study shows institutional actors are active participants in (re-)interpreting multiple logics in ways that are guided by, and shape, their social position.

Our analysis thus extends the study of Jarzabkowski et al. (2009, 2013) around the relational and interdependent features of institutional complexity, through which potentially competing logics are part of a greater system of institutional interactions. Aligned with Jarzabkowski et al., we show evidence of mutual adjustment between interdependent actors in the face of institutional complexity. Extending the analysis by Jarzabkowski et al., we detail the process of mutual adjustment – powerful agents (doctors and executive managers) enable agency for relatively less powerful agents (CHF Nurse Consultants) by transferring a degree of power to them. At the same time, the less powerful actors are cognizant of, and take care to align with, the logic held by their powerful

counterparts, deploying strategies to minimise local conflicts in order to enhance their power. Our study also highlights mutual adjustment is only evident when the logic held by powerful actors is not threatened. Our case comparison reveals that, when powerful actors' interests are threatened, such mutual adjustment dissolves, with limited agency granted to less powerful actors by the more powerful actors.

Our study also highlights the importance of the social position of interdependent actors in the blurring and blending of institutional logics (Battilana, 2011; Lockett et al., 2015). Multiple logics can be conceived as a set of re-arrangeable parts (Greenwood et al., 2011; Reay, 2014), which can be enacted in a bricolage way (Christiansen & Lounsbury, 2013; Goodrick & Reay, 2011; Pache & Santos, 2013) to pursue positional gain. Conceiving institutional logics as malleable, lower status actors in inter-professional terms moved beyond merely re-arranging them, towards re-interpreting and elaborating such logics (McPherson & Sauder, 2013).

Finally, it may appear that logics are segmented, with different groups operating according to different logics and co-existing in a cordial relationship (Reay & Hinings, 2009), or that logics are additive, with actors satisfying demands of more than one logic simultaneously to legitimize their actions (Goodrick & Reay, 2011). However, we cannot assume that institutional logics easily co-exist (Reay, 2014; Waldorff et al., 2013). Institutional logics may be latent, enacted in the face of situational constraints, when higher status actors find their position and interests threatened. As might be expected, some higher status actors have greater influence over what logics are interpreted, for what ends, in the face of potential incompatibility (Greenwood et al., 2011). In this light, our study warns that possibilities for agency by lower status actors in interpreting institutional logics

are only realized, when (re-)interpretation of institutional logics aligns with interests of higher status actors, otherwise the latter are likely to enact multiple logics in a way that 'bites back' at positional gains of the former. Translating this to the organizational level, we highlight situational constraints – in our empirical study, financial deficit and performance pressures – influence whether potentially incompatible logics can be integrated in an organization (Almandoz, 2012). Thus we highlight interpretation and enactment of institutional logics is part of a fluid negotiation of professional jurisdictions, in response to the call for such studies by McPherson and Sauder (2013).

In practical terms, our study highlights the 'paradox of embedded agency' (Seo & Creed, 2002) regarding which actors are best positioned to drive change (Lockett et al., 2015). On the one hand, CHF Nurse Consultants were well positioned to drive change that contextualized policy in a way that blended managerial and professional logics. Further, they welcomed the opportunity to act in a hybrid managerial role and interpret multiple logics to drive change, since it allowed them to enhance their social position (Lockett et al., 2015). On the other hand, as a consequence of their lower professional status, CHF Nurse Consultants are dependent for agency to enact change upon higher status actors, such as doctors. However, in one of case studies, ever-increasing financial and performance pressures cause more powerful actors to resist service change, and limit change agency of lower status actors (Burgess & Currie, 2013).

Regarding future research, first, in considering the interaction of social position and situational constraints upon interpretation of multiple institutional logics, within our study, situational constraints varied but our focal actor was constant. We engaged in some limited comparison of interpretation of multiple logics by hybrid managers from the nursing and

medical professions, which others may more systematically investigate, tracing interpretation of institutional logics across actors located in different social positions within professional organizations. Further, whilst we argue our healthcare setting represents a particularly propitious empirical site for study, nevertheless, for other low-status actors in other professionalised domains, the interaction of institutional logics and social position may play out rather differently. Thus we encourage research to assess the transferability of our findings to other professionalized contexts, with particular concern for the sustainability of positional gain for those lower status actors interpreting institutional logics in the face of complexity.

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Figure 1: The analysis process and the progression from simple coding to more aggregate theoretical categories

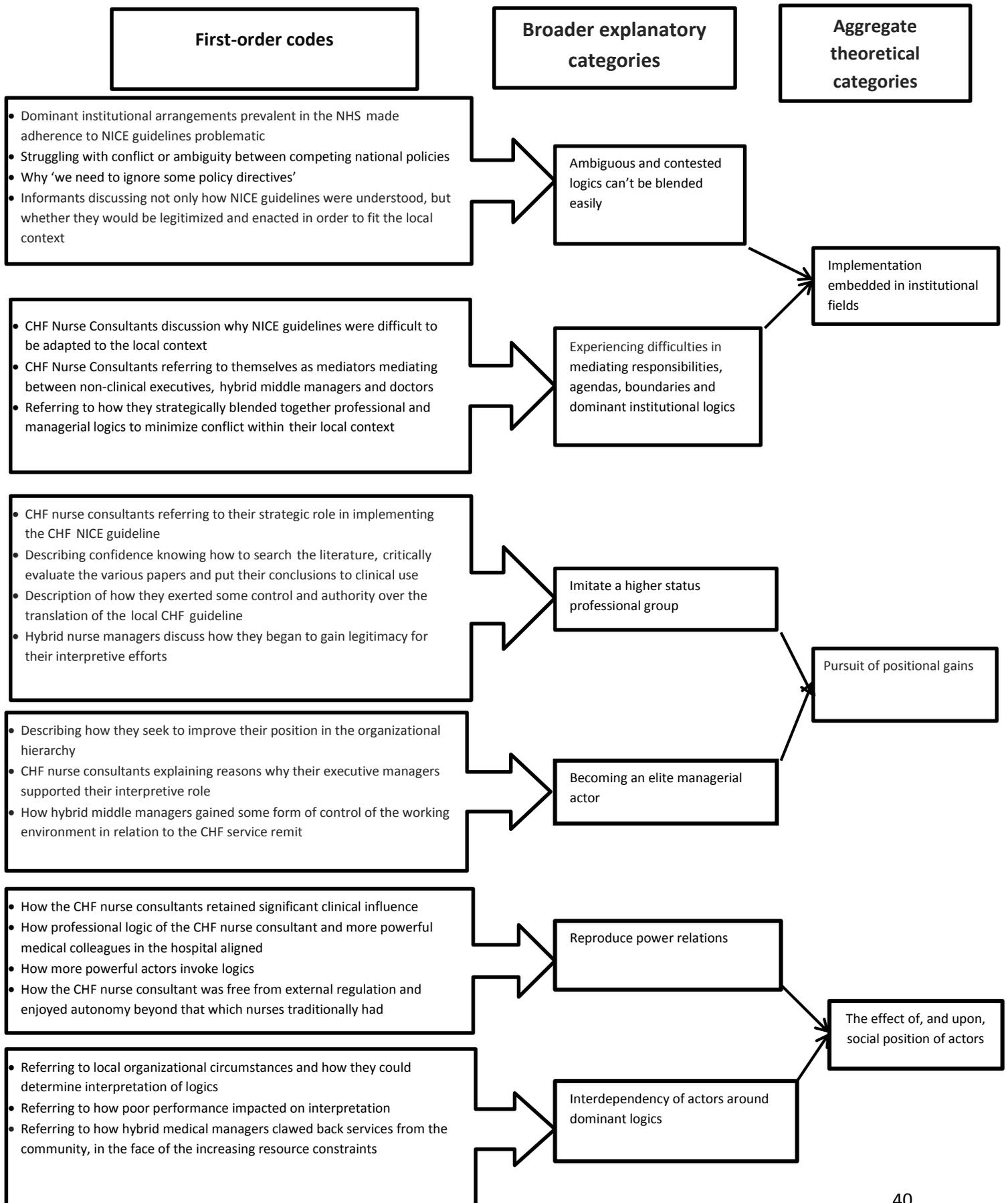


Table 1: Interviewees

Interviewees	2010–2011		2012	
	Hospital 1	Hospital 2	Hospital 1	Hospital 2
CHF Nurse Consultants	1	1	1	1
Other hybrid nurse managers	5	7	1	1
CHF frontline nurses	7	9	–	–
Hybrid medical managers	3	2	1	1
CHF frontline doctors	1	2	–	–
Non-clinical executive managers	4	5	–	–