Institutional complexity and individual responses: delineating the boundaries of partial autonomy

Abstract

Research highlights how co-existing institutional logics can sometimes offer opportunities for agency to enterprising actors in organizational fields. But macro- and micro-level studies using this framework diverge in their approach to understanding the consequences of institutional complexity for actor autonomy, and correspondingly in the opportunities they identify for agents to resist, reinterpret or make judicious use of institutional prescriptions. This paper seeks to bridge this gap, through a longitudinal, comparative case study of the trajectories of four ostensibly similar change initiatives in the same complex organizational field. It studies the influence of three dominant institutional logics (professional, market and corporate) in these divergent trajectories, elucidating the role of mediating influences, operating below the level of the field but above that of the actor, that worked to constrain or facilitate agency. The consequence for actors was a divergent realization of the relationship between the three logics, with very different consequences for their ability to advance their interests. Our findings offer an improved understanding of when and how institutional complexity facilitates autonomy, and suggests mediating influences at the level of the organization and the relationship it instantiates between carriers of logics, neglected by macro- and micro-level studies, that merit further attention.

Keywords

Institutions; institutional logics; healthcare; professionalism; managerialism; markets; National Health Service; England

Introduction

Academic understanding of conformity, differentiation and change in organizational fields has been advanced in recent years by a burgeoning literature drawing on the concept of institutional logics. From its foundations in neo-institutionalism, the institutional logics perspective has rapidly advanced to theorize how diverse institutional forces not only compete for dominance, but also frequently interact and co-exist, and how this affects organizational and individual behaviour. It offers a rich explanatory framework that accounts for heterogeneity as well as conformity, and which better allows for the potential of agency as well as structure in enacting, contesting and transforming institutions.

Within this approach, a particularly vibrant thread of research has focused on the consequences of *institutional complexity*—that is, the presence of multiple logics with conflicting, or at least diverging, prescriptions for behaviour. At the macro level, theoretical and empirical studies have, as a rule, found that institutional complexity adds further constraints to organizations' and individuals' behaviour, since it poses expectations from additional audiences, all of whom must be satisfied for legitimacy (Pache & Santos 2010; Kraatz & Block 2008). Yet such predictions have not always been borne out in micro-level studies of individual behaviour under conditions of complexity, which often find that actors 'on the ground' exercise a remarkable degree of autonomy in their day-to-day practice (e.g. Hallett 2010). The objective of this study, therefore, is to attempt to bridge this gap, through a longitudinal comparative case study of the consequences of a period of intensifying institutional complexity for actor autonomy, in the English National Health Service (NHS). Existing theory predicts that this period of change, which saw the increasing *centralization* and *formalization* of institutional expectations (Pache & Santos 2010; Greenwood et al. 2011; Thornton 2002), would impose more exacting expectations on individual-level behaviour. But we found a mixed picture, with two cases remaining recalcitrant to changing institutional

prescriptions, while in two others actors' behaviour was more conforming. We seek to add to an emerging literature on organizational-level factors in the constitution of institutional logics (e.g. Besharov & Smith 2014) by elucidating this meso-level influence on the degree of latitude enjoyed by actors in the face of apparently determinative institutional prescriptions. In so doing, we outline alternative forms of organizational influence on the experience of logics 'on the ground', and begin to identify the building blocks for a bridge between macro-level and micro-level work on institutional logics that has to date been missing. We respond to calls for research that takes seriously the partial and contingent nature of agency in institutional fields (Thornton et al. 2012; Greenwood et al. 2010; Waldorff et al. 2013), and accounts for institutional complexity more adequately by considering more than two logics (Greenwood et al. 2010; 2011; Goodrick & Reay 2011).

We begin by reviewing the institutional logics literature, including its propositions on how logics co-exist, and how actors respond to this. We highlight the disconnection between macro- and micro-level studies, and argue that, while micro-level studies have gone some way to fulfilling their promise of returning neo-institutionalism to its 'microfoundations' (Powell & Colyvas 2008), the methodological approaches predominant in this literature mean that in aggregate it risks overstating the "avenues for partial autonomy" (Thornton et al. 2012, p.7) available to individual actors. Then we briefly describe our empirical setting, a particularly complex institutional field in terms of the dimensions set out by Greenwood *et al.* (2011). After accounting for our methods, we explore the dynamics of institutional change and the divergent consequences for our four cases through time. We then discuss our findings and their implications for theory and future research.

Institutional logics: coexistence and its consequences

Over the last 15-20 years, the institutional logics approach has offered an increasingly sophisticated means of accounting for change and stability in organizational fields. Institutional

73 logics are “the socially constructed, historical pattern of material practices, assumptions,
74 values, beliefs, and rules by which individuals produce and reproduce their material
75 subsistence, organize time and space, and provide meaning to their social reality” (Thornton &
76 Ocasio 1998, p.804). In other words, institutional logics are the key means by which social
77 reality is reproduced and changed. Distinctive domains of social practice—organizational
78 fields—have their own sets of institutional logics, derived from societal-level logics, from the
79 logics of neighbouring fields, and from the endogenous action of the individuals who populate
80 them (Thornton et al. 2012).

81 Formative research within the institutional logics approach focused primarily on the
82 dominance of given logics: how this was created, maintained and challenged (e.g. Scott et al.
83 2000). Increasingly, however, research has found that many fields are characterized by the co-
84 existence of a plurality of logics—often with no single logic dominant in determining actors'
85 disposition and behaviour. Rather than representing a temporary, transitional phase between
86 epochs of dominance by a single logic, “some fields are better portrayed as leaning towards the
87 ‘relative incoherence’ of enduring, competing logics” (Greenwood et al. 2011, p.323).
88 Greenwood et al. (2011, p.332) note that research on institutional complexity has tended to
89 assume that coexisting logics are “inherently incompatible,” but more recent studies have
90 challenged this assumption. Several have found that contradictory logics may coexist in an
91 organizational field, often in a kind of ‘creative tension’ which means that their influences
92 affect actors simultaneously (e.g. Reay & Hinings 2005; 2009; Lounsbury 2007; Greenwood
93 et al. 2010; Goodrick & Reay 2011; self-citation). The plurality of institutional prescriptions
94 available means that a diversity of actor behaviours is often in evidence: for example,
95 Lounsbury (2007) finds that different fund managers operate according to ‘trustee’ and
96 ‘performance’ logics concurrently, depending on their geographical location.

97 The presence of divergent behaviours, however, should not automatically be interpreted

98 as signalling greater actor autonomy. The influence of logics, studies have found, is often
99 'segmented', such that different groups of actors are affected differentially by logics'
100 prescriptions (Reay & Hinings 2009; Pache & Santos 2010; Goodrick & Reay 2011). Reay and
101 Hinings (2009, p.646), for example, find that the rivalry between an incumbent logic of medical
102 professionalism and an increasingly powerful logic of business-like healthcare is managed by
103 collaboration between physicians and administrators, with each group maintaining its
104 independence but engaging "in collaborations that result in mutually desirable outcomes and
105 thus sustain the co-existing logics." Often, therefore, studies of sustained institutional
106 complexity find that carriers of different logics—for example, professional and managerial
107 groups—remain bound to their 'home' logics and referent audiences, and are able to continue
108 to act in accordance with their expectations. Alternatively, the same group of actors may have
109 to satisfy the expectations of more than one audience for legitimacy, such that different aspects
110 of their practice are governed by different logics (e.g. Smets et al. 2015).

111 To observe that multiple logics are available within a field, therefore, is not to imply that
112 individuals are able to pick and choose freely from their prescriptions. Due to their prior
113 socialization, the expectations of their referent audiences, and other structural determinants,
114 actors continue to face the constraints presented by the need for legitimacy, as identified by the
115 earliest exponents of neo-institutionalism. The most recent developments in our understanding
116 of the consequences of institutionally complex fields for actor autonomy arguably retain this
117 structural focus. A promising recent line of inquiry is the consequences of the specific
118 configuration of logics in a field: the 'constellation' in which they are formed (Reay & Hinings
119 2009; Goodrick & Reay 2011; Waldorff et al. 2013). The same logics may be configured
120 differently in different fields, with important consequences for actor behaviour, as Waldorff et
121 al. (2013) demonstrate with a comparison of Danish and Canadian healthcare. A similar set of
122 logics existed in each setting, but they were arranged in rather different constellations, so that

123 a complementary relationship between market and professional logics in Canada led to changes
124 in behaviour that did not arise in Denmark, where the relationship was more antagonistic.
125 Waldorff et al. (2013, p.125) claim that "the concept of constellation of logics [offers] a new
126 way of understanding agency. We see that it is the arrangement and relationship among logics
127 that helps to explain how action can be both constrained and enabled." Yet their analysis
128 remains at the level of the field: the constellation of logics is a product of field-level dynamics
129 (most notably, in this example, incentive structures and regulatory regimes), and these
130 determine the repertoires available to different actors. There is less sense in such analyses of
131 the way, as Smets and Jarzabkowski (2013, p.1301) have it, "constellations are constructed
132 rather than given, and which dimensions of agency drive their construction."

133 Partly in response to the shortcomings of the macro-level focus of much of the work on
134 institutional logics, another—largely separate—body of literature considers the micro-level
135 enactment of logics by individuals at the 'coalface' (Barley 2008) of everyday work—that is,
136 the unremarkable, day-to-day interactions of actors in institutionalized fields, far removed from
137 the battles between institutions and high-level institutional entrepreneurs. Scholars in this line
138 argue that much neo-institutional research neglects "interpretation and subjectivity, which […]
139 offers considerable degrees of agency and freedom to reinterpret and even change institutional
140 templates" (Bévort & Suddaby 2015). Where institutionalists have considered agency, they
141 have focused disproportionately on what Smets et al. (2012, p.878) call "'hypermuscular'
142 institutional entrepreneurship": the work of "heroic actors" (Powell & Colyvas 2008, p.277)
143 with unusual levels of individual or collective clout, who feed back into the constitution of
144 institutional logics themselves (e.g. Greenwood et al. 2002; Murray 2010). What this neglects,
145 critics argue, is the everyday work of lower-profile actors who nevertheless are active in their
146 interpretation and application of institutional logics.

147 Accordingly, work on 'inhabited institutions' (Hallett & Ventresca 2006) has examined

the lived experience of actors in institutionalized fields, and the practices they pursue, consciously or unconsciously, that reproduce or challenge institutional expectations. Often deploying ethnomethodological approaches, these studies highlight the interpretive, non-deterministic processes that translate situations of institutional complexity into day-to-day reality (e.g. Heimer 1999; Binder 2007; Hallett 2010; Everitt 2013; McPherson & Sauder 2013; Smets & Jarzabkowski 2013; Smets et al. 2015). They vividly demonstrate Powell and Colyvas's (2008, p.277) assertion that a division between "heroic actors and cultural dopes [is] a poor representation of the gamut of human behavior." For example, Binder (2007) shows how professionals in different parts of the same organization meld together institutional demands, personal beliefs and localized meaning systems in the way they enact their organization's mission. Everitt (2013) looks at the professional socialization of teachers as agentic and active, combining institutional prescriptions with social influences and personal preferences. Such work focuses above all on the everyday work of actors who are not in the business of "intentionally pursuing a clear institutional 'vision'" (Smets & Jarzabkowski 2013, p.1300): they are not seeking to transform the rules of the game in an institutional field, but to forge a legitimate path through complex organizational settings characterized by a profusion of prescriptions, power relationships and personal interests (Smets et al. 2015).

Taken together, these studies provide an important corrective to neo-institutionalism's focus on the power of institutional logics. Yet their key methodological advantage—detailed examination of practice as it takes place in real-life environments—also creates a limitation. With few exceptions, these papers offer in-depth understanding of single organizations or even single organizational sub-units, rather than cross-sectional comparisons. This means that they are unlikely to reveal organizational-level contingencies in the way that, for example, a comparative case-study approach might. They also tend to ascribe a remarkable degree of autonomy to individual actors—perhaps in consequence of case selection, or of a desire to

173 challenge the structuralist predictions of macro-level studies, or of the preferences of journals
174 for studies that indicate new or unexpected findings. In aggregate, these studies suggest that
175 actors enjoy a great deal of latitude, in contradiction to the findings of the macro-level
176 institutionalist literature. If a macro-level focus fetishizes structure, then a risk of a micro-level
177 focus is fetishizing agency. Thus, echoing Hardy and Maguire's (2008, p.199) critique of the
178 institutional entrepreneurship literature, we need to "ensure that the efforts of institutional
179 theorists to incorporate agency—in order to move beyond an over-emphasis on the constraining
180 effects of institutions—do not swing too far in the opposite direction."

181 What has been less prominent in the literature is examination of the circumstances in
182 which such agency is possible. With this in mind, our study considers the consequences of
183 institutional complexity, and rapid institutional change, in four organizations in the same field,
184 which exhibited divergent outcomes in terms of the room for manoeuvre achieved by the
185 central actors, each of whom sought to maintain a novel service intervention that became
186 misaligned with the prescriptions of the dominant logic within the field. We sacrifice the
187 ethnomethodological depth of the 'inhabited institutions' tradition for comparative breadth, but
188 nevertheless offer a detailed, qualitative, longitudinal study covering seven years of change.
189 Our approach is not without precedent: the work of Reay and Hinings (2005; 2009) similarly
190 combines field-level analysis with qualitative interviews with key actors, but whereas their
191 focus is the consequences for the composition of the field, ours is the consequences for the
192 autonomy of everyday actors (not muscular institutional entrepreneurs) at the coalface.
193 Whereas the success of institutional entrepreneurs is often attributed to the power deriving from
194 their social position or to exceptional creative vision (Hardy & Maguire 2008), we address the
195 question of what enables or constrains these 'coalface' actors, who cannot rely on such
196 attributes, in acting autonomously. We ask: what are the conditions that precipitate and inhibit
197 actors' ability to defy changing institutional prescriptions in defence of their own beliefs and

198 interests?

199 Institutional logics in English healthcare, 2005-2011

200 The field of healthcare is quintessentially institutionally complex. It has offered a fertile ground
201 for the development of institutional theory, with key contributions arising from analysis of
202 healthcare systems globally (e.g. Scott et al. 2000; Reay & Hinings 2005). As Pache and Santos
203 (2010) note, healthcare is a fragmented field where stakeholders from a wide range of logics
204 co-exist, but is also dependent on a small number of resource providers (in England's case, the
205 state). "The most complex fields for organizations to navigate," argue Pache and Santos (2010,
206 p.458), "are moderately centralized fields" of this kind, "characterized by the competing
207 influence of multiple and misaligned players whose influence is not dominant yet is potent
208 enough to be imposed on organizations." Besharov and Smith (2014) conceptualize such fields
209 as combining 'high centrality' (with multiple logics central to organizational functioning) with
210 'low compatibility' (because the logics' prescriptions are contradictory), and suggest that such
211 fields produce 'contested' organizations characterized by extensive conflict.

212 In common with healthcare systems worldwide (e.g. Scott et al. 2000), the NHS is the
213 site of long-term conflict among logics. Of particular note is the influence of the professional,
214 corporate and market logics. The professional logic in healthcare can be characterized as the
215 dominance of professionals over not just clinical but organizational decision-making, and
216 deference among others (managers, patients and lower-status clinicians) to (medical)
217 professional knowledge (Reay & Hinings 2009). The market and corporate logics are
218 sometimes conflated (e.g. [self-citation]), but we follow Thornton (2002) in distinguishing
219 between them as two potentially complementary, but conceptually separate, institutional
220 logics. The corporate logic is realized through managerial techniques for controlling
221 professionals' activity, for example performance-management regimes, standardization of
222 clinical care, and development of capacity for surveillance and audit. The market logic

represents a shift towards use of competition among providers and market signals to induce improvement and contain costs. Traditionally dominated by medical professionalism, the English system was subject to increasing managerial and market influences from the 1980s onward, as the state sought to challenge professional jurisdictions and provider monopolies as part of wider ‘new public management’-style reforms (Ferlie 1996). Within this longer-term shift in the balance of logics, the period of our study, 2005-2011, can be seen as a particularly turbulent period of change, marking as it did the end of an unprecedented increase in healthcare spending in England, followed by a rapid retrenchment into austerity. Government funding for healthcare rose rapidly in the early 2000s (at a real-terms rate of 7% per annum) before plateauing and finally declining slightly relative to GDP (OECD 2014). The exogenous jolt of the global financial crisis from 2008 was partly responsible for this transition, but by this point the government had already begun to shift its focus from increasing capacity to increasing productivity (Secretary of State for Health 2008). In 2006 the government required that the NHS’s £520-million deficit be transformed into a £250-million surplus by 2008 (Day 2006), and as the financial situation became straitened, in 2009 the NHS chief executive called for efficiency savings of 20% within five years (Nicholson 2009).

This turnaround in the financial environment translated into pronounced shifts in the organizational field, with the government seeking to increase the influence of market and corporate logics. Firstly, in line with the corporate logic, there was an increased emphasis on more managerial approaches to improving quality (e.g. care pathways, skill-mix reconfiguration) (Secretary of State for Health 2008). Secondly, again following the corporate logic, the government introduced a more intensive regime of performance management of NHS provider organizations, including a pledge to reduce waiting lists to 18 weeks, backed by the ability to invoke Draconian sanctions against ‘failing’ organizations (Lewis & Appleby 2006). Thirdly, following the market logic, the government took renewed steps to increase

248 competition in the NHS. Although an internal market for acute healthcare services had existed
249 since the early 1990s, further steps were taken from 2006 to extend the scope of the market, by
250 increasing service provision outside traditional hospitals (Secretary of State for Health 2006),
251 increasing the power of 'commissioners' (holders of healthcare budgets for a locality,
252 responsible for paying for the healthcare needs of the local population) over providers (Ham
253 2008), and removing all responsibility for providing care from commissioning organizations,
254 known as primary care trusts (PCTs), so that services were tendered competitively rather than
255 offered 'in house'. Thus there was a sustained effort to ensure that the logic of the market
256 pervaded the entire healthcare system, including areas that had previously been immune to its
257 influence.

258 This period, then, was characterized by particularly intensive change, as government
259 sought to adapt to the end of a period of sustained increases in funding by introducing evermore
260 extensive market and managerial policies into the NHS system. Of course, changes in policy
261 do not instantaneously give rise to a shift in the logics governing actors' behaviour;
262 nevertheless we can detect in these policies an attempt to strengthen the market and corporate
263 logics—and correspondingly weaken the professional logic. At the start of the period, the NHS
264 was enjoying unprecedented real-terms increases in funding; by the end, it was facing
265 unprecedented levels of efficiency savings. A system of performance management that was
266 emerging at the start had grown into a fully-fledged set of central-government prescriptions by
267 the end, accompanied by the ability to 'punish' non-compliant or ineffective organizations with
268 sanctions or wholesale replacement of management. At the beginning, only secondary-care
269 services provided by hospitals were subject to a competitive system of resource allocation, but
270 by the end all community-based services, previously provided in-house by PCTs, were exposed
271 to the same expectation. The period was thus characterized by great institutional turbulence,
272 with increasing *centralization* and *formalization* (Greenwood et al. 2011; Pache & Santos

273 2010) of the market and corporate logics.

274 **Setting and methods**

275 Our paper follows the trajectory of four new service developments over this period, through a
276 longitudinal understanding over the period 2005-2011 of how those responsible for leading the
277 development of these services—the 'focal actors'—and other stakeholders responded to the
278 changing institutional environment. The four services in question had their roots in a national
279 government initiative in 2004 which aimed to encourage the 'mainstreaming' of clinical-
280 genetics knowledge across the English NHS. This initiative (Secretary of State for Health 2003)
281 provided pump-priming funding to 27 pilot services, each of which sought to introduce a new
282 approach to delivering genetics services in its locality—for example by changing the way risk
283 assessment or counselling was provided—but maintaining professional control over this. Our
284 team evaluated the initiative, studying the changes attempted in a theoretical sample of 11 of
285 the services. The initiative ran on the basis that successful services would be sustained using
286 local monies, and host organizations committed to this as a condition of funding. However, in
287 the event, when pilot funding ended in 2007, only a minority of services were sustained,
288 including just four of the 11 we studied (see Table 1). The challenges inherent in sustaining
289 organizational innovations are an area of significant policy interest in the UK (e.g. Buchanan
290 et al. 2007), and we therefore developed, and succeeded in obtaining external funding for, a
291 follow-up study that revisited the four sustained services post-pilot, to examine in more detail
292 what had made a difference in their successful continuation. This paper derives from both the
293 original evaluation and the follow-up study, offering a longitudinal analysis of the work of
294 actors involved in the four services covering the seven-year period 2005-2011. While we lack
295 the data from the seven discontinued services to consider them in detail in this paper, Table 1
296 shows how they resemble and differ from our sample of four according to key variables, and
297 briefly summarizes the reasons for their termination.

298 [TABLE 1 ABOUT HERE]

299 For our original evaluation, our sample was driven by a theoretical approach to obtain
300 variation in key variables of interest, *inter alia* host organization (e.g. hospitals versus primary-
301 care organization), professional affiliation of focal actor (e.g. doctors, nurses), and disciplinary
302 affiliation (e.g. specialist geneticists, other specialist clinicians, generalists). These variables
303 are highlighted as pertinent in the existing literature (e.g. Battilana 2011); they were
304 supplemented in our sampling strategy by other variables raised as of potential significance in
305 discussions with our funder, such as clinical focus of the service and amount of funding
306 allocated. Cases exhibiting various combinations of these variables were sampled to facilitate
307 cross-case comparison. Our follow-up study included all sites from this original sample that
308 were sustained with further funding beyond the pilot period (4/11). While they differ in detail,
309 all four embodied a professionally led approach to improving genetics provision by breaking
310 down organizational boundaries (e.g. between specialisms or between primary and secondary
311 care) that gave rise to disjointed provision. Given that the focal actors in each case were
312 successful in obtaining post-pilot funding where their peers in the other seven services failed,
313 they could be seen as exceptional; but as our findings demonstrate, they did not have significant
314 power over local decision-making. In one site (Bolbourne), ongoing funding ceased after six
315 months; in the other three, it continues today.

316 [TABLE 2 ABOUT HERE]

317 Table 2 summarizes the four cases. Of particular note in the composition of our sample
318 are the similarities and differences in two dimensions: professional allegiance of focal actor;
319 and organizational host. Whereas Ashover's focal actor was a nurse by training who had more
320 recently become involved in a managerial capacity in her organization, the other three cases
321 were led by physicians of varying backgrounds. The focal actor in Bolbourne was a general
322 practitioner (family physician), while Carsridge was led by a clinical geneticist and Dovington

by a specialist physician in the ‘mainstream’ clinical area into which genetics provision was being incorporated (we leave this unspecified to protect participant anonymity). Nurses are of lower status than doctors in English healthcare as worldwide (Battilana 2011); the intraprofessional hierarchy within medicine tends to place specialists above generalists, although the changes afoot in the English system explicitly sought to raise the standing of general practitioners and increase their influence on resource allocation (Secretary of State for Health 2006). The host organizations in Ashover and Bolbourne were both primary care organizations: PCTs responsible for budget-holding and resource allocation, but which also at the *start* of the period provided some services in-house, including these genetics services. Carsridge and Dovington’s services were hosted by acute hospital trusts: large hospital organizations providing services to the populations covered by several PCTs.

Both studies used a combination of qualitative methods, drawing primarily on in-depth interviews with key actors (e.g. focal actors, others involved in service delivery, those in key decision-making and budget-holding roles beyond the services), supplemented by observational data and document collection and analysis. In total, across the two studies, we undertook 83 interviews over four time points, broken down as shown in Table 2. For the original evaluation, we undertook the majority of interviews in 2005-6 (hereafter referred to as T_1), with follow-up interviews in 2008 (T_2). For the second study, we undertook further interviews in 2010 (T_3) and 2011 (T_4). Thus our data offer a longitudinal perspective on the trajectories of the four cases spanning seven years, albeit with data collection unevenly distributed across the period. Interviews ranged from approximately 30 to 130 minutes, with an average length of around one hour. Our topic guide in the original evaluation covered a wide range of issues, most notably for this paper the rationale for the service, how it related to and modified existing provision, relationships with key stakeholders and organizations, plans for the future, and (at T_2) progress towards maintaining provision post-pilot. In the follow-up study

our topic guide focused more specifically on the trials and tribulations of sustaining these small service innovations in a changing environment, the degree to which they had evolved in their service models, and the organizational, financial and relational work that had been done and was anticipated to maintain their existence.

All interviews were transcribed in full. They were analysed using an approach informed by the constant-comparative method (Charmaz 2007), with specific attention directed towards certain 'sensitizing concepts'—ideas that had informed our thinking in developing the study, derived from prior conversations, analysis of policy documents, and the existing literature on healthcare and organizational change—covering the social, professional, organizational and policy influences on service innovation and sustainability. We thus developed themes both inductively and deductively, to cover issues derived from existing conceptual frameworks, but also issues that emerged from close, repeated readings of the data sources. GPM and SW both read the source materials several times over, and GPM then led coding and analysis using NVivo software. This involved an initial 'broad-brush' coding of all documents to identify portions that offered potential insights for the purpose of this paper (since a substantial proportion of the material from the original evaluation was not relevant), informed by our existing knowledge. In discussion with the other authors, GPM then undertook several rounds of more refined, inductive coding, firstly coding items in terms of the actions described by interviewees in relation to the development and sustaining of the services (Charmaz 2007), and then a further round of more theoretically oriented coding that sought to identify the influence and enactment of different logics in the activities interviewees described and the way they justified them. He then developed case histories describing the trajectories of the four cases over the period studied, which he discussed with co-authors before returning for a final round of coding, merging some existing codes and disaggregating others.

372 **Findings**

373 We present our findings over three sections. First, we examine the way the services were set
374 up, and the impact of the rapid shift in the policy landscape for the continued legitimacy of
375 services premised on a professional logic. Next, we consider the focal actors' response to this
376 challenge, which was differentially successful across the four cases, with very different
377 outcomes in terms of the logics that were most evident in actors' behaviour. Finally, we explore
378 the reasons for this. By examining the data from across the cases in more detail, we suggest
379 that the answer lies neither in the constellation of logics present in the field, nor solely in the
380 creative capacity of the focal actors to make instrumental use of these logics, but in a
381 confluence of micro- and macro-level circumstances, mediated at the meso (organizational)
382 level, that meant that institutional repertoires that were accessible and held legitimacy in some
383 cases were beyond the reach of focal actors in others.

384 *Professionally led services and shifting institutional logics*

385 When originally designed and initiated in 2004 through central government funding, all four
386 services embraced a model premised on professional ownership and accountability. The white
387 paper that announced the initiative had emphasised the role of clinical professionals in devising
388 new genetics services (Secretary of State for Health 2003), and accordingly, all the projects
389 funded were led by clinicians, not managers—primarily clinical geneticists, but also other
390 physicians, and nurses. Focal actors emphasised the centrality of a professional ethic in their
391 approaches to delivering the new services, though in slightly different ways. In Carsridge and
392 Dovington, they stressed the importance of ensuring that genetic knowledge was mainstreamed
393 in a way that maintained or enhanced specialist involvement, rather than reducing it to a
394 protocolized approach that might be more in line with the corporate logic. In the two primary-
395 care cases, Ashover and Bolbourne, the emphasis was on integrating genetics into a generalist
396 model of care, emphasising holism and the wider public health:

397 “We were aware right from the early stages that patients really didn’t get a terribly good
398 deal in terms of any kind of comprehensive service. There was very little continuity and
399 I thought we could do a better job.” (Focal actor (mainstream physician), Dovington,
400 T_1)

401 “Anybody who’s concerned that they’ve got a family history of cancer and are at risk
402 can be referred into our service. […] We also do a lot of health promotion so we don’t
403 actually just talk about cancer, we also talk about things related to cancer like diet, like
404 giving up smoking, sunbathing, those types of things.” (Focal actor (nurse-manager),
405 Ashover, T_1)

406 Each focal actor thus enacted the professional logic in the way they set up their service, albeit
407 with variations on the theme reflecting their professional affiliation: it was presented in terms
408 of esoteric expertise by the specialist physicians in Carsridge and Dovington, but in terms of
409 holistic, generalist care by the nurse and family physician in Ashover and Bolbourne.

410 Each focal actor had obtained agreement in principle from their host organization to
411 continue to fund the service following the pilot period. The shift in the policy landscape from
412 2005, however, threw such plans into disarray. An increased emphasis on markets and targets,
413 and the organizational changes that accompanied it, had a marked effect on genetics service
414 developments, and meant that commitments made years earlier counted for little:

415 “We’ve gone from a position of completely unprecedented investment in the health
416 service, where it was attractive to invest money in bits of the service which had not
417 previously had large amounts of money invested in them. [… But now] we’re in a
418 position where it’s not clear how we’re going to continue to provide what everybody
419 would regard as core NHS services, [so] slightly unusual developments are much less
420 easy to make.” (Director, genetics service, Bolbourne, T_3)

421 There was a tangible shift in the language of those in decision-making positions in all four

422 cases, towards an acknowledgement of the need for parsimony and demonstrable value.
423 Professionally led services, in the view of these stakeholders, needed to address changing
424 expectations around, for example, consumer-responsiveness in a competitive environment that
425 mirrored the market logic:

426 "The mistake I've seen a lot of services make is that they try really, really hard to
427 establish because they think there's a need to convince people, there's a need to get
428 funded, and they start seeing stakeholders, but then it stops. […] Products don't survive
429 in the market very long unless they inhabit the environment they're in, learn from it and
430 modify based on their clients' continuously changing needs. And that's what
431 differentiates successful products from not-successful products." (Director of
432 Commissioning, Ashover, T3)

433 As they reached the end of their pilot funding and considered how to maintain their services,
434 therefore, focal actors found themselves in an environment that had changed markedly. The
435 rise of the market and corporate logics in policy demanded evidence of cost savings or cost-
436 effectiveness, and this posed a threat to services founded on a different logic. But as we see
437 next, the ultimate outcome of this shift in logics at the field level for the four services was very
438 different.

439 *The outcomes: domination; resistance; transformation*

440 Focal actors in all four cases worked hard to defend the services they had built, and secure
441 continued funding for them in this changing environment, while ensuring they remained true
442 to the professional logic on which the services had been founded. As noted above, all four
443 succeeded initially in obtaining ongoing funding, in contrast to their peers. But beyond this,
444 their success varied.

445 At one extreme, in Bolbourne, despite the focal actor's extensive efforts, local budget-
446 holders decided six months later to terminate their funding for the service. The focal actor, a

family physician, made robust arguments for the continued importance of her service and the holistic understanding of the place of genetics in wider primary care that it promoted,. Alongside a costed business case, her efforts included compiling evidence of impact in the form of “e-mails, comments from other GPs saying, ‘This is great, the website’s fantastic, really good about having the advice line’,” “pictures in the [local] newspapers saying what a wonderful thing,” and lobbying commissioners and genetics specialists: “I think we covered most avenues really.” But as she bluntly reflected in her final (T_4) interview:

> “From an outside perspective perhaps it seemed a bit woolly what I was doing, but I think it was actually much more worthwhile to focus my attentions in that way. It wasn’t as sexy and didn’t look quite as good; I wasn’t seeing all these patients.”

Essentially, she found that arguments premised on a logic of professionalism failed to hold sway in an environment now dominated by concerns around efficiency and throughput (“seeing all these patients”). Her view was confirmed by the decision-makers themselves. The director of the genetics service felt that the focal actor was “selling something which […] commissioners didn’t want to buy” (T_3). Another decision-maker was even franker:

> “It isn’t going to release huge savings, […] so when commissioners are prioritizing, it will not tick all the boxes I’m afraid. It’s undeniable that well informed GP specialists able to support their GP colleagues can have an impact both on improving resources but more importantly making sure that patients get the right service at the right time, but I think in the current economic situation it’s going to be difficult to see many primary-care genetics services being established.” (Primary care commissioning lead, T_3)

Further work undertaken by the focal actor to resurrect her service following termination of funding was unsuccessful, and by the end of the study period she was resigned to the fact that “it’s just gone back to how it was. The website is the only lasting legacy” (T_4).

At the other extreme, in Carsridge and Dovington, focal actors were much more successful in defending the professional logic in the changing field, such that their services remained in place, largely unaffected by the wider environment and the rise of the market logic for the duration of the period studied. As the focal actor in Dovington put it, with some surprise, “actually to move us into the whole commissioning process and to make it sustainable was a far more fraught process *potentially* than it *actually* was” (T_3). The model of service delivery continued to follow a professional logic, with patient-centredness taking precedence over throughput or efficiency savings:

> “Patient satisfaction is high, clinic sizes are relatively small although efficient, and time spent with medical staff and nursing staff is higher and so we get a much better patient experience and outcome with all of that. We’re always going to be able to be criticized on the basis that we’re providing a luxury service as opposed to an economy service, but they’re a very vulnerable group of patients.” (Clinical geneticist, T_4)

Similarly, in Carsridge, ongoing funding was secured and the service remained faithful to the original design, without any challenge to the professionally determined service model: “I don’t think there was ever any major problems: it just seemed to happen” (Genetic counsellor, T_3). Only minor changes were instigated, such as adjustment of the skill mix to enhance the professional responsibilities of the clinical staff: “the function of the team is exactly the same, but we have up-skilled one of the administrators to take some of the more mundane activities from [the clinicians]. And I suppose that’s the biggest change actually” (Focal actor (clinical geneticist), T_3). Whereas in Bolbourne, adherence to the professional logic meant that the service was seen as anachronistic by budget-holders (“selling something which […] commissioners didn’t want to buy”), the services in Carsridge and Dovington retained legitimacy with key decision-makers despite their avowedly professionally driven ethos:

> “To me it’s actually really pretty streamlined, a very efficient service. […] What

497 they've done in terms of bringing things up into the twenty-first century is of value to
498 the population, so I think they provide a valuable service." (Clinical director, Carsridge,
499 T3)

500 Between the contrasting experiences of Bolbourne, and Carsridge and Dovington, lay
501 Ashover's. Here, funding was sustained throughout the period, but achieving this required
502 fundamental changes to the ethos and delivery model of the service. At the behest of local
503 decision-makers, the original holistic, public-health focus of the service gave way to something
504 much narrower in remit, and better aligned with corporate and market expectations around
505 efficiency and performance against specific measures. The focal actor was expected to agree
506 to a "service specification" with "specific key performance indicators" developed with
507 managers, "which I disagreed with but had to put them forward anyway" (T4). The service was
508 incorporated into a managed care pathway, with a much more tightly defined service-level
509 agreement that focused on triaging patients at possible risk of inherited cancer. Alongside this,
510 more forensic examination of the service's activities was introduced: "we have now a scoring
511 of interventions, sort of whether it's a low intervention or a high intervention, […] and they're
512 now reviewing that data collection as well, so there'll be a whole new system coming out"
513 (Focal actor (nurse-manager), T4). The positioning of the service within a managed pathway,
514 along with this extra scrutiny and oversight for managers and commissioners, gave the service
515 legitimacy with key decision-makers. It was now aligned with normative conceptualizations of
516 how to deliver efficient and well managed healthcare, as part of a defined pathway that offered
517 a cheaper alternative to hospital-based care:

518 "Community services we know are darn site cheaper than secondary and tertiary care
519 services. […] It's a community-led service, you know, and necessarily, it's broken
520 down the boundaries between primary care and secondary care. So it's a pathway-
521 driven service from the community which ticks all the boxes at the moment of things

being community-driven, closer to home." (Associate medical director, T_3)

Besides more focused performance management, this also brought a much stricter set of eligibility criteria for patients. For example, the service took fewer self-referrals from worried patients who had not been screened by their family physicians, and was contemplating stopping self-referrals altogether since budget-holders were unlikely to see this is as appropriate expenditure:

> "When we first started in the pilot phase, it was very much self-referrals that outweighed any professional referrals. Whereas now I would say that's reversed and self-referrals probably come at the bottom of the referral rate and it's secondary-care and GP referrals that probably top. […] I don't know how GPs will feel about patients referring themselves in, because they're not going to have control of that budget. (Focal actor (nurse-manager), T_4)

This process of adaptation to the new realities of the market continued through time. Between T_3 and T_4, as part of its continued funding, the service was incorporated into a different organization with much greater managerial capacity than its original host, and with a strong market orientation:

> "[New host organization] have an operating model which they would apply to all of their products. So […] they'll have to change certain aspects of the way they just run the service to fit in with their corporate model. […] If they can't robustly describe the value this service would have on the whole of cancer care, then the more likely the risk that this service won't be commissioned." (Commissioner, T_3)

The future for the service looked more secure—it had reinvented itself as part of an integrated care pathway with a tightly defined remit and expectations around efficient resource use—but this had meant fundamental changes to its service-delivery model. From her original affiliation with the professional logic, the focal actor had been forced to fundamentally realign herself to

the corporate and market logics, in terms of both the discursive justification, and the service provided.

Making sense of the contrasting outcomes

From similar starting positions, then, the four cases exhibited divergent trajectories. While the focal actors in Carsridge and Dovington continued to espouse the professional logic, and maintained services formed in a professional image despite the changing environment, in Bolbourne the focal actor's fidelity to the professional logic saw her service terminated, while in Ashover the focal actor had to embrace alternative logics to secure her service's future (see also Table 3). How might these divergent outcomes be explained?

[TABLE 3 ABOUT HERE]

In all four cases, hard evidence about the efficiency or effectiveness of the services was in short supply (see self-citation). Evidence of this nature was difficult for focal actors to generate—partly because they had never devised their services with such a crudely economic calculus in mind, but also because generating such evidence was difficult in genetics with its long-term, not short-term, outcomes: "it's difficult to demonstrate their value or the amount of money they're saving," as a manager in Carsridge acknowledged (T_3). Explanations for the divergent outcomes premised on a rationalistic understanding of organizational decision-making can therefore be discounted.

Yet while the services in Ashover, Carsridge and Dovington may have been no more cost-effective than that in Bolbourne, we have seen that as far as key decision-makers were concerned, they were more in keeping with how a service of this nature *should* look. Although all services lacked a clear economic rationale that would offer a firm alignment with the expectations of the market logic, this was more problematic for some than others. From our data, a number of explanations for this might be invoked, with differing degrees of support.

First, it might be argued that the divergent outcomes were down to the differential skill

of the focal actors in making the case for their services. Other micro-level studies have noted the importance of actors who are "highly reflexive and somewhat creative in interpreting the pressures for institutional change" (Bévort & Suddaby 2015; cf. Smets & Jarzabkowski 2013; self-citation), and going against the 'institutional grain' clearly requires capacity for lateral thinking and persuasive ability. There was some support for this notion in our data. One decision-maker in Bolbourne intimated that the focal actor did not have "the right personality to go out there and engage people and get people stirred up" (T_3). However, it was clearly not the case that any of the focal actors was naïve about the changing environment they were facing: over the course of our four interviews with each of them, they demonstrated an astute, reflexive understanding the changing healthcare system and the risks this posed to their services. And of course, unlike the seven other services sampled in our original evaluation, these focal actors had at least obtained initial local funding beyond the pilot monies provided by central government.

A second plausible explanation is that the status and power enjoyed by the focal actors affected their ability to defy the vagaries of the shifting institutional prescriptions. Certainly the position of nurses in terms of professional status, authority and autonomy is weaker than that of physicians, in England and elsewhere (see, e.g., Battilana 2011). Socio-demographic characteristics such as gender may also contribute to this positional power. But while Ashover's focal actor was a (white, female) nurse, there was little to differentiate the status of those in Bolbourne, Carsridge and Dovington, all of whom were doctors (white and female in Bolbourne and Dovington, white and male in Carsridge), albeit from different subspecialities. Indeed, if anything, the changes afoot over the study period—which saw more powers given to family physicians in terms of funding allocation, and encouragement of community-based over hospital-based care (Secretary of State for Health 2006)—should have raised the power of Bolbourne's focal actor *vis-à-vis* that of Carsridge and Dovington's.

A more convincing and comprehensive explanation is possible if we focus on neither actors' social position nor their creative capacity *per se*, but on the consequences for these of the wider changes taking place in the field at the time. While the rise of the market logic over the period of the study applied equally across the English healthcare field, its effects at an organizational level were unequal. For the primary-care organizations that hosted the services in Ashover and Bolbourne, the rise of the market was unprecedented, and brought significant structural changes. As commissioning organizations (budget holders for the healthcare needs of the local population), they were required to relinquish their responsibility for service provision to enable competition for services that had been provided in-house. The services that had been a part of these organizations, including Ashover's and Bolbourne's genetics services, had to be reconstituted as financially independent standalone bodies, or incorporated into existing provider organizations. Consequently, the focal actors in Ashover and Bolbourne found themselves in the midst of a complicated process of organizational disengagement, and were cut adrift from their organizational sponsors. The focal actor in Ashover found that her new managers "didn't have as much insight into the service and were less committed to seeing it expand" (T3), while in Bolbourne, the service's manager had "less direct involvement" in the service, "although because there was not really anyone else to do it I did carry on to an extent" (T3). Further, and more critically, the focal actors were exposed to a range of expectations associated with the market logic that were foreign to them—and lacked the managerial support necessary to coherently argue their case in response.

On the face of it, this challenge also applied to Carsridge and Dovington. However, here the services were hosted by hospitals with long experience of participating in a competitive market—and this equipped them much better to deal with the changing expectations of the new regime. The primary-care organizations in which Ashover's and Bolbourne's focal actors worked had only ever encountered the competitive market as budget holders, choosing between

competing bids: making a business case as a potential *contractor* was not something they had experienced before. As hospitals, the organizations in Carsridge and Dovington had long experience of a competitive market for secondary care that stretched back into the 1990s. Thus while the market-oriented shifts were just as dazzling to the focal actors themselves, they were surrounded by an established managerial infrastructure that was adept at managing such demands, and did not have to contend with rapid organizational change. They could rely instead on extensive managerial support—an instantiation of the corporate logic with its focus on the monitoring, audit and justification of professional activity—to deal with such shifts.

The consequences for the ability of the focal actors to defend their services were profound. In Ashover and Bolbourne, they found themselves with little support and little idea of how to make a case for themselves:

> "Just after the pilot finished once we'd secured ongoing funding there was the commissioner-provider split, so the service went into mainstream services in the provider arm. […] I don't mean to sound derogatory, but I suppose the senior managers within the provider arm didn't have as much insight in to the service and were less committed to seeing it expand." (Focal actor, Ashover, T_3)

> "My final line manager, essentially he and I put together a business plan very much on our own, and we met with the medical director and the deputy medical director and we put our case." (Focal actor, Bolbourne, T_3)

In Carsridge and Dovington, focal actors enjoyed the full support of their organizations' corporate apparatus:

> "The key relationship going forward […] is the relationship between our service, the business planning directorate, and their relationship with whatever commissioner organization exists after that, because we as a clinical service can't keep up with changes in commissioning. But the business planning section do. And it's that

relationship that's really important." (Focal actor, Carsridge, T_2)

"We have had no direct dealings with commissioners at any stage, because we are part of [a wider funding] envelope, from the point of view of the service that's provided, it's completely embedded in [the wider service]." (Focal actor, Dovington, T_4)

Intriguingly, then, in Carsridge and Dovington, the presence of a well established corporate logic, manifest in the activities of the hospitals' dedicated business-planning staff, shielded the focal actors from the full force of the market logic, and enabled them to continue to enact the professional logic in the way they ran their services. Focal actors here could rely on others around them, carriers of the corporate logic but also well versed in the language of the market logic and the expectations of financial decision-makers, to frame their projects accordingly and deflect challenges:

"What we've been doing is pulling together our experience and our outcomes in a brief report that we can send to the business-planning department of this hospital, so that they can use that in their negotiations." (Focal actor, Carsridge, T_3)

In the absence of such support, Ashover and Bolbourne faced greater challenges. Bolbourne's focal actor floundered, but in Ashover the focal actor was able to draw on her experience as a manager—her dual embeddedness in the professional and corporate logics (Pache & Santos 2013)—to reframe her service. As we have seen, though, this came at the cost of transforming the service model itself, so that it was premised not on a professional logic but on notions of efficiency and throughput. For all four focal actors, however, the ability and opportunity to invoke and make advantageous use of logics was heavily shaped—one might even say structured—by influences beyond their capacity and social position as individual agents, but below the level of the field as a whole. Organizational context and the nature of their relationship with other agents—themselves affiliated with other logics—were crucial mediators of the relationship between field-level configuration of logics and individual-level

672 autonomy.

673 **Discussion**

674 Our paper seeks to bridge macro-level and micro-level work on responses to institutional
675 complexity by using comparative, longitudinal analysis to examine the conditions under which
676 actors are able to defy changing institutional prescriptions. In particular, we show that a
677 common 'constellation' of institutional logics (Goodrick & Reay 2011; Waldorff et al. 2013)
678 could give rise to divergent outcomes at the level of practice. Constellations are thus not just
679 'celestial' features of the field-level 'sky': the relationship between logics was also realized
680 through the work of actors on the 'ground'. Most notably, whereas the corporate logic aligned,
681 as the literature predicts (Thornton 2002; [self-citation]), with the market logic in some cases,
682 in others it proved a remarkably robust defence for the professional logic against the market
683 logic. But none of the actors had free rein to pick and choose from the plurality of logics present
684 in this complex field. Rather, influences above the level of the actor but below that of the field
685 were important mediators and shapers of autonomy.

686 As noted above, much of the micro-level work on the enactment of institutional logics
687 'at the coalface' has focused on the 'hypermuscular' work of institutional entrepreneurs with
688 unusual degrees of power, deriving from their social position, their "reflexivity or insight" and
689 "their superior political and social skills" (Hardy & Maguire 2008, p.211). But even where
690 studies have looked at the day-to-day work of lower-profile actors, they have often found a
691 high level of autonomy, and attributed this to the creative capacity or social position of the
692 individuals studied. For example, Bévort and Suddaby (2015) suggest that liberation from
693 institutional prescriptions "appears to rest in the differential ability of some individuals in a
694 common field to interpret the phenomenological fragility of logics and to be somewhat immune
695 to their 'totalizing' cognitive influence." Greenwood et al. (2011, p.349), summarizing the state
696 of the field, submit that the ability to advance the prescriptions of one logic over others is in

697 part "a function of how logics are given voice within the organization; but the ability of a voice
698 to be heard is linked to the influence of that logic's field-level proponents over resources." One
699 way or another, these studies suggest that the ability to selectively enact logics derives
700 primarily from some combination of status and creativity. But as Hallett (2010, p.67)
701 acknowledges, this ability is produced (and denied) at a "supra-individual," social level. And
702 a key level at which this process takes place, we argue, is the organizational level, and
703 particularly the way in which logics are configured and represented in organizational processes
704 and personnel.

705 Others have shown how organizations can act as 'filters', whereby different
706 organizational units are subject to different institutional logics. Binder (2007, p.562), for
707 example, finds that actors in different sections of the community organization she studied enact
708 different logics, since different constellations of logics predominate: those in the housing
709 department follow a more corporate logic, since "there are no countervailing institutional logics
710 that staff in this department draw on." This reflects the findings of others about how in some
711 fields, institutional complexity is 'segmented': some prescriptions apply to one group of actors;
712 others to another (e.g. Pache & Santos 2010). In other settings, collaboration across logics may
713 be a prerequisite for organizational functioning (e.g. McPherson & Sauder 2013; Smets et al.
714 2015). What we witness in this study, however, is a combination of what Besharov and Smith
715 (2014) call high centrality and low compatibility: a field characterized by multiple institutional
716 logics which must all be adhered to, and yet are mutually conflicting. This results in what they
717 term 'conflicted' organizations, and they recount many examples from the literature of where
718 this has led to organizational dysfunction or even disintegration. Yet, as Besharov and Smith
719 (2014) argue, centrality and compatibility are not determined only at the field level: they are
720 also a function of organizational form. Since 'structurally differentiated hybrids'—in which
721 the influences of different logics sit side-by-side, in different units in the same organization

722 (Greenwood et al. 2011)—are especially vulnerable to dysfunction (e.g. Battilana & Dorado
723 2010; Greenwood et al. 2011), Besharov and Smith suggest two organizational interventions
724 to mitigate this: recruiting personnel without prior institutional affiliations (to move from a
725 *structurally differentiated* hybrid towards a *blended* hybrid, thereby reducing logic
726 incompatibility), or reducing resource dependency by shifting strategic focus (to diminish the
727 number of logics that must be accounted for, thereby reducing logic centrality). But these are
728 not options for all organizations, particularly in the public services, where structural
729 differentiation is itself necessary for legitimacy (and so blending is difficult to achieve) (see
730 Greenwood et al. 2011, p.355), and organizational objectives are externally dictated (and so
731 shifting strategic focus is not tenable). Logics' influence cannot always be reduced in this way.

732 What our findings suggest is how the tension between logics can be managed even where
733 structural differentiation, so prone to disintegration, is necessary. What appears crucial is the
734 *internal configuration* of structurally differentiated units. Thus in Carsridge and Dovington,
735 the presence of carriers of the corporate logic in a separate unit—who could intervene actively
736 to moderate its influence on their professional colleagues—paradoxically helped to secure
737 latitude for the focal actors; the lack of such a buffering influence in Ashover and Bolbourne
738 resulted in constraint.[1] We suggest, therefore, that at least in public-service organizations,
739 efforts to hire or socialize 'non-affiliated' staff to create blended hybrids that increase
740 compatibility, or realign mission to reduce logic centrality, are likely to be forlorn or even
741 counterproductive: attention might be more appropriately addressed to developing a cordial,
742 interdependent and mutually beneficial relationship between carriers of logics in structurally
743 differentiated units. Indeed, in Ashover the focal actor's socialization (or dual embeddedness)

[1] It might be noted in passing that of the seven services included in the original evaluation which did not obtain post-pilot funding, three had organizational set-ups involving collaboration between two or more host organizations (see Table 1). This may have added complication to the relationship among logics and their carriers, accounting in part for their failure to secure post-pilot funding, though we do not have the data to sustain this argument.

744 within both the professional and the corporate logic proved a mixed blessing, enabling the
745 service to continue but only through transformation in its character. Boxenbaum and Battilana
746 (2005, p.359) echo Besharov and Smith's (2014) contention that staff with multiple
747 institutional affiliations can help to reduce incompatibility and increase autonomy: "the more
748 contexts individuals are embedded in, the more options they have available for transposing
749 practices." But while this helped Ashover's focal actor avoid the termination of the service that
750 occurred in Bolbourne, it offered her substantially less discretion than that enjoyed by the focal
751 actors in Carsridge and Dovington. Dual embeddedness may then improve actors' *access* to
752 different logics, but it does not necessarily give them freedom of choice in *enacting* them. The
753 configuration of organizations and the carriers of logics within them, not just their composition,
754 matters, and as such structurally differentiated hybrid arrangements have the potential, at least,
755 to reconcile conflicting logics as effectively as blended hybrids.

756 Understood this way, the findings of other micro-level studies that have emphasised the
757 ingenuity of individual actors might be seen in a slightly different light. For example, Murray
758 (2010, p.379) sees the response of scientists to unfamiliar commercial pressures arising from
759 the patenting of the genetic modification of 'OncoMouse' as the "sophisticated [production] of
760 new hybrids," in which the "expertise that allows [key actors] to transpose elements from each
761 logic" to protect the autonomy of science was crucial. Yet it is also evident from her study that
762 the privileged access to a wider, supportive, infrastructure—including "lawyers, TTO
763 professionals, university counsel, and corporate executives"—was also critical to this
764 endeavour: it was not expertise or status alone that enabled autonomy. McPherson and Sauder
765 (2013, p.186) show that actors in a drugs court draw relatively freely upon a "shared toolkit"
766 of logics in pursuit of their interests, but some actors are better placed than others to do so: the
767 relational position of probation officers means they occupy a position of 'brokerage' that allows
768 them privileged access to the 'home' logics of others, even though they lack the status of other

769 professional groups in the court.[2] Heimer (1999, p.61) argues that in disputes about the care of
770 neonates in intensive care, doctors' arguments tend to overpower those of other actors because
771 they are on their home turf, with greater knowledge of "how to get problems onto the agenda,
772 how to propose their solutions in a persuasive way" and so on. She thus concludes that "the
773 ranking of various professions [will shape] outcomes" of such disputes; "laws that are useful
774 to high status professionals like physicians are more likely to be incorporated into NICU
775 routines than laws that might be useful to lower status staff" (Heimer 1999, p.62). But our
776 findings show that it is more than simple professional hierarchy that is important here: in itself,
777 it is no guarantee of greater legitimacy, as the contrasting experiences of Ashover's nurse and
778 Bolbourne's physician indicate. It was perhaps not then physicians' position as "high status
779 professionals" *per se* that was important in Heimer's study, but the privileged access to wider
780 resources and networks that this afforded.

781 We suggest, then, that organizations—and specifically the way organizations instantiate
782 relationships between multiple logics—thus contribute crucially not just to the *availability* of
783 logics at individual level, but also to the *manner* in which they become available: the degree to
784 which the appearance of a logic constrains or enables autonomy. Broadly, we propose three
785 overarching alternative ways organizations might mediate the influence of logics, deploying a
786 physics-based metaphor that we hope helps to convey the means by which different
787 organizational forms may intervene in the transmission of logics. First, organizations may
788 *deflect* logics, protecting those within them from the need to align with logical prescriptions.
789 We did not see this in our study, but other studies (Binder 2007; Pache & Santos 2010; Jones
790 1999), where organizations have the power to defy institutional expectations or buffer their
791 members from the influence of competing logics, might be conceptualized in this way. Second,
792 they may simply *transmit* logics, so that prescriptions are largely unmediated and it is left to

[2] We thank an anonymous reviewer for drawing this connection to our attention.

793 individual-level actors to resolve (or fail to resolve) the contradictions between competing
794 logics. We see this in Ashover and Bolbourne, where the professional actors were left exposed
795 to the vagaries of new prescriptions from the market logic in the absence of an effective
796 corporate buffer. Third, they may *refract* logics, altering or refocusing their influence and
797 thereby offering some shield to individuals and opportunity for autonomy. We see this in
798 Carsridge and Dovington, where a functional relationship between carriers of the corporate and
799 professional logics saw the former shield the latter from some aspects of new institutional
800 prescriptions, such that they retained autonomy. The notion of refraction has some similarities
801 with one of the oldest concepts in the institutionalist repertoire, that of decoupling (Meyer &
802 Rowan 1977). However, as our choice of metaphor indicates, we consider this to be more than
803 a simple matter of one organizational unit providing legitimacy in the terms of the corporate
804 logic, while another, decoupled unit continues its own work untainted. Rather, by refraction
805 we mean that the institutional logic, like white light passing through a prism, is slowed, bent
806 or even dispersed into its component parts. Thus in the cases of Carsridge and Dovington, staff
807 in business-planning units were able to translate the requirements of the market and corporate
808 logics into terms comprehensible to the services' professional leads, and then reframe the
809 professional leads' cases back into terms that would satisfy the expectations of the corporate
810 and market logics. This was not so much a decoupling, then, as a conscious, selective coupling.
811 Though carriers of the corporate logic, the relationship between these business-planning units
812 and professional clinicians was organized in a way that encouraged co-operation, enabling this
813 refraction to take place—in stark contrast to the situation in Ashover and Bolbourne. The
814 notions of deflection, transmission and refraction represent a tentative typology requiring
815 validation and further development, but might serve as an initial touchstone for further
816 investigation of the organizational-level mediation of institutional logics.

817 For all four focal actors, then, creative capacity, professional status and embeddedness

818 in the rules and norms of different logics were only as good as the organizational setting and
819 social relationships they enjoyed. Autonomy was constrained where these were lacking and
820 enabled when these were favourable. Over the period studied, institutional prescriptions were
821 consolidated, with greater *centralization* of logics and the ascendency of market and corporate
822 logics that seemed incompatible with the professional logic. Both of these changes should work
823 to constrain actors' autonomy. Nevertheless, meso-level features of organizations within the
824 field made a significant difference to the consequences for actors, maintaining latitude for some
825 while others faced constraint (cf. Besharov & Smith 2014). We contend that attending to these
826 features could go a long way towards explaining the disjuncture between macro- and micro-
827 level findings about the partial autonomy afforded to professionals at the coalface.
828 Our analysis offers several suggestions for future research. In particular, we suggest that
829 more attention to the meso-level mediators of agency, perhaps building on the typology we
830 outline above, would help to understand how the prescriptions and openings for discretion at
831 the field level do or do not translate into opportunities at the individual level. Further work that
832 combines a detailed, phenomenological understanding of micro-level activity with comparison
833 of similar or divergent contexts would be helpful. Relatedly, further conceptual development
834 of Thornton et al.'s (2012, p.7) notion of "avenues for partial autonomy" would be helpful in
835 reconciling macro- and micro-level work in the field of neo-institutionalism. As noted above,
836 while many macro-level studies claim to show how institutional complexity affords
837 opportunities for autonomy, they often remain steadfastly structuralist in the way they describe
838 these (e.g. Waldorff et al. 2013). Finally, we strongly endorse Greenwood et al.'s (2011) call
839 for research that embraces the impact of the coexistence of more than two logics, and Thornton
840 and Ocasio's (2008) point that what constitutes a logic needs to be carefully considered by
841 those seeking to study their effects. The market and corporate logics appear, on the face of it,
842 to present a concerted threat to the professional logic in rapidly changing fields such as

healthcare. Indeed, others have analysed their impact collectively: for example Reay and Hinings' (2005, p.358) logic of 'business-like healthcare' combines elements of both. But we show that the experience of the two logics can diverge in different contexts, and that they do not necessarily operate synergistically in practice. We therefore recommend careful disaggregation of logics (and perhaps their constituent elements) in future studies.

Conclusion

Through comparative study of the trajectories of four change initiatives in a complex organizational field, we have sought in this paper to contribute to the institutional logics literature by examining the divergent consequences of a common constellation of logics for actors in different organizational contexts. Actor autonomy, so often valorized in micro-level studies of institutional logics in action, depended greatly on mediating factors at the meso level: opportunities for autonomy were determined neither at the field level nor in the status and creativity of individual actors. Rather, organizations—not just as containers of carriers of logics (Besharov & Smith 2014) but more importantly, as configurations of relationships between those carriers—constituted a prism which could act to transmit field-level institutional prescriptions into micro-level constraints, or refract them into something more pliable and productive. Further research taking a 'nested' case-study approach—studying multiple cases across two more fields where logics are arranged in different constellations—may be fruitful in adding further nuance to our understanding of how logics facilitate or obstruct discretion, and with what consequences for day-to-day practice and indeed reproduction and change in organizational fields.

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985 **Table 1: Overview of the 11 pilots included in the original evaluation**

	Stream	Pilot lead	Profession of lead	Host organization(s)	Continued post-pilot?	Reasons for non-continuation
Ashover	Cancer genetics	Nurse by background; now manager	Nurse	Primary care organization	**Yes**	
Bolbourne	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**Yes**	
Carsridge	Cancer genetics	Clinical geneticist	Physician	Hospital organization	**Yes**	
Dovington	Service development	Specialist physician	Physician	Hospital organization	**Yes**	
E	Cancer genetics	Nurse	Nurse	Consortium of primary care organizations	**No**	Reconfiguration of primary care organizations and consequent failure to agree to continued funding
F	Cancer genetics	Clinical geneticist	Physician	Two hospital organizations	**No**	Failure to agree to continued funding (scaled down version maintained in one hospital)
G	Service development	Specialist physician	Physician	Three hospital organizations	**No**	Conflict over allocation of resources and professional roles among host organizations leads to agreement to discontinue
H	Service development	Specialist physician	Nurse	Hospital organization	**No**	Project ceased at end of funding; results included in guidelines for referrals to genetics service
I	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**No**	Always intended to be a time-limited educational intervention
J	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**No**	Geneticists refuse to support (see [self-citation])
K	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**No**	Limited ongoing ‘associate’ role under geneticist super vision (see [self-citation])

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988 **Table 2: Summary of the four cases**

	Service model	Profession of focal actor	Initial host	Number of interviews				
				T_1	T_2	T_3	T_4	Total
Ashover	Implemented a national model to provide cancer-genetics risk assessment and triage using primary care-based staff, and wider health-promotion advice aimed at high-risk groups	Nurse	Primary care organization	12	2	12	2	28
Bolbourne	General practitioner with a special interest: provides training and advice to other GPs to inform proper management and referral of patients with suspected genetic conditions	Physician	Primary care organization	5	2	7	1	15
Carsridge	Implemented a national model to provide cancer-genetics risk assessment and triage provided by secondary care-based staff, replacing *ad hoc* provision by oncologists and surgeons	Physician	Hospital organization	12	2	10	2	26
Dovington	New multidisciplinary clinic, incorporating mainstream and specialist consultant-led care, for a group with a genetic disorder previously seen in separate clinics	Physician	Hospital organization	6	2	5	1	14

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990 **Table 3: The differential translation of institutional change across cases**

	Time	Ashover	Bolbourne	Carsridge and Dovington
Focal actor		Nurse/manager	Physician	Physician
Organizational host		PCT (T_1); PCT provider arm (T_2-T_3); community provider organization (T_4)	PCT (T_1); PCT provider arm (T_2-T_3)	Hospital organization
Original logic espoused by focal actors	T_1 (2005-6)	**Professional** Emphasis on ensuring holistic care and addressing public health, rather than providing a narrow care pathway delivered by deskilled occupational group	**Professional** Emphasis on utilizing broad skills of a family physician to facilitate holistic care, rather than replicating work done by lower-status occupational groups.	**Professional** Emphasis on ensuring patient-centred care delivered by a highly skilled professional team, rather than a narrow care pathway delivered by deskilled occupational group
Impact of rise of market logic	T_2-T_3 (2008-10)	Market logic conflicts with professional logic; corporate logic exacerbates	Market logic conflicts with professional logic; corporate logic exacerbates	Market logic conflicts with professional logic; corporate logic mitigates
Response of focal actors	T_2-T_3 (2008-10)	Focal actor adapts behaviour to comply with market and corporate logics	Focal actor defends alignment with professional logic	Focal actors draw on corporate apparatus to shelter service from market logic
Outcome	T_3-T_4 (2010-11)	Service is transformed in character: reflects **market and corporate logics**	Service is discontinued: focal actor's defence fails to deflect **market logic**	Services are maintained unaltered: **corporate logic shields professional logic**

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