Co-optation as a response to competing institutional logics: Professionals and managers in healthcare

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ABSTRACT

Researchers working under the institutional logics perspective find the struggle between managerial logic and various professional logics one of the most intriguing issues in healthcare organizations. Previous research provided several explanations at both the organizational level (mediation, hybridization, and selective coupling) and the individual actor level (hierarchization, sense making, reinterpretation, and hijacking) for the coexistence of professional and managerial logics in healthcare. However, all of these explanations are based on the underlying institutional logics not changing. In this article, we show that co-optation can explain the coexistence of institutional logics, but that it also causes the underlying institutional logics to change. Co-optation means that an actor adopts a strategic element from another logic that retains the most important elements of its own logic. Empirically, this article illustrates co-optation processes through a qualitative study of outpatient units in child and adolescent psychiatric care in Sweden. Using an institutional logics framework, we describe and explain how managers co-opted elements of professional logics and professionals co-opted elements of managerial logic in their attempts to support their own interests. Even if co-optation is performed to protect the home logic, the co-opted elements ultimately change it. This study contributes to the institutional logics framework by describing and explaining how co-optation can be a dynamic response to competing logics at the individual actor level.

KEYWORDS: co-optation; healthcare; institutional logics; managers; professionals

INTRODUCTION

This article investigates healthcare professionals' responses to competing managerial logic, and healthcare managers' responses to competing professional logic. This has been traditionally described in terms of power struggles between professionalism and managerialism (Scott et al. 2000), resulting in either colonization (Hunter 1996; Courpasson 2000; Thorne 2002; Bejerot and Hasselbladh 2011) or decoupling (Meyer and Rowan 1977; Kitchener 2002; McGivern and Ferlie 2007). This means that either something bad happens (professionals are colonized) or nothing happens (decoupling of managerial influence), which entails that professionals' more active involvement in managerial logics is neglected (Levay and Waks 2009). These two

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theoretical explanations mainly describe how one of these conflicting logics triumphs over the other, but fail to describe cooperative or interactive efforts.

Later research toned down this focus on power struggles and the idea that one institutional logic must dominate fields or organizations. Instead, Reay and Hinings' (2009) pioneering work on how competing institutional logics can coexist created a new stream of research explaining how multiple logics sometimes compete (Reay and Hinings 2009; Greenwood et al., 2010), but sometimes are complementary (Goodrick and Reay 2011; Smets et al. 2015). Such studies illustrate how coexistence and competition between institutional logics in healthcare organizations lead to different forms of cooperation (Reay and Hinings 2009) or hybridization (Choi et al. 2011; McGivern et al. 2015)—concepts that are useful for describing situations in which competing logics can coexist to balance power (Greenwood et al. 2011).

Several recent studies have been directed towards the internal dynamics on an individual actor level (Llewellyn 2001; Iedema et al., 2004, Pache and Santos, 2010; Thornton et al. 2012; McPherson and Sauder 2013; Arman et al. 2014; Blomgren and Waks 2015; Smets et al. 2015; Bévort and Suddaby 2016; Reay et al. 2017). For example, McPherson and Sauder (2013) explain how professional actors may align actions and argumentation with the content of certain logics for strategic purposes, and Pache and Santos (2010) outlined under which conditions this can be accomplished. These studies indicate that actors can temporarily borrow elements from a logic other than their 'home logic'. However, McPherson and Sauder (2013) emphasize that these results may be different in a context with strong dominating logics. In fact, they question whether negotiations in such environments will lead to negotiation across different logics, causing professionals to 'negotiate the meaning and enactment of elements of the dominant logic' (McPherson and Sauder 2013: 187).

We see potential in this research path and respond to McPherson and Sauder's (2013) call to further explain actors' possibilities to hijack other institutional logics in highly institutionalized settings with strong dominating logics, such as healthcare. We thereby emphasize the importance of the underlying power strategies of actors that has not gained much attention in current research, despite its importance in highly institutionalized settings, such as healthcare organizations. There are at least three competing logics continually in play in a healthcare context: the medical logic, the care logic, and the managerial logic (Fincham and Forbes 2015). This article aims to investigate which power strategies actors representing competing logics use in response to situations in a complex institutional setting like healthcare. We focus specifically on the interplay between two of the most predominantly competing logics continually in play in a healthcare setting: the medical logic and the managerial logic. The specific research question is: how does an interchange of strategies and strategic elements between cooperating actors from the medical profession and managers occur in healthcare?

The recent re-interest in Selznick's work means new possibilities to explain such matters, because old institutional theory puts more attention on agency, influence, power, interests, competing values, and deflecting purpose (Hinings and Greenwood 2015), which can further understanding of coexisting competing logics on an actor level. Selznick's (1949) concept of informal co-optation can extend McPherson and Sauder's explanations of actors' responses to competing logics in highly institutionalized settings such as healthcare. Informal co-optation means that actors absorb new elements as a means of averting threats to stability or preserving the status quo (Selznick 1949). In our study, the absorbing actors are healthcare professionals and healthcare managers.

Co-optation is neither the result of decoupling/ negligence nor rejection/surrender of one logic for another. Rather, co-optation is adopting a strategic element from another logic that retains the most important elements of its own logic. There are co-optation studies of actors in healthcare (Currie et al. 2012), but co-optation is then used to explain how professions maintain power. This article illustrates the different logics in the practice of child and adolescent psychiatric (CAP) outpatient care in Sweden. Based on CAP case data, our study shows how healthcare professionals respond to competing managerial logic.

The article is structured as follows: we first describe previous research on the coexistence of

competing institutional logics in healthcare organizations, the criticism against these studies, and a possible path of development for the institutional logics perspective. We next describe the concept of co-optation. This is followed by a description of the methodology, including a presentation of the features of professional and managerial healthcare logics. After that, we describe two cases that show how professionals in CAP respond to managerial attempts at control in the form of increased accountability pressure. After presenting examples of co-optation practices, we analyse how co-optation processes can explain outcomes that transform the logics of professionalism and managerialism. Finally, we summarize the contribution to previous studies in the discussion and conclusion.

THE COEXISTENCE OF COMPETING INSTITUTIONAL LOGICS IN HEALTHCARE ORGANIZATIONS

Thornton and Ocasio (2008) define an institutional logic as 'the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality'(101). However, this definition of institutional logic is close to the definition of institution. The institution is static, and reconfigurations of the logics are necessary to achieve changes in the actors' way of acting.

Institutional logics guide social actions (Greenwood et al. 2010) by providing assumptions and values on ways to interpret organizational reality. The institutional logics perspective is a framework for analysing the interrelationships among institutions, individuals, and organizations, in which a core premise is that the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics (Thornton et al. 2012).

Healthcare organizations are characterized by institutional complexity (Greenwood et al. 2011). They are complex, with many, often simultaneously competing institutional logics. Different institutional logics provide different interpretations of reality. In healthcare organizations, different professional logics are present—cure is mainly represented by

physicians, and care is represented by nurses and other healthcare professionals—together with control as a managerial logic and community in public healthcare (Glouberman and Mintzberg 2001). The strong division between these different logics creates a sense of hospitals as consisting of different worlds that are poorly integrated. Even though there are multiple logics at play in healthcare organizations (see Fincham and Forbes 2015), the present study focuses only on the professional logic of physicians and managerial logic. In so doing, we regard the interplay between these logics, whereas other logics also represented in a healthcare setting are only seen as aspects of the complexity in the setting. This binary approach is a simplification that is common in the research field of competing logics in healthcare, often motivated by the fact that physicians are representing the ideal type of a profession (Freidson 2001). In our case, it is motivated by the idea that if we can find any evidence of a finer-grained mechanism in the tensest relation (cf. Glouberman and Mintzberg 2001), it is plausible to also find similar patterns in other combinations. One exception to this binary approach is the study of Fincham and Forbes (2015), which deals fully with multiple logics.

Responses between managerial and professional logic in healthcare have been repeatedly described over the last 30 years. These responses have been traditionally described in terms of conflict and confrontation (e.g. Freidson 1994; Exworthy and Halford 1998; Scott et al. 2000; Kitchener 2002; Reay and Hinings 2005). However, when research started to focus on the coexistence of competing logics, new explanations emerged. Reay and Hinings (2009), using the institutional logics paradigm made an essential contribution by identifying strategies on how these two competing institutional logics coexist in healthcare. Most of these strategies are examples of a middle way that indicates actors' active involvement (Gadolin and Andersson 2017) and uses explanations that draw more on cooperation than conflict. These strategies entail that both actors keep their own logic, but new advantages appear for both of them (Reay and Hinings 2009). There have been several studies that further developed our understanding of how managerial and professional logics could coexist in healthcare, with explanations such as mediation (Waring and Currie 2009), organized

professionalism (Noordegraaf 2011), leaderism (O'Reilly and Reed 2011), hybrid forms of professional discourse (Thomas and Hewitt 2011), hybridization (Choi et al. 2011; McGivern et al. 2015), and hierarchization (Arman et al. 2014). Consequently, focusing on coexisting logics in healthcare research has entailed that we understand responses to conflicting logics, but we need to understand more about underlying power strategies that actors can use in responding to such institutionally complex situations.

In general, making institutions more 'inhabited' reveals the effects that individual actors actually can have on institutions (Bévort and Suddaby 2016). Reay et al. (2017) provide such an example in healthcare. They show that healthcare's institutionalization makes it resilient because roles, approaches, and activities are largely taken for granted. Yet, individual actors can reinterpret and rearrange institutional logic that guides collective professional role identity, and how non-professionals and professionals can engage in social interactions to facilitate these processes. Reay et al. (2017) show the potential for getting close to individual actors in healthcare to understand their sense making and interpretation of institutional logics. We will continue this promising path, but will add how actors' power strategies can influence these processes.

Studies focusing on actors' power strategies in relation to institutional logics have been performed in less institutionalized contexts than healthcare. McPherson and Sauder (2013) illustrate how individual actors can hijack an entire institutional logic other than theirs, without showing signs of professional threats. McPherson and Sauder studied a drug court, in which professionals with four distinct logical orientations were required to discuss cases, negotiate interpretations, and reach an agreement about how to proceed. Their research is important, but they doubted whether these processes would look the same in a more institutionalized context, wherein actors might be less free to hijack other logics because of stronger adherence to their home logics. Furthermore, McPherson and Sauder (2013) focused more on the fact that hijacking occurs, and how often, rather than going deeper into how and why. This study addresses McPherson and Sauder's (2013) call for research on hijacking of logics in highly institutionalized contexts and aims to explain the how and why of hijacking in highly institutionalized contexts by (re)-introducing the concept of co-optation.

UNDERSTANDING CO-OPTATION

Co-optation relates to other relational strategies in Najam's (2000) 4 C framework. It explains characteristics of relationships between two actors, based on their preference for ends and means (strategies). Najam (2000) proposed four different relationships: cooperation, confrontation, complementarity, and co-optation. *Cooperation* means that there are similar ends and similar means. *Confrontation* entails dissimilar ends and dissimilar means. *Complementarity* means similar ends but dissimilar means. Finally, *co-optation* means dissimilar ends but similar means. This article concentrates on the two main institutional actors in healthcare—professionals and managers—and investigates how they relate to each other. Based on adherence to different institutional logics, they may have different ends (different views on what is important) and different means. Managerialism is both evasive and direct in its attempts to control professionalism (Scott et al. 2000). According to Najam (2000), this should lead to confrontation. Yet, there is little evidence of constant confrontation between healthcare managers and professionals in their everyday work, despite differing views (Andersson and Liff 2012; Arman et al. 2014; McGivern et al. 2015). One explanation for this would be if professionals co-opt their managers' attempts to control them.

Co-optation usually refers to processes of legitimating unequal power structures through, for example, a company appointing female board members. Selznick (1949) labels this process *formal co-optation*, which relates to the absorption of new individuals into leadership positions in the public arena. Selznick distinguishes between this and *informal co-optation*, which takes place outside the public arena. Building on Selznick's work, Thompson and McEwan (1958) define informal co-optation as the process by which a spokesperson for a certain logic recognizes external strategic elements and absorbs them into policy decisions. In our study, we apply this definition specifically to institutional logic. Co-optation is somewhat similar to selective coupling (Pache and Santos

2013), which concerns how organizations selectively couple elements from other logics. Lozeau et al. (2002) describe similar processes in which health-care organizations capture and distort managerial techniques. However, the major difference is that both studies (Lozeau et al. 2002; Pache and Santos 2013) explain how organizations deal with multiple logics, whereas we focus on the individual actor level.

Selznick (1949) regarded informal co-optation as a response to specific individuals or groups that command necessary resources, resulting in the co-opted party (which has strategies that are partially adopted by the co-opting party) obtaining real influence. Selznick concluded that informal co-optation was inevitable because 'individuals within the system tend to resist being treated as means' (Selznick 1949: 251) to an end by the organization. The individual employee (or group of employees) who brings desires, aspirations, and goals to the organization participates in the larger social system of cultural norms and values. Following Thompson and McEwen (1958), co-optation is a strategy that limits one party's opportunities to choose goals unilaterally. They argue that co-optation is required when one party realizes that it is impossible to fulfil its goals, or possible but at a high cost. Co-optation affects both co-opting and co-opted actors. It is a control strategy because the co-opting party will prevent the other party from being equally influential in the goal setting, but it is also a co-operative strategy, in which both parties search for compatible goals. According to Selznick (1949), managers must refrain from publicly recognizing this informal relationship, so as not to undermine the legitimacy of their authority.

Therefore, co-optation is not the result of decoupling or negligence. Furthermore, it does not reject or surrender one logic for another. Instead, co-optation is about how individual actors adhere to one logic, relate to other logics, and co-opt strategic elements from other logics. In a highly institutionalized context, this strategy, which is more subtle than hijacking, might be a fruitful way of achieving cooperation among individual actors, because co-optation means an actor adopts a strategic element from another logic that retains the key elements of the actor's own logic. We believe that co-optation becomes a fruitful way of achieving cooperation

among professionals and between managers and professionals during the process of negotiating diagnosis and treatment.

CASE BACKGROUND AND SETTING

At the time of our research, the CAP units each had between 13 and 16 employees: a team leader, an administrative secretary, psychologists, social counsellors, psychiatrists, and nurses. The team leader—a professional with administrative duties—was the formal team manager.

Team leaders are subject to personal risk in the form of poor salary increases or un-renewed contracts because they are held accountable for their budgets and resource allocation. Resource responsibility is a challenging task, given the difficulty of predicting the level of resources any one CAP patient may need. If the team leader allocates resources to not enough patients or the wrong patients, it creates a risk for the entire patient group.

The various professionals in the team all act according to the requirements of their professions. The Swedish National Board of Health and Welfare stipulates requirements for the security of patients under psychiatric care. The main governing principle is that all treatment professionals (social counsellors, psychologists, nurses, and psychiatrists) are individually responsible for the care they provide patients. In addition, an attending psychiatrist is involved in every patient's diagnosis and initial treatment plan.

Even though there are fewer psychiatrists than psychologists or social counsellors in the CAP units, they have a strong position in their unit because of their medical responsibility for patients, which increases their risk of a formal reprimand, leading to a reputational damage and, in the worst case, a loss of the legitimation.

The team leader (a psychologist in one unit and social counsellors in two units) is accountable to the supervising manager for using resources to achieve unit goals (such as patient flow and treatment time), whereas legislation and professional standards regulate individual team members. The boundaries between the two areas of responsibility—patient care and resource allocation—are not always clear. Very few issues are just medical or resource related.

Successful collaboration among the team members, and between the team leader and team members, require that they attend treatment conferences (TCs), in which each professional presents a patient case for discussion of current treatment, difficulties encountered, and future treatment concerns. The presenting professional listens to feedback from other team members and determines future treatment, perhaps even changing preconceived ideas about treatment. This multi-professional team setting provides the prerequisites for cooperation around shared patient cases with specific, complex symptoms that require multi-professional expertise. The setting has a tight control structure, in which a team leader's managerial views may potentially threaten the views of the professionals.

METHOD

Qualitatively capturing institutional logics

The main challenge with research on institutional logics is to ensure that it really is institutional logic and not just any pattern of actions. Reay and Jones (2016) argue that there are three main (but nonexclusive) ways of capturing institutional logics in an empirical study: deducing patterns, matching patterns, and inducing patterns. In this study, we mainly matched patterns by identifying the two studied competing logics as two different ideal types. We did this because physicians are particularly regarded as the best example of professionalism and offer the best opportunity to test theories of professionalism (Freidson 2001). Managerialism, or business-like healthcare, is the second archetypical logic represented by managers (Reay and Hinings 2009). Moreover, we also induced patterns to some extent, since our interpretative analysis specifically emphasized the healthcare context.

This article briefly describes the two archetypes and how they relate to one another in healthcare. Our society expects healthcare professionals to uphold the service ideal as a condition of their independent right to act for, treat, represent, and teach others. Therefore, professional judgement is the central element of healthcare. Numerous researchers have argued that the professions' insistence on determining their way of working has created a control problem, based on a resource perspective (Wilensky 1964; Ferlie et al.

1996; Freidson 2001). Professionals are not accountable for resource efficiency, but only for making the right judgements about their individual patients, based on their professional logic (Andersson and Liff 2012).

On the other hand, healthcare managers were given greater responsibility as part of New Public Management and became more accountable for organizational resources (Hood 1995). According to this line of reasoning, the conflict concerns the difficulty in combining professionals' claim to trust their judgement with the managers' claim to control the professionals' output and regulate the behaviour and standardization of their procedures and methods. The demands of managerialism concern reducing complexity to achieve a resource-efficient production and customer orientation (Hood 1995). Whereas professionals focus on their individual patients, managers must focus on patients, in general, as customers. Through these insights, management is regarded as a profession with its own vocabulary (Hodgson 2002).

The instrumental way of invoking the co-opted strategic element is by using classifications of patients and treatment methods. We interpret that the actors' intend to influence the decision making in the team in these respects because we suppose the actors' believe following their own logic will be beneficial to the patients. Thus, strategic refers to acting leading to the actor's goal achievement. According to Mäkitalo (2003), categorization in professional talk is the basis of professionals' justification of their action in their social setting. Categorization is a matter of making an abstraction, such as matching clients/patients to categories (Mäkitalo and Säljö 2002). The clients/patients may be classified according to their membership (whether or not they are clients/patients) or the type of treatment (talk therapy or medical treatment). The categorizations of membership and type of treatment depend on categorizations of the event that may have caused the illness, and the parents and children (normal, except for the illness vs. pathological).

These categorizations form the basis for deciding the type of treatment offered to the patient. Most often, there is more than one option for making these patient categorizations. However, professionals may not necessarily agree. It will then be necessary to work with the categorization system and negotiate (Mäkitalo and Säljö, 2002). These negotiations must

follow the logic of appropriateness (March 1994) and established traditions of argument (Mäkitalo and Säljö 2002).

Data collection

This study is part of a larger research project on multi-professional teams in healthcare, conducted as a qualitative, interpretative, field study at three CAP units. The units have similar responsibilities, operations, staffing, reception areas, and other facilities. Supervisory management evaluated each of the units as well functioning. It was essential for us to study business-as-usual; therefore, we studied professionals' and managers' approaches to each other in their daily ongoing activities. This was a so-called typical case (Flyvbjerg 2001).

To answer our research question, we studied cooperation among the CAP units, which comprised professionals and their managers (team leaders). Two researchers (the authors) collected and analysed data from interviews, shadowing, and observations. Although it has become more common in the field of institutional logics to use interviews as data-collection techniques, participant observations are underused (Scott et al. 2000; Kitchener 2002; Reay and Hinings 2009). Several researchers (Reay and Hinings 2009; Greenwood et al. 2011; Fincham and Forbes 2015) have commented on this scarce use of the methodology of observation. For our research on institutional logics, we chose a qualitative approach that allowed us to get close to the professionals and managers by observing their daily work activities. Our goal was to understand how they cooperated.

We were present at team conferences, where we observed and took manual notes on participants' conversations. We took notes on their comments after the TCs before they left the setting (see Bryman 2015). We printed and edited notes the day after our observations (see Merriam 1998). Our observations focused on what the actors did and said, rather than what they thought about their practice (Weddington 2004; Silverman 2006; Bryman 2015). Furthermore, we shadowed several professionals on the teams. Research shadowing is a special form of observation that allows the researcher to study actions, choices, and strategies in action (Czarniawska 2007).

Our choice of observation as our primary data-collection method allowed us to make first-hand observations of professional–managerial interactions in actor-to-actor episodes. The conversation sequences in our empirical section come from these observations. We are unaware of the same use of observations in previous research.

Interviews are useful for acquiring knowledge from actors engaged in sense-making processes as they conduct complex medical activities (e.g. Hewison 2003). We interviewed 52 team members—team managers, administrative secretaries, and professionals—before and after various observations and shadowing. In the pre-observation interviews, we focused on team members' relationships with each other and the connections among their various practices and responsibilities. In the post-observation interviews, we asked team members to comment on the meetings we had observed. In both interview sets, our goal was to assemble rich, varied reflections on the actors' experiences. Most interviews lasted between 50 and 60 minutes and concluded when respondents began to repeat comments (see Glaser and Strauss 1967). All interviews were audiotaped and then transcribed.

Data analysis

In the larger study, we found that the actors used different strategies in their work around patients: conflict, parallel work, and cooperation (see Andersson and Liff 2012). In the current study, we reviewed our original empirical data to search for more subtle mechanisms that might explain the spirit of harmonious cooperation among the team members. Our data analysis was guided by the research logic of analytic induction, which seeks to infer general conclusions from particular instances (Charmaz 2006; Denzin and Lincoln 2011).

From Najam's (2000) 4 C framework on complex relationships of cooperation, confrontation, complementarity, and co-optation, we specifically focused on co-optation to analyse our data and answer our research question: how does an interchange of strategies and strategic elements between cooperating actors of different professions and managers occur in healthcare?

We chose this focus because it best matched our empirical data, wherein the actors had dissimilar ends but similar means.

We analysed our data in two steps. In Step 1, we identified conversation sequences in which the professionals and the team leaders decided on particular patient treatments based on categorization. Such conversation sequences illustrated how professionals constructed and defended the practices they thought appropriate for individual patient cases. We identified several examples of conversation sequences in which membership categorization (a patient at CAP or elsewhere) and treatment categorization were the basis for decision-making.

Step 2 analysed conversations. The intent of such analyses is generally 'to describe people's methods for reproducing orderly social interaction' (Silverman 2006: 167). In a conversation sequence, each speaker's contribution relates to the context associated with prior speakers. Therefore, it is necessary to have extensive excerpts that reflect the episodes. Moreover, it is plausible that conversation sequences represent a structural organization, in which the talk exhibits stable patterns that are independent of particular speakers (Silverman 2006).

Because our study is about institutional talk, we sought to understand how the conversations 'become specialized, simplified, reduced or otherwise structurally adapted for institutional purposes' (Maynard and Clayman 1991: 407). Therefore, we analysed the following:

a. Speakers' categories
b. Speakers' strategic elements to claim validity for their categories
c. Speakers' institutional arguments

Following this analysis, we examined how speakers co-opted strategic elements from each other in the conversation sequences. The notion of co-optation was operationalized with the following questions: did a professional (such as a physician) co-opt elements from the manager's home logic, or vice versa? Did the participants use co-optation as arguments in decision-making situations? What was the discursive context in these conversation sequences? Using the analytical method, a relatively small set of conversation sequences can determine whether co-optation explains how people reach a particular decision.

Validity of the data

The validity of our data depends on its authenticity. Researchers recognize their presence in meetings, conferences, and other venues may influence individuals, which may distort the researchers' impressions (Merriam 1998; Yin 2003). People who are observed, shadowed, and interviewed may describe and present an account of their true understanding of their social reality or present the social reality they think the researcher expects to hear or witness. There may be a temptation to shade or misrepresent opinions and facts to present a certain picture or advance a certain purpose. This may be the consequence of the fact that the researchers' presence might unavoidably cause some psychological threat to the observed actors. The counteraction is a matter of blending in (Czarniawska 2007). To blend in, we spent considerable time in the field. The study of each of the three units spanned over 1.5 years and included participation in coffee breaks, internal planning meetings, and internal day-long conferences.

We followed the code of *Good Research Practice*, adopted by the Swedish Research Council (2011). We protected all the team members' interests by following generally accepted rules for ethical research (see Kvale 1996).

CO-OPTATION PRACTICES

We witnessed co-optation practices in which the team leaders (who, despite their professional status, use mainly managerial logic) conferred with the psychiatrists, psychologists, nurses, and social counsellors (who all tend to use professional logic). Even though managers and professionals in healthcare all engage in the same decision-making areas, neither professionals nor managers exercise decision authority over the other. The team leaders do have the ultimate decision-making power, but the psychiatrist has medical responsibility, which may support their opinion. Psychiatrists generally base their decisions on medical logic, derived from education, experience, and a code of ethics that prioritizes quality of care, patient safety, and evidence-based medicine. CAP's team leaders generally support their decisions with

Table 1. Categorization of patients by facility membership and by treatment method

Categorization	
Facility membership	Treatment method
1. The patient should be treated in the CAP unit.	1. Condition diagnosed by the psychiatrist
2. The patient should be treated elsewhere, but the CAP unit should be consulted on that treatment.	2. Psychological testing
	3. Various talk therapies
3. The patient should be treated elsewhere, with no further contact with the CAP unit.	4. Family therapy
	5. Combination of diagnosis and treatment methods

managerial logic that prioritizes efficiency, budgets, and costs.

We present two cases from the TCs that illustrate two ways of categorizing patients in the CAP units to explain the use of co-optation:

a. Categorization by facility membership, as illustrated in Case 1
b. Categorization by treatment method, as illustrated by Case 2

Table 1 lists the probable outcomes of these two categorizations.

We analysed in the two cases:

• Categorization for which the participants argue in the TC
• Strategic element(s) they co-opt (from others) in their arguments
• Arguments they use

Case 1: categorization by facility membership

The following exchange is from a TC in which a nurse (NUR) and a psychologist (PSY) discuss a patient in a meeting with two psychiatrists (DOC 1 and DOC 2), the team leader (TL), and a social counsellor (SC). The patient was finally denied admission to the CAP unit.

After briefly presenting a new patient case of an adolescent male, the TL requests a case description and discussion:

NUR and PSY present the facts of the case:

The 16-year-old patient was treated the previous day when his mother contacted

emergency services. He was admitted to Emergency Care. Although the Habilitation Department was contacted, the paediatricians in that department questioned if a diagnosis of autism was correct [Habilitation is mainly responsibility for children and adolescents diagnosed with autism. AN was the psychiatrist the patient had seen in Habilitation]. The patient was also involved in criminal activities. About a year-and-a-half ago, a senior psychologist at CAP [identified as BD—not at this meeting], who specialised in talk therapy, treated him until he refused to further sessions. Although a psychiatrist prescribe medication for hallucinations at the time, the patient no longer took this medication. Although he was assigned to residential care, he obtained a court order releasing him from residential care because of his psychiatric condition. He no longer attended school and stayed home, composing music. He was difficult to talk to, but said he was ready to talk. His hallucinations were in check, but had difficulty sleeping. [Line numbers are references in the discussion of the case.]

1. PSY: He says he has difficulty coping because of his panic, anxiety, and psychotic experiences.
2. NUR: Now he wants help.
3. PSY: His mother is very demanding.
4. NUR: He is not suicidal. Both he and his mother want someone to talk to.
5. PSY: She demands someone to talk to now. She requests a very competent person with all the capabilities [to deal with the situation].

She is threatening to take her demands higher up in the hierarchy. She wants a written report on the decisions from today's meeting.

6. DOC 1: Which doctor has he seen?

7. NUR: AN.

8. DOC 1: AN is in Habilitation. It's a pity that he isn't still in Paediatrics.

9. SC: The patient has been moved. The mother is difficult.

10. PSY: She doesn't have confidence in Social Services or BD [the psychologist at CAP, who the patient met previously].

11. NUR: Recently, AN talked to the hospital psychiatric unit. They didn't admit him.

12. DOC 1: He belongs in Habilitation. He has been diagnosed as autistic. CAP can be consulted [AN, who is responsible for his care, is not part of CAP].

13. PSY: He has psychiatric symptoms.

14. DOC 1: That can also be evidence of autism. AN tries to go his own way. [with an irritated voice]

15. TL: We can't make a decision without BD.

16. PSY: We have talked to BD. He can continue with the therapy. But the mother won't accept BD.

17. DOC 2: Hash may cause hallucinations.

18. DOC 1: We can't allow AN to dismiss patients! We need more information! This is a mess! We have to think more about the patient before we make a decision! [with a strong voice, very demanding in body language]

19. TL: We can't make a decision yet! We have to talk to Habilitation! Call them! Check with Social Services before we do anything! [with a strong voice, waving with hands, pointing at the telephone]

20. DOC 1: We need to know which doctor has responsibility for his treatment. Who prescribes his medication?

21. PSY: BD is prepared to continue his talk therapy.

22. TL: Check with Social Services and check with Habilitation! [strong and demanding, like giving orders]

23. DOC 1: I don't want to be the psychiatrist responsible for this patient. [dismissive in her appearance]

The discussion concludes, and the team leader continues with the next patient case.

Categorizations. This discussion reveals that the category of facility membership appropriate for the patient was the result of negotiations based on different institutional logics. The participants attempt to categorize their patients to decide if they should be treated at the CAP unit. The professionals, especially the psychologist, insist that the young man should be treated as a CAP patient (Introduction and Lines 4, 13, 16, and 21). The two psychiatrists challenge this categorization because they do not think he should be treated as a CAP patient (Lines 8, 12, 14, 17, and 18). The team leader, who initially favours the first categorization (Line 15), changes his mind (Line 19) and agrees with the psychiatrists (Line 22). The team leader offers no response to the psychiatrist's final comment (Line 23), which concludes discussion of the case. Given the team leader's tacit agreement with the psychiatrist, the decision is that the patient will not be treated in the CAP unit.

Co-opted strategic elements. Medical diagnoses are aspects of professional logics. However, different diagnoses have different administrative consequences because they determine where and how patients are treated. The psychiatrist was accountable for medical treatment, and the team leader is accountable for resource utilization. The patient's mother was very critical of her son's previous treatment and demanded that a different professional be assigned to him. If a new psychiatrist took the patient's case, some of the analysis would likely be repeated. Because the patient had complex medical issues, multi-diagnosis treatment was required. This change in treatment implied intensive use of resources and the risk of failing to treat the patient in a medically responsible manner. The psychiatrists who concluded that the patient should be treated in a different unit used strategic elements of diagnosis (Lines 12, 14, and 17). The team leader, who agreed with the psychiatrists (Lines 19 and 22), co-opted their diagnosis as protection against failure to meet the resource utilization accountability. When the psychiatrist referred to physician-patient responsibility (Line 23), which is an administrative tool to allocate medical and financial responsibility, she co-opted a managerial logic to promote her self-interest.

This pattern of refusing patient admissions was typical at the CAP units we studied. The psychiatrists agreed with the team leaders on the need to limit admissions to match patients to the appropriate category of facility membership and offer proven treatment methods. The diagnosis is the instrument for this matching process. A common risk-control strategy in this study was constructing the patient in medical terms that matched the facilities' capabilities.

Institutionalized arguments. The participants used patient diagnosis as an institutionalized tool in their argument for choice of facilities and treatment. A medical diagnosis is generally perceived as a scientific, objective evaluation based on patient symptoms. Because a medical diagnosis has resource implications, some subjective negotiation is also involved in the diagnosis. The team leader and the psychiatrists used the authority of their positions in the CAP unit. The team leader selected the external contacts (Line 19). A psychiatrist refused to accept the doctor–patient responsibility (Line 23). With co-optation, the various actors could exercise their authority using institutionalized arguments without inter-professional conflict of interests, based on their respective logics.

Change of institutional logics. The psychiatrist focused on one of several possible diagnoses that would justify referring the patient elsewhere. The psychiatrist co-opted managerial logic (by focusing on the division of resources) to support her professional logic, which created a new action pattern, even as it disrupted the current action pattern. The psychiatrist maintained an overall professional jurisdiction, while simultaneously disrupting the boundaries of this jurisdiction and creating new boundaries. Even though patient-centred care is a central element of professional logic, the co-optation decreased the centrality of the element when restrictions were placed on difficult-to-treat patients. Patients with multiple diagnoses are clearly candidates for this group. Co-optation meant that resource aspects from the managerial logic become part of the professional logic of treatment prioritization.

Case 2: categorization by treatment method

In Case 1, the psychiatrist and the team leader agreed to use diagnose*s* strategically when they denied treatment at the CAP unit to the referred patient. Case 2 describes another strategy with similar consequences. In this case, the decision was to require further investigation from the entity that referred the patient to the CAP unit. Even though the patient was categorized as acceptable for CAP, the participants concluded that the patient required additional investigation by another actor. The negotiation of the patient's treatment is shown in the TC discussion. The participants were two psychiatrists (DOC 1 and DOC 2), a psychologist (PSY), and the team leader (TL). A social counsellor (SC) was also present.

After briefly presenting a new patient case of a young girl, TL requests a case description and discussion:

> PSY and SW present the following case facts, summarised here. The patient was a 10-year-old girl who had previous treatment until her mother ended contact with the CAP unit. The patient had difficulty controlling her impulses and exhibited aggression. Although she had shown anxiety and evasion in meetings with PSY, neither the school nor the patient's father had experienced direct problems with her. The parents were divorced, and the patient's father was not interested in family therapy. He only wanted psychiatric treatment for his daughter. Both the PSY and the SW thought an ADHD evaluation should be made, and contact should be established with the patient's school. [Line numbers are references in the case discussion.]
> 1. DOC 1: What did the referral from the school say?
> 2. PSY: The school psychologist is concerned about ADHD.
> 3. DOC 1: It's possible that ADHD symptoms can appear in many different situations. What's your impression of the patient?
> 4. PSY: She's anxious, evasive. An investigative report is necessary.
> 5. DOC 2: It would be good to have a written report on her school behaviour and performance.
> 6. TL: We've requested that the school provide a BAS investigative report [an evaluation of a pupil's adaptation to the school environment, based on teachers' comments and conversations with the family about the student's problems].

7. DOC 1: I agree.

8. TL: She's on the waiting list for this evaluation.

9. PSY: We can tell the school and the school psychologist that we want a BAS report.

10. TL: Yes, and we can tell the parents that she's on the waiting list. We must stick to our plan. They [the school] want us to do their job. [shaking his head and looks discontent]

The discussion concludes, and TL continues with the next patient case.

Categorizations. The patient was a CAP patient undergoing examination for a possible attention-deficit hyperactivity disorder (ADHD) condition (Introduction, and Lines 2 and 4). The psychiatrist questioned this diagnosis (Lines 1 and 3) and suggested that the school psychologist should investigate this case further before the CAP unit reached that diagnosis. The team leader, who also requested a BAS investigation, thought that the school was avoiding some responsibility for the patient (Line 10) by simply placing the patient on a waiting list and taking no further action. The psychiatrist and team leader agreed on the categorization to guide future treatment. Insistence on the BAS investigation meant that the referral unit (the school) must collect more data. From a resource-use perspective, the request for the BAS investigation may benefit the CAP unit. If it did not make this request now, it may be difficult to obtain the report from the school later, when the school may claim that the CAP unit took responsibility for the patient. However, from a professional perspective, the patient's case was unspecific, as presented by the school psychologist. The patient and her parents were more interested in help than in the diagnosis. They came to the CAP unit seeking specialist help.

Co-opted strategic elements. This discussion may be interpreted as co-optation by the psychiatrists (Lines 5 and 7), who strategically used an administrative tool (the BAS investigation) to postpone treatment and limit their responsibility. Others in the TC did not challenge this suggestion, probably in order to save CAP resources. (In our interviews with the school-support unit, the school psychologist and school counsellor/administrator strongly opposed this request.)

Institutionalized arguments. The BAS investigation is an institutionalized administrative tool that requires schools to do everything within their means and power to assist students with school problems by using special pedagogical methods such as small-group learning. When the dominant profession in the TC (psychiatrists) co-opts the BAS investigation as a tool (Line 5), it becomes even more institutionalized, and support for the team leader's use of it is strengthened.

Change of institutional logics. In Case 2, the result was to concentrate on neuropsychiatric patients in the CAP units. Furthermore, the co-optation created room for managerial logic in the resource struggle between organizations. By supporting the psychiatrist's strategy, the team leader transferred the patient's case to the school. This co-optation created a reconfiguration of managerial logic.

Summary of Cases 1 and 2 In the two cases, the team leaders co-opted elements of the professional logics and the professionals co-opted elements of the managerial logic. We observed that both the team leaders, in their managerial role, and the professionals, in their medical-professional roles, used strategies related to their accountability. By co-opting institutionalized administrative tools, the professionals used managerial logic. The co-opting party then used a control strategy to prevent the other party from being equally influential in setting goals, which was also a cooperative strategy, in which both parties sought compatible goals.

In addition to exercising the authority of their hierarchical positions; demonstrating expertise on medical issues; taking medical responsibility; and making patient diagnoses, the medical professionals also influenced budgets and costs. In this way, the professionals supported the team leader's attempts at providing efficient, high-quality patient treatment. Co-opting other institutional logics means that managers and professionals strategically act to gain advantages and have their own way. However, even if the co-optation is intended to maintain present institutional logics, it would inevitably change them. Co-optation disrupts the current institutional logics.

The psychiatrist focused on one of several possible diagnoses to justify referring the patient elsewhere. Co-optation was appropriate because the

psychiatrist realized that it was impossible to fulfil the professional goals of effective treatment when a long treatment period with poor probable outcome was likely. The psychiatrist co-opted the managerial logic to support her professional logic by focusing on the division of resources. Here, the psychiatrist exercised a control strategy to diminish the influence of other team members, even as she searched for compatible goals with the team members. This co-optation created a new action pattern, disrupting the current one. The psychiatrist maintained overall professional jurisdiction but simultaneously disrupted the boundaries of this jurisdiction and created new boundaries.

DISCUSSION

The result of the co-optation conducted in the TC was admission denial and referral of unsuitable patients. Although patient-centred care is a central element of professional logic, the co-optation in Case 1 decreased the centrality of that element when restrictions were placed on difficult-to-treat patients. Those with multiple diagnoses are clearly candidates for this group. The co-optation implicitly meant that aspects of a managerial logic become part of the professional logics.

Even if the discussion in Case 2 maintained the power hierarchy between the professions of psychiatry and psychology, it also disrupted the harmony between professional logics and created new boundaries for managerial logic. Though the majority of the professionals at the CAP units were psychologists, the psychiatrists achieved authority using co-optation (the division of resources argument) to allocate patient cases from CAP psychologists to psychologists at other organizations. In Case 2, teamwork led to a focus on neuropsychiatric patients in the CAP units and created room for managerial logic in the resource struggle between organizations. By supporting the psychiatrist's strategy, the team leader transferred the patient's case to the school. Co-optation created a new use of managerial logic.

Co-optation implies that there is real change. Strategic actors co-opt elements from other institutional logics and act within their free space to manoeuvre within differing institutional logics to support their own interests. Incorporating managerial concepts in professional practices led to increased legitimacy and autonomy. Even if it is possible to view co-optation practices as a form of subtle resistance, it is better understood as a form of interaction. Because professionals co-opt strategic elements from managerial logic and, therefore, use them in their own interest, there is no need to resist them. By co-opting strategic elements from other institutional logics, individual actors also change their home logics, which explains the coexistence of different institutional logics in highly institutional settings.

Most studies on coexisting institutional logics study the organizational level and explain the coexistence by mediation (Waring and Currie 2009), hybridization (Choi et al. 2011), and selective coupling (Pache and Santos 2013). These studies offer less information about underlying mechanisms at the micro-level, because they only address how competing logics are handled at an organizational level (see A in Table 2). Currently, more research interest is directed at the individual actor level to understand coexistence of different institutional logics. Explanations such as hijacking (McPherson and Sauder 2013), sense making (Bévort and Suddaby 2016), re-interpretation (Reay et al. 2017), and hierarchization (Arman et al. 2014) illustrate that the individual actor has considerable agency in relating to different institutional logics (see B in Table 2). Though the individual actor level varies widely, there are no explanations of micro-mechanisms that cause changes in underlying institutional logics. Co-optation is one such micro-mechanism. It describes fine-grained mechanisms at the individual actor level that change the underlying institutional logics (see D in Table 2).

Co-optation supplements McPherson and Sauder's (2013), and Pache and Santos' (2010) important findings. They outlined under which conditions actors can temporarily hijack a logic other than their 'home logic'. In these explanations, the actors exchange logics, but the logics are still invariant. McPherson and Sauder (2013) show that in professionals' daily actions, they first negotiate to solve problems without necessarily adhering to a certain professional logic. They can hijack another logic without showing signs of professional threats. However, McPherson and Sauder (2013) studied a less institutionalized context than healthcare and questioned whether the same

Table 2. Examples of previous studies of responses to competing institutional logics

	Organizational level	Individual actor level
Unchanged logics	A. • Mediation (Waring and Currie 2009) • Hybridization (Choi etal. 2011) • Selective coupling (Pache and Santos 2013)	B. • Hijacking (McPherson and Sauder 2013) • Sense-making (Bévort and Suddaby 2016) • Re-interpretation (Reay etal. 2017) • Hierarchisation (Arman etal. 2014)
Changed logics	C.[a]	D. Co-optation

[a]There are theoretical frameworks other than the institutional logics perspective that deal with changed institutional logics at the field/organizational level.

outcome would happen in a strongly institutionalized context, in which the actors representing one logic try to dominate those representing other logics. Our study supports their hypothesis that negotiations between actors in strongly institutionalized environments (e.g. healthcare) lead to negotiation across different logics, and professionals would 'negotiate the meaning and enactment of elements of the dominant logic' (McPherson and Sauder 2013: 187).

McPherson and Sauder (2013) called for research on why different logics are used, which is analogous to why co-optation is used in a highly institutionalized setting such as healthcare. Co-optation is a control strategy, used to exercise power, which makes it possible for actors to both keep their own logic and prevent the other party from increasing their relative influence in daily decision-making. However, it is also a cooperative strategy, in which the parties search for compatible goals. Furthermore, the organization keeps its legitimacy for appropriately conducting its mission. Decisions based on arguments in which strategic elements are co-opted from the other party and make logics overlap are hard to criticize, which make it possible for the team to perform its intended tasks and uphold the idea of the team as a comprehensive unit. Organization in teams can be preserved as a control strategy in the entire organization's management-control strategy. Co-optation contributes to preserving both the institutional and the organizational structure; the team and the roles in the team as the logics are changed to admit cooperation.

We argue it is possible for competing logics to coexist without any party being suppressed, for the team—comprising actors representing competing logics—to stay stable over time, due to home logics that are not invariant. This argument contradicts Najam's (2000) assumption that co-optation means that an unstable situation with implicit power struggles occurs, but will ultimately end in confrontations or one logic dominating the others.

We identified three preconditions for this stable situation to occur to explain this divergence. First, it is difficult to observe the informal co-optation process, as it is never openly discussed. Divergence from the home logic is never publicly recognized, which prevents professionals from having their legitimacy of authority undermined. If this happened, the team would probably destabilize, following Selznick's (1949) argument. Second, the co-opted elements cannot be just any elements, but must be supported by reference to institutionalized tools. Examples of institutionalized tools include diagnoses, formal positions, medical responsibilities, and treatment routines (Liff 2011). The results of co-optation cannot lead to just any argument or any logic, but to those that are well-recognized due to invoking institutional tools, despite not necessarily coming from an anticipated professional source. Furthermore, if the actors are not skilled enough in the co-optation process, they will lose legitimacy, and the team will destabilize. Third, the highly institutionalized setting of healthcare means there is great pressure to work in patients' best interests, as seen from outside the multi-professional team. This corresponds to what McPherson and Sauder (2013) found in a less institutionalized setting. Organizational pressure on the team to fulfil its demands, further boosted by demands from patient groups, will override

tendencies to destabilize competition between different institutional logics.

Co-optation sees individual actors neither as cultural dopes trapped by institutional arrangements nor as hypermuscular institutional entrepreneurs (cf. Lawrence et al. 2009). Instead, co-optation builds on embeddedness of agency, because the individual actors must act in the cultural frames in their choice of co-opted elements. This study illustrates how the interplay between culture and agency shape healthcare decision-making and organization. Logics connect cultural frames to individual level action and provide choices of norms and practices. In the studied case, decisions are based on logic interaction used to deal with demand for service and to ration services. This may lead to a shift in professional identities (Kyratsis et al. 2017).

CONCLUSIONS

We described informal co-optation (Selznick 1949), which refers to co-opting the elements of strategy that other actors use. Informal co-optation is more subtle than formal co-optation (cf. Currie et al. 2012), where actors rather than strategic elements are co-opted. We described how professionals co-opt strategic elements of managerial logic to drive their professional interests. By co-opting resource arguments, patients with complex needs are excluded, thus decreasing professionals' perceived medical risk. We also described how managers co-opt strategic elements of professional logic to meet accountability for resources. By co-opting diagnoses as an argument, resource-demanding patients are referred to other organizations.

The individual actors in this study co-opted strategic elements from opposing institutional logics. Co-optation means that professionals do not necessarily threaten an organization's ability to manage its resource limitations, and managerial-control models do not necessarily pose problems for professionals undertaking their various activities. Cooperation is possible between managers and health professionals, despite often being regarded as opponents.

Paradoxically, we find that the institutional logics perspective (Thornton et al. 2012) —which is the current development in institutional theory—can develop through the discovery of such concepts as co-optation from Selznick's (1949) old institutional theory. It, therefore, addresses criticism of the institutional logics perspective; its proponents do not consider the more finely grained mechanisms on an actor level. We argue that our main theoretical contribution is the understanding of co-optation as a dynamic, interactive explanation of the coexistence of different institutional logics in healthcare that also show how institutional logics can change through individual actors' co-optation of strategic elements.

Our study has some practical implications for healthcare. On the downside, co-optation seems to increase the risk that difficult-to-diagnose and difficult-to-treat patients will fall by the medical wayside. When accountability pressures related to managerial logic increase, professionals respond with claims of increased productivity in simple output terms such as throughput time and availability. At the same time, neglecting the wider definition of patient-centredness takes such forms as not collaborating with other care providers or not using holistic approaches that are in patients' best interests.

As our study has just studied one combination of several present inter-logic relations, future research may concern the more complex relations including multiple logics (cf. Fincham and Forbes). Future researchers may also take interest in how the institutional logics perspective can explain how changed logics at the organization level occur (combination C in Table 2). Furthermore, future researchers may study the impact of co-opting strategies among professionals on shifting professional identities, and on how this can be achieved (cf. Kyratsis et al. 2017).

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