



Understanding institutional work through social interaction in highly institutionalized settings: Lessons from public healthcare organizations



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ABSTRACT

The present study describes and analyses how social interactions between individual actors form institutional work in the highly institutionalized setting of healthcare organizations. Based on a qualitative case study, we affirm that social interactions mainly form maintaining institutional work, thus primarily upholding the rigidity of healthcare organizations. Social interactions either preserve distance between different actors or prevent their mutual influence, which decreases the effects of institutional complexity. However, when institutional work goes beyond maintaining, social interaction is characterized by processes of claiming influence and granting influence between individual actors who adhere to different institutional logics, which allows effects of institutional complexity. Such institutional work is contingent upon physicians' strong power position, and granting influence is likely to precede claiming influence.

1. Introduction

The highly institutional and complex nature of healthcare organizations can be explained by multiple co-existing, often competing institutional logics (Reay, Goodrick, Waldorff, & Casebeer, 2017). While institutional complexity can generate creative tension and a dynamic setting (Martin, Currie, Weaver, Finn, & McDonald, 2017), healthcare organizations are often described as the opposite with assumed norms, values and beliefs that almost make them rigid (Reay et al., 2017). One important reason for such a description is strong maintaining mechanisms of medical professionalism at both the macro (Currie, Lockett, Finn, Martin, & Waring, 2012; Waring & Currie, 2009) and micro levels (Wright, Zammuto, & Liesch, 2017). These mechanisms constitute the institutional work (Lawrence & Suddaby, 2006) that maintains the rigid and highly institutionalized character of healthcare organizations.

However, increased interest in the micro-dynamics of institutions (e.g., Andersson & Liff, 2018; Arman, Liff, & Wikström, 2014; McCann, Granter, Hyde, & Hassard, 2013; Reay et al., 2017; Wright et al., 2017) shows that institutional research has started to place more emphasis on actions than on outcomes (cf. Dobbin, 2010). Zilber (2013) claimed that when institutional work research focuses on outcomes, it is restricted to meta-level analysis through macro-level processes, based on archival data. By focusing instead on actions (and especially interactions), we take advantage of the processual merits of institutional work

(Lawrence, Leca, & Zilber, 2013; Zilber, 2013) that enables us to understand how change could occur in such complex, highly institutionalized settings as healthcare organizations (Goodrick & Reay, 2010; Reay et al., 2017). Institutional work can explain changes that result from individual actors modifying and challenging institutions through improvisation in their everyday work (Battilana & D'Aunno, 2009), but it can also show how institutional maintenance is performed through reification by individual actors (Dacin, Munir, & Tracey, 2010).

Institutional research focusing on individual actors often notes that interaction is important for understanding institutional logics at the micro level (e.g., Bévoort & Suddaby, 2016; Lok, 2010; Reay et al., 2017) and translating macro-ideas to micro-level practices (Vossen & van Gestel, 2019). However, studying institutional work through social interaction in healthcare organizations – considering their history of strong power positions for physicians and a rigid character created by individual actors' tendencies to adhere to a single institutional logic (Martin et al., 2017) – creates an opportunity to study social interaction between individual actors as carriers of different institutional logics. Some healthcare studies have highlighted the role of social interaction as an enabler of change (Gadolin & Andersson, 2017), especially when connecting manager and physician thinking, since everyday human interaction is key for achieving mutual appreciation (Bååthe & Norbäck, 2013). Following this line of reasoning, social interactions among different individual actors may be pivotal in making the actors 'work' with

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institutions in ways that also modify and challenge them. Such social interaction is likely to be especially challenging (but potentially more meaningful) between physicians and managers in healthcare organizations considering the great conflict between their 'home' logics (Andersson & Liff, 2018).

While some relational models on institutional work (e.g., Smets & Jarzabkowski, 2013; Topal, 2015) have created the foundation for social interactions, they have focused on relational characteristics rather than characteristics of social interaction forming institutional work. The particular focus of social interaction and how it can contribute to institutional work – especially going beyond maintenance – has been empirically underexplored. The present paper aims to describe and explain institutional work through social interaction between individual actors adhering to distinct institutional logics in healthcare organizations.

To understand institutional work through social interaction, we turned to studies of how social interactions can incorporate claiming and granting influence processes by different individual actors (DeRue & Ashford, 2010). In the above process view, social interaction must involve claiming and granting in order for the actors to be able to influence each other. Thereby, the present paper shows how reciprocal social interactions consisting of both claiming and granting influence between individual actors adhering to different institutional logics could form institutional work beyond maintenance in highly institutional settings. However, it also illustrates the difficulties of changing institutions in such settings, because typical social interactions reify existing institutional logics and the rigidity of the setting by reducing the effects of institutional complexity through maintaining distance between different institutional logics. While it is difficult to establish reciprocal social interaction, doing so may enable logics to encroach upon each other since it 'allows' for effects of institutional complexity when institutional logics 'meet' in the social interaction. The paradox is that institutional work through social interaction both maintains institutional logics and leads to encroachment.

The remainder of the paper is organized as follows. We start by describing the highly institutionalized character of healthcare organizations and how multiple, co-existing institutional logics form the setting for institutional work. In the next section we will describe current research on institutional work at the micro level. We highlight that more focus on practical-evaluative and iterative agency could contribute to research on institutional work in highly institutionalized settings, which has been dominated by research based on projective agency. We then examine how institutional work is formed by social interaction between individual actors adhering to distinct institutional logics. We operationalize social interaction as processes of claiming and granting to understand how individual actors could influence each other. We then present our empirical results on institutional work through social interaction. The results are organized into two main parts: maintaining institutional work and institutional work beyond maintaining. The discussion section highlights how our focus on institutional work through social interaction contributes to current research on institutional work. Finally, we conclude and highlight our primary contributions.

2. The highly institutionalized nature of healthcare organizations

When we describe healthcare organizations as highly institutionalized, we refer both to the many taken-for-granted norms that give such organizations a rigid character (Reay et al., 2017) and to the complexity that is often explained by multiple, coexisting, often conflicting institutional logics (Martin et al., 2017). The main conflict is between professional logic, which previously dominated healthcare (Scott, Ruef, Mendel, & Caronna, 2000), and managerial logic (related to marketization, business, bureaucracy, and management), which currently challenges this dominance (e.g., Andersson & Liff, 2018; Arman et al., 2014; Bévort & Suddaby, 2016; Currie & Spyridonidis,

2016; Kristiansen, Obstfelder, and Lotherington (2015); Reay et al., 2017; Reay & Hinings, 2005, 2009; Wright et al., 2017). However, even if institutional complexity can generate creative tension (Goodrick & Reay, 2011), healthcare tends to remain rigid because of its taken-for-granted norms, values, and beliefs on how to do things, who should do them, and under which circumstances; that is, beliefs that make different role identities become 'locked' to each other (Reay et al., 2017). A driving force behind the rigidity in institutional constellations is that adherence to certain institutional logics tends to be strong among individual actors in healthcare (Gadolin, 2018). It leads to compartmentalization (Ashforth & Mael, 1989; Jansen, 2008; Liff & Wikström, 2015) and creates the perception that hospitals comprise different, poorly integrated worlds (Glouberman & Mintzberg, 2001).

However, the strong influence of particular institutional logics in healthcare organizations does not inevitably mean there is no room for agency. The increasing body of research on micro-level enactment of logics by individuals has shown that there is a considerable degree of agency for individual actors (Martin et al., 2017), in which they may re-interpret institutional signals that are imposed on them (Bévort & Suddaby, 2016). This is exemplified in healthcare by individual actors co-opting elements from other logics (Andersson & Liff, 2018), re-balancing institutional logics that influence collective role identities (Reay et al., 2017), hierarchization (Arman et al., 2014), prioritizing logics (Sirris, 2019), manager/clinician hybrids who facilitate lateral integration of different compartmentalized worlds (Ernst, 2019; Fitzgerald, Ferlie, McGivern, & Buchanan, 2012), and professional hybrids that translate between different institutional logics (Blomgren & Waks, 2015). However, micro-level enactment of logics inevitably raises identity challenges with regard to strong adherence to particular logics (Andersson, 2015) and offers no guarantee of a balance among different logics (Llewellyn, 2001; McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). In sum, there has been major progress in research regarding how individuals' sense-making, re-interpretation and identity processing creates forms of partial autonomy within healthcare organizations (Martin et al., 2017).

Although individual actors have a degree of freedom in interpreting institutional prescriptions, healthcare organizations tend to retain their compartmentalized character. An important factor here is that relationships between individual actors adhering to different logics are usually dialectical rather than dialogical in healthcare, which limits their interactions and influence on each other (Macintosh, Beech, & Martin, 2012). If individual actors are viewed as carriers of institutional logics (Lindberg, 2014), and if the adherence to distinct logics is as strong as in healthcare (Andersson & Liff, 2018; Gadolin, 2018; McGivern et al., 2015), the social interaction between individual actors represents an interesting arena for institutional work (McGivern et al., 2015; Sartirana, Currie, & Noordegraaf, 2018). Interactions are often more important than individuals' discrete actions in complex systems such as healthcare (Plsek & Wilson, 2001). Therefore, we will complement micro-level research on individual actors' approaches to competing institutional logics by focusing on social interaction between individual actors, adhering to different logics in terms of their influence on each other. If individuals are carriers of institutional logics (Lindberg, 2014), social interactions may imply intended or unintended attempts to influence interpretations, based on adherence to distinct logics. We complement previous research by using institutional logics to understand the settings and constellations that influence the conditions of the social interaction in healthcare organizations. We focus on how the social interaction between individual actors both reproduces and challenges the institutional constellation in healthcare organizations; that is, how social interaction forms institutional work.

3. Institutional work at the micro-level in highly institutionalized settings

Institutional work has been presented as a part of the institutional

logics perspective when used in its holistic sense (Thornton, Ocasio, & Lounsbury, 2012). However, institutional logics and institutional work have different theoretical underpinnings and have seldom been examined together (Zilber, 2013). Although the present study is about institutional work in social interactions, we understand healthcare organizations as constituting multiple institutional logics that make it possible to understand the institutional setting of the study. Most institutional logic research tends to take institutional logics for granted and focuses too much on how they create consequences, whereas institutional work research focuses on the ongoing work required to reproduce, challenge, modify, and disrupt institutions (Lawrence, Suddaby, & Leca, 2011; Zilber, 2013). Empson, Cleaver, and Allen (2013) claimed that empirical studies of institutional work have traditionally focused on the macro level and have rarely investigated the interactions of individual actors, which has created a picture of organizations as uninhabited (Bévoort & Suddaby, 2016). As Suddaby (2010, 17) noted: 'Institutional work, of course, is conducted by individuals and it is somewhat surprising to me how individuals often disappear from institutional research.' Institutional work at the micro-level remains understudied in institution literature, despite its great potential for explaining how individuals reproduce, challenge, modify, or disrupt institutions by their social interactions; efforts will either maintain institutions or create institutional change over the long term (Lawrence et al., 2011).

Institutional work studies a flux state of becoming, rather than the static state of being, by underscoring the continual movements of institutions (however small) and their arrangements. Institutional work has been defined as 'purposive action aimed at creating, maintaining, and disrupting institutions' (Lawrence & Suddaby, 2006, 217; emphasis added). The original definition of institutional work as *purposeful* implies that institutional work research is dominated by projective agency (Smets & Jarzabkowski, 2013), in which the agency of strong individuals is exaggerated (Kraatz, 2009), such as in institutional entrepreneurship (Lounsbury & Crumley, 2007). Projective agency means actors' projection of the future and leading action in such a direction. Strong projective agency implies explicit forms of creating and disrupting institutional work, such as inventing, establishing, attacking, or undermining (Battilana & D'Aunno, 2009). By concentrating on everyday interactions – as in the present study – iterative or practical-evaluative agency (Battilana & D'Aunno, 2009) becomes more relevant. Iterative and practical-evaluative agency mean that creative and disruptive institutional work are more nuanced and implicit in improvising, modifying, translating, or failing to enact or select other institutionalized practices (Battilana & D'Aunno, 2009).

To avoid the narrow focus on projective agency, *intentionality* must instead be understood as incorporating a wide range of levels (Battilana & D'Aunno, 2009). One example may be actors' intentions to accomplish their everyday, mundane, practical work (Andersson & Liff, 2012; Martin et al., 2017; Smets & Jarzabkowski, 2013; Zilber, 2013). We address this point by relying on the more subtle forms of agency that iterative and practical-evaluative agencies constitute. Whereas projective agency means projecting the future, iterative agency is related to habits and reactivating previous actions (Battilana & D'Aunno, 2009). Practical-evaluative agency focuses on the present and how actors respond to perceived contingencies (Smets & Jarzabkowski, 2013). By relying on iterative and practical-evaluative agencies, institutional work brings a more nuanced view to agency (Battilana & D'Aunno, 2009; Martin et al., 2017; Smets & Jarzabkowski, 2013). Such a perspective answers Lawrence, Suddaby and Leca's (2009, 1) call for: 'a broader vision of agency in relationship to institutions, one that avoids depicting actors either as 'cultural dopes' trapped by institutional arrangements or as hyper-muscular institutional entrepreneurs.' Evolving institutions are not restricted to institutional entrepreneurs but can subtly occur in the everyday work of any actors as informal, agentic, street-level, institutional work (McCann et al., 2013; Wankhade, Heath, & Radcliffe, 2018). In contrast to institutional entrepreneurship,

institutional work directs attention from the actor to the act (Styhre, 2014) or, as in our case, the social interaction.

4. Institutional work through social interaction as claiming and granting processes

As demonstrated previously, the highly institutionalized character of healthcare organizations influences the conditions of social interaction and how it may generate institutional work. Our definition of social interaction rests on Weberian social action (Weber, 1991). *Social action* is an agentic act that takes into account individual actors' actions and reactions. Accordingly, we define *social interaction* as the face-to-face process of actions, reactions, and mutual influence between individual actors. The present paper focuses on social interaction between individuals adhering to different home logics (McPherson & Sauder, 2013). We are particularly interested in interactions that involve attempts to influence each other based on each actors' own home logic. When social interactions are repeated and become more regular, as in organizations, they shape social relationships, just like social relationships influence social interactions (Sztompka, 2008).

Fitzgerald et al. (2012) showed that social relationships in which both parties can influence each other are prerequisites for social interactions that can generate change in healthcare; that is, institutional work that goes beyond maintaining. The importance of the quality of relationships between individual actors in healthcare, and how it can enable interactions that lets them influence each other, is further underscored by the extensive body of research on teamwork and distributed leadership in healthcare organizations (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Chreim, Langley, Comeau-Vallée, Huq, & Reay, 2013; Finn, Currie, & Martin, 2010). Relationships that enable change depend on power distribution, with different characteristics in different situations and settings (Andersson, Cäker, Tengblad, & Wickelgren, 2019; Currie & Lockett, 2011). Power distribution highlights the hierarchization (see Arman et al., 2014; Gadolin & Wikström, 2016) among different institutional logics in healthcare, which prescribes that social interaction between actors who adhere to different institutional logics will produce different conditions, depending on the various institutional logics in play.

The connection between relationships and institutional work is illustrated by studies that describe how relational characteristics influence and direct institutional work (e.g., Smets & Jarzabkowski, 2013; Topal, 2015). Topal (2015) provided a relational model to predict institutional work, based on individual actors' power positions and meaning frameworks, whereas Smets and Jarzabkowski (2013) proposed a relational model of institutional work and complexity that depicts how different logics can trigger and produce institutional work in relation to each other. Consequently, the relationships between individual actors seem particularly important for institutional work in healthcare organizations, since individual actors as carriers of different logics tend to remain bound to their home logics (Martin et al., 2017). The social interactions between individual actors adhering to different home logics might either form maintaining institutional work or go beyond maintaining. One of the cycles in Smets and Jarzabkowski's model (2013) illustrates how the relationship can maintain perceived, strange logics as separate, which explains the compartmentalized character of healthcare organizations (see Liff & Wikström, 2015). However, their model also shows that this polarization is not self-evidently static as maintaining institutional work, but could also go beyond by constructing logics as contradictory, compatible, or complementary (Smets & Jarzabkowski, 2013). The question is: What role does social interaction play in this process of institutional work?

In terms of operationalizing the social interaction processes between individual actors adhering mainly to distinct institutional logics, we gained inspiration from DeRue and Ashford (2010). They described how influence is built on reciprocal, mutual reinforcement through processes of claiming and granting in the interaction, in which both

claiming and granting are required to achieve influence on each other. DeRue and Ashford (2010) argued that claiming and granting can either be explicit or implicit. Explicit claiming is about one individual actor directly telling someone else what to do or think, whereas implicit claiming involves more subtle ways to influence someone else in such a way. However, as part of the interaction, such claims will have the character of a negotiation, in which claims can either be accepted or rejected (Marchiondo, Myers, & Kopelman, 2015). *Granting* can be defined as allowing someone else to influence one's actions and thoughts, either by verbal acknowledgment or nonverbal signals such as nodding. As part of the interaction, granting can either precede a claim – such as by asking a question – or it can arise as a response to another actor's claim of influence (Marchiondo et al., 2015).

The fact that individual actors in healthcare organizations tend to subscribe to one logic (Martin et al., 2017) does not exclude the strategic use of other logics (McPherson & Sauder, 2013). However, we can assume they will be less likely to grant influence based on logics other than their own (Gadolin, 2018), especially physicians, considering their power position (cf. Scott, 2008). Social interactions between individuals who adhere to distinct logics can mean that different logics meet in an arena where individual actors, as carriers of the logics (Lindberg, 2014), 'work' with institutions through the social interaction forming institutional work that is maintaining, but it can also include institutional work that goes beyond maintenance.

5. Settings

As previously stated, healthcare organizations are highly institutionalized. However, the logics that constitute the foundation for the institutionalization are embedded in practice (Lindberg, 2014), which means they cannot be objectively studied. Instead, the institutional substance of healthcare organizations is enacted and interpreted by individual actors. The foundations for engaging in institutional work materialize through individual actors' practices, which makes it more advantageous to study institutional work in highly institutionalized contexts when institutional arrangements are challenged than when they are static. Such challenges compel individual actors to materialize the institutional substance that forms the foundation for institutional work (cf. Seo & Creed, 2002).

Following the above notion, the present paper takes a stance in a managerially instigated, improvement work project that aims to decrease the average level of HbA1c¹ (glycated haemoglobin) among child and adolescent patients in the diabetes care unit of a hospital. The improvement work project was officially approved and instigated in 2010 by the department manager, pursuant to evidence of relatively high levels of HbA1c (by national comparison) among the patients. The managerial interventions (cf. Bejerot & Hasselbladh, 2013) included an intentionally stricter adoption of a process-oriented system of care, manifested in managerial logic with the ability to structure the everyday work of healthcare professionals. In this case, the quality improvement work constituted an intervention that involved assessing institutionalized patterns. The quality improvement work offers a fertile context for studying institutional work through individual actors' interactions. As such, it was possible to study social interactions in everyday work among diverse actors who primarily adhere to distinct logics. Consequently, the case setting enabled us to study institutional work through social interactions of individual actors to accomplish their everyday, practical work (cf. Smets & Jarzabkowski, 2013). Thus, we were able to outline certain characteristics of these social interactions to delineate them as either maintaining institutional work or going beyond maintaining.

¹ Glycated hemoglobin (HbA1c) is a marker for average blood glucose levels and is a vital indicator of successful medical treatment of diabetes.

6. Analytical approach and methods

However, because institutional creation and change are long, slow processes, it is difficult to study them fully through the social interactions that form institutional work. In our efforts to study and understand institutional work as the social interaction of individual actors, we did not strive to describe institutional change. Instead, we wanted to show that institutional work should be 'about action, not outcomes. People are constantly doing things to build, sustain, and tear down institutions, and we should be interested in their action, rather than in whether they succeed' (Dobbin, 2010, p. 673). If the above notion is not integrated into how institutional work should be understood, we are restricted to studying institutional work solely at the meta level of analysis through macro-level processes based on archival data (Zilber, 2013). Restricting institutional work to such processes is misaligned with the intention to focus on social action to counteract the notion of uninhabited institutions (cf. Bévort & Suddaby, 2016). Accordingly, we aligned ourselves with the idea of iterative and practical-evaluative agencies (Battilana & D'Aunno, 2009), while focusing on how individual actors respond to contingencies they perceive in their everyday work (Smets & Jarzabkowski, 2013). The present paper treats the institutional logics that encompass the highly institutionalized setting of healthcare organizations as the background and institutional work, expressed through social interactions among individual actors, as the focal point (cf. Zilber, 2013).

Subsequently, we used a qualitative case study to engage in multiple efforts of data collection to focus on individual actors' iterative and practical-evaluative agency through social interactions while manoeuvring in their institution's complex milieu. Data were mainly collected by interviews and observations. A total of 27 semi-structured interviews were conducted with all employees and managers in the diabetes care unit, and approximately 40 h of observations on 10 occasions were documented. The interviewees comprised all employees who were members of the multi-professional team responsible for the care of children and adolescents with diabetes, plus the formal managers, all of whom were nurses. In total, there were six nurses, four physicians, two counsellors, two dieticians, two play therapists, one psychologist, two improvement workers, and two managers. Some individuals were interviewed multiple times to expand on topics and themes requiring further exploration. The interviews ranged in length from 30–100 min. Follow-up interviews were often shorter, given their limited scope. All interviews were digitally recorded, with the consent of the interviewee, and later transcribed verbatim.

The observations were primarily conducted at workplace team meetings, which enabled us to study the continuous institutional work being undertaken by various actors to accomplish their everyday, practical work through interactions (cf. McCann et al., 2013; Smets & Jarzabkowski, 2013). Our observation periods provided first-hand experience of individual actors' interactions, whereas the interviews facilitated the attributing purpose and meaning to such interactions. In other words, the observations enabled us to study work, whereas the interviews clarified our understanding of the intent behind the work. The combination of interviews and observations allowed the interviewees to be reflexive concerning the interactions studied during the observations. Therefore, the integration of data from interviews and observations was vital in our efforts to delineate the characteristics for social interactions that could form institutional work. In order to make the presented data more meaningful, the results section will not just present iterations of the social interactions but also interpretations as to why certain kinds of interactions took place.

We started our analysis by sorting the data regarding when social interactions occurred between individual actors primary adhering to different institutional logics. Those social interactions materialized in the highly institutionalized setting of the healthcare organization, which enabled us to study institutional work through interactions encompassing iterative and practical-evaluative agencies (Battilana &

D'Aunno, 2009) and actors responding to contingencies they perceive in their everyday work (Smets & Jarzabkowski, 2013). However, denoting everyday work as intuitional work presents certain challenges when studying it as it means that all social interactions form institutional work, to some extent. Accordingly, we sorted the social interactions in our dataset, which we interpreted as (1) forming explicit maintaining institutional work or (2) institutional work beyond maintaining, in relation to acts of claiming and granting influence, following the notion of qualitative conventional content analysis (Hsieh & Shannon, 2005). The initial sorting found that individual actors were rarely able or willing to engage in any kind of social interaction that could be interpreted as anything other than maintaining institutional work, as they did not contain acts of reciprocal acts of claiming and granting influence. We felt the lack of such social interactions illustrated the rigid character of healthcare organizations, reflecting the notion that individual actors primarily identify with and adhere to one logic (cf. Gadolin, 2018), often perceiving it as more legitimate than others (cf. Cloutier & Langley, 2013), while maintaining the inherent power positions of physicians in relation to other actors (Martin et al., 2017). An act of 'claiming influence' meant an actor attempted to influence the actions of other individual actor(s), based on the perception that the initiating actor held legitimacy to prescribe best practice based on their knowledge and expertise. An act of 'granting influence' meant an actor allowed another actor – who was not primarily adhering to the same institutional logic – to influence their actions.

Most of the situations previously labelled 'keeping distance' stemmed from the notion that physicians were unwilling to let other actors influence their daily work; the physicians collectively defended their right to act with discretion and ignored attempts by other actors to influence. At other times, individual actors avoided interactions entailing reciprocal claiming and granting influence between individual actors through interactions characterized by *granting without claiming* and *claiming without granting*. The absence of reciprocal claiming and granting influence characterized all of the categories of social interactions that formed maintaining institutional work. Each respective category of social interaction is described in the empirical section, where certain interactions are selected to capture the essence of how maintaining institutional work may manifest.

When individual actors exercised reciprocal agency – that is, when claiming was preceded by granting (or vice versa) – the social interaction moved beyond maintaining institutional work. The social interactions were idiosyncratic as they enabled bridging institutional logics at the individual actor level of analysis and institutional work beyond maintaining, by allowing effects of institutional complexity. Aligned with previous research that has aimed to highlight idiosyncratic occurrences in otherwise highly institutionalized settings (Gadolin, 2018), we chose to describe in more detail sequences that could illustrate the rare occasions when social interaction enables institutional work beyond maintaining.

Using two groups of sequences (non-reciprocal social interaction and reciprocal social interaction), we describe and explain how and why social interactions primarily maintain the highly institutionalized character of healthcare organizations. We then explain how and why social interactions can go beyond maintaining current institutionalized patterns of actions and form institutional work that in the prolonging may instigate institutional creation and change. Consequently, our analysis conceptualizes how certain characteristics of individual actors' social interactions may indicate whether or not they may (in the prolonging) give rise to institutional creation and change, even though the consequences of individual actors' social interactions on the institutional order are unknown at the time they are being carried out.

7. Institutional work through social interaction in a healthcare organization

In the case reported here, institutional work chiefly maintained

current institutional arrangements, thus segregating the different co-existing and competing institutional logics. Individual actors adhering primarily to different institutional logics were not likely to influence each other. Consequently, the studied quality improvement work was less likely to have a substantial influence on healthcare practices. In this first part of the results presentation we describe typical social interactions that constituted maintaining institutional work. The subsequent part on institutional work beyond maintaining describes three circumstances under which social interaction enabled actions that modified or challenged the established practices.

7.1. Institutional work – maintaining

7.1.1. Granting without claiming – maintaining professional hierarchization

There are several different professional groups in healthcare and the informal hierarchy among them influences the interaction. During a planning meeting for a diabetes camp for children, physicians tried to involve the dietitians in decisions about food and the content of lectures. However, the dietitians declined any involvement in decision-making, despite several attempts, which required the physicians to make all the decisions. Regarding the content of the lectures, the social interaction was finally closed by a snapping comment from a dietitian: *You, as physicians and nurses, must know what is important. Tell us.*

Despite repeated attempts to grant influence to the dietitians, they never claimed it. There were no tendencies toward a reciprocal claiming and granting interaction. Instead, the social interaction reinforced the hierarchization between the different professional institutional logics, despite repeated attempts to grant influence. Consequently, the dietitian remained passive in relation to affecting the practice of the diabetes care team.

7.1.2. Claiming without granting – maintaining by disparaging other institutional logics

Improvement workers supported diabetes professionals' work, according to a process-driven view of activities. Such support entailed improvement workers being integral for the diabetes team's quality-improvement work through taking part in team meetings and engaging in dialogue. However, the improvement workers often had difficulty attaining legitimacy when interacting with team members. Despite efforts to influence how the team's quality improvement work was carried out, the improvement workers were seldom successful in doing so. An improvement worker discusses a diabetes care process that generated excellent results in process measurement:

The excellent results don't mean that it is a good process. The team has improved, and they reached good measures. They obviously work well, but it is not a well-functioning process. They don't seem to understand why we organize in processes.

The organization of activities into processes is based on managerial logic. However, the diabetes care team did not embrace the tools and procedures that the improvement workers, charged with streamlining its implementation, felt they must use and adapt in order to 'correctly' adapt the process way of thinking. Instead, although the team of professionals called what they did a 'process', they did not organize the activities based on process mapping. In illustrating such a mentality, one of the improvement workers recalled an interaction when starting to work with the diabetes care team. During one of the first meetings that the improvement worker attended, the improvement worker provided the diabetes care team with an empty process flow chart for the professionals of the diabetes care team to fill out. The improvement worker's explicit aim was for the diabetes care team to map their care process in order for them to continuously work on improving it, given the tools provided by the improvement worker. Instead, during the subsequent meeting, the diabetes care team gave back the improvement worker the filled-in process flow chart. To the improvement worker's astonishment, the physician responsible for the quality improvement

work of the diabetes care team had stated: 'I guess we will give this back to you now, so that you can continue the work.'

Subsequently, the improvement worker's claim of influence in social interactions with the healthcare professionals based on managerial logic was not granted the influence from the healthcare professionals. Without such a reciprocal interaction, collision between the logics constituted institutional work that only maintained each logic, with each side defending its own logic and disparaging the other. Consequently, the social interactions between improvement workers and the diabetes care team constituted maintaining institutional work.

A similar claim to influence the work of the healthcare professionals was found during a social interaction between the unit manager and the nurses who were members of the diabetes care team. The social interaction took place at a meeting concerning the staffing situation. The nurses suggested that the diabetes care team should hire a new nurse to replace one who was due to retire shortly. The unit manager did not agree, arguing that there would not be enough nurses remaining to carry out the work required. However, the nurses argued such a situation would require them to change their usual way of working, hindering their usual care routine. Following an intense dialogue concerning the staffing situation, the head nurse stated the nurses' final position concerning the staffing situation as follows:

The most important aspect is that we have the possibility to care for our patients the way we usually do. We do not want any abating resources or any other arrangements that may hinder us from doing so.

The unit manager's claim of influence was explicitly based on managerial logic, following the notion that managers care for the organizations well-being as a whole, but the nurses did not grant influence in return. Instead, the nurses argued their way of carrying out their professional work must be maintained, regardless of the changes the unit manager proposed. Similar to the social interactions with the improvement workers, the individual actors defended their own logic and disparaged the other. In other words, the social interaction constituted institutional work that maintained each logic at the individual actor level of analysis.

7.2. Institutional work – beyond maintaining

The social interaction between actors committed to different institutional logics sometimes went beyond maintaining. The interactions produced real influence that modified or challenged the ways of doing things.

Claiming following granting between different professions – joint consultation

Physicians' and nurses' work is more intertwined in paediatric diabetes care than in general healthcare, which means they often interact with each other while providing care. During the quality improvement work studied, new procedures for joint consultations were introduced, which involved the physician and the nurse meeting with the patient together. The joint consultations created a new forum in which physicians and nurses had to interact with each other. One of the nurses reflected on this interaction as follows:

There are, of course, matters that the physician takes care of, just as there are more technical matters regarding equipment that are my responsibility, but in general I think our interplay is very good. We meet patients together, meaning that we learn from each other. And we are both experienced. It is not often that there is a question to [the physician] that I feel I couldn't have answered regarding the treatment; however, there are other physiological things that [the physician] can explain better. (Diabetes nurse)

Before the joint consultation was introduced, the nurse would see the patient first for specimens, followed by the 'real' meeting with the

physician to discuss the case. The nurses perceived the new form of interaction with patients as constructive, as they were able to meaningfully contribute with their expertise during the joint consultation. One nurse reflected upon the prerequisites for such meaningful contribution as follows:

There are some physicians with whom I could have joint meetings with patients who really let me join and participate but there are other physicians with whom joint meetings with the patient would be meaningless. For them, my competence and my contribution are worth nothing. They would let me sit there, but they won't 'let me in' for real. (Diabetes nurse)

Consequently, the social interaction between the physicians and the nurses in relation to the joint consultation requires the more powerful professional (the physician) to invite the less powerful professional (the nurse) to participate. If not, the social interaction between physicians and nurses when meeting the patient remained entrenched, despite the fact that the nurses tried to claim influence within the interaction based on their professional expertise. As previously noted, different professional groups in healthcare have informal hierarchies. Hence, although the physicians and the nurses adhered to the same ideal-typical professional logic, the nurses who were unable to claim influence without the physicians granting it were unable to influence the professional logic of the physicians.

7.2.1. Claiming following granting – managers dealing with physicians

When approaching professionals, especially physicians, managers are extremely careful about choosing how to interact with them and avoid trying to direct them to do certain things. Managers are more indirect, choosing to influence by not hindering worthwhile initiatives and by providing objectives for actions, which is also an indirect basis of influence. However, the possibility of influencing physicians remains limited:

I think [the manager] knows that [the manager] can't control [the responsible physician], and then settles for something that is good enough. It wasn't exactly according to plan, but it was a step in the right direction, and then [the manager] is satisfied, without pushing it further. (Improvement worker)

Such a delicate approach to the physicians – based on the insight that they do not take kindly to managerial attempts that directly interfere with everyday practice and routines – manifested several times. During the initiation of the quality improvement work project, for instance, a manager approached a physician with an almost pleading question – affirming the autonomous nature of the physician's professional logic. The manager was fully aware a direct order would accomplish nothing, as a manager does not simply tell a physician what to do. Moreover, the question was anchored in a problem the physicians perceived as important: Equal care for boys and girls. Therefore, the manager provided further support for the professional logic of the physician, for whom patient health outcomes are placed above costs. Both of the above situations illustrate how the social interaction starts with the manager granting influence to the physician, based on the manager's experience of the futility of starting the interaction with a claim. The reciprocal granting and claiming constitutes and nurtures institutional work that leads to established practices being modified and challenged, as the physicians engaged in quality improvement work instigated by managerial representatives of the organization.

Claiming following granting – improvement workers dealing with physicians

Although the healthcare professionals regarded many improvement workers with scepticism, some interactions developed more positively. Improvement workers who were able to influence practices interacted with physicians in ways similar to the manager in the previous example. The improvement workers employed a humble approach,

understanding that physicians generally had little interest in methods and tools traditionally associated with quality improvement work. Instead, the improvement workers focused on how they could improve patient care, which promoted what the healthcare professionals considered important: the outcome of quality-improvement work rather than its vocabulary and specific tools. In our study, both the professionals and the improvement workers perceived such a method of approaching the healthcare professionals to be more beneficial for the quality improvement work:

The physicians want to do it their own way, meaning that we improvement workers have to be extremely flexible. (Improvement worker)

Consequently, improvement workers started interactions by granting influence, rather than claiming it by introducing their vocabulary and tools. The subsequent claims of healthcare professionals directed at improving results for patients demonstrated the existence of reciprocal interactions and relationships in which institutional work took place in the convergence between the two institutional logics. Subsequently, although the improvement worker masked the rhetoric to fit the professional logic of the physicians, it was the managerial logic that was granted legitimacy as the quality improvement work was both managerially initiated and carried out as intended by the improvement workers, who were able to redress issues found to be relevant for the physicians. Hence, through social interactions between individual actors adhering to different institutional logics, institutional work went beyond maintaining.

8. Discussion

The present study contributes to institutional research emphasizing the localized and inhabited character of institutions (e.g., Bévort & Suddaby, 2016; Hallett, 2010; Smets & Jarzabkowski, 2013) by focusing on institutional work through social interactions in highly institutionalized settings. Other researchers have made significant contributions to the ways in which individual actors balance coexisting logics (Smets, Jarzabkowski, Burke, & Spee, 2015) by strategically using different institutional logics (McPherson & Sauder, 2013) to reinterpret (Bévort & Suddaby, 2016) and rebalance them (Reay et al., 2017). Our chief contribution is related to how social interactions between individual actors can form institutional work, which may enable the actors to modify or challenge established practices (Lawrence & Suddaby, 2006; Lawrence et al., 2013) and induce change, despite the institutionalized character of healthcare organizations (Reay et al., 2017).

Table 1 summarizes the different types of social interactions among individual actors adhering to distinct institutional logics and indicates the institutional work implied by the social interactions.

However, before going into the different categories of social interaction in Table 1, we describe the problems and consequences of the many attempts we observed in our data collection to avoid real interaction between individual actors adhering to different institutional logics. Even if a full discussion of this topic is beyond the scope of our study, it better situates our contribution as it provides an understanding of what happens (and not) in the lack of 'real' social interaction. We describe such strategies as 'keeping distance' in our case settings, since they created a form of social enclosure, in similar ways as places can in

institutional work (Lawrence & Dover, 2015). The strategies also explain the mechanisms behind the compartmentalization of healthcare organizations (Glouberman & Mintzberg, 2001; Liff & Wikström, 2015) and how strong maintenance of the institutional work of medical professionalism can continue relatively undisturbed, despite other co-existing institutional logics in healthcare (cf. Waring & Currie, 2009; Wright et al., 2017). These unfulfilled social interactions form maintaining institutional work that may decouple (e.g., Reay & Hinings, 2009), hierarchize (see Arman et al., 2014), and polarize logics (Smets & Jarzabkowski, 2013) to avoid or minimize influence from other institutional logics in social interactions and preserve individual actors' home logic (e.g., McPherson & Sauder, 2013). Through such non-interactions, the individual actors reduce the effect of institutional complexity, since they do not 'allow' for competing institutional logics to really meet. This situation adds to Smets and Jarzabkowski's (2013) illustration of how institutional complexity is constructed by individual actors.

As Table 1 shows, when interaction attempts are not reciprocal (involving granting without claiming, and claiming without granting; DeRue & Ashford, 2010), influence attempts are either rejected or influence invitations are not accepted. Macintosh et al. (2012) claimed that clinician–manager relationships are more often dialectical than dialogical, which limits their social interaction and their influence on each other. The present study confirms those results and adds an explanation of how the dialectical character entails maintaining institutional work by reducing the effects of institutional complexity, preventing individual actors from deviating from the bounds of their home logic (cf. Martin et al., 2017). Topal (2015) claimed relationships between individual actors shape the nature of institutional work based on different power positions and divergent meaning frameworks. The present research provides empirical evidence of Topal's claim by demonstrating how the influence of power positions, especially that of physicians, made them less willing to grant actors adhering to other logics influence on them, but it also shows that when reciprocal interaction did occur, it was conditioned by physicians granting influence.

While the present study affirms that maintenance is the most common type of institutional work in highly institutionalized healthcare settings, our most interesting contributions are the descriptions and explanations of institutional work that go beyond maintaining (Battilana & D'Aunno, 2009; Lawrence et al., 2013). These are finer-grained mechanisms (Lounsbury, 2007), by which institutional logics can not only coexist, but can change through institutional work based on practical-evaluative and iterative agency, rather than projective agency (cf. Smets & Jarzabkowski, 2013) by allowing for institutional complexity. The paradox is that social interaction can maintain logics but also enable them to encroach upon each other. Even if relationships may keep different logics separate (Smets & Jarzabkowski, 2013), this polarization is not self-evidently static as maintaining institutional work; it could go further by constructing logics as contradictory, compatible or complementary (Smets & Jarzabkowski, 2013). The present study contributes by describing how the character of social interaction through granting and claiming influence enables individual actors to 'work' with the institutions beyond maintaining, by 'allowing' for institutional complexity generating creative tension and a more dynamic setting (cf. Martin et al., 2017).

Nonetheless, such reciprocal sequences were rare in this case, which underscores the highly institutionalized nature of healthcare organizations (Currie et al., 2012; Reay et al., 2017; Scott et al., 2000). Sequences in which institutional work went beyond maintaining in the form of modifying, improvising or selecting institutionalized practices (Battilana & D'Aunno, 2009) were characterized by reciprocal interactions that are dialogical rather than dialectical (Macintosh et al., 2012) and involve influence being both claimed and granted (DeRue & Ashford, 2010). An important addition here is that the reciprocal social interactions meant that all individual actors had some level of autonomy in the social interactions, which enabled influence but also

Table 1
Social interactions and institutional work.

Social interaction	Institutional work
Granting without claiming	Maintaining through hierarchization
Claiming without granting	Maintaining through disparaging
Claiming following granting	Beyond maintaining through reciprocal interaction

made the outcomes unpredictable. This situation can be contrasted with the types of social interactions that rituals constitute, in which the ritual interactions restrict individual autonomy. Such ritual interactions tend to support institutional maintenance (Dacin et al., 2010). What makes healthcare organizations highly institutionalized is the rigid ways in which role identities are tied to each other (Reay et al., 2017), forming an almost ritual interaction and thereby institutional maintenance. However, if the identified 'new' ways of interacting from the study are repeated and become more regular, they will inevitably shape social relationships, just as such relationships influence future social interactions (Sztompka, 2008), and we can catch a glimpse of possible modified institutions.

The social interactions were important because they enabled individual actors adhering to distinct institutional logics to really meet and influence each other. Otherwise, as demonstrated, mechanisms often prevented individual actors who adhered to different institutional logics from interacting to influence each other's actions and interpretations. On the other hand, when influence was both claimed and granted in social interactions, actions could take other directions influenced by another institutional logic. The resulting modifying and challenging actions then amounted to institutional work that could go beyond maintaining. As Smets and Jarzabkowski (2013) noted, there has been insufficient study of institutional work at the individual actor level through everyday action (in our case, focused on social interaction), based on a less projective, more iterative/practical-evaluative agency (Battilana & D'Aunno, 2009; Martin et al., 2017; McCann et al., 2013). Institutional work based on projective agency is probably more common in research because it is more distinct and explicit, both to researchers and individual actors, than more subtle institutional work based on practical-evaluative and iterative agency. It is unlikely that any of the individual actors in our case realized they were performing institutional work beyond maintaining. Their only intentions were to accomplish their everyday, practical work through the studied social interactions (see Martin et al., 2017; McCann et al., 2013; Smets & Jarzabkowski, 2013; Smets et al., 2015). However, improvising, modifying or challenging the established ways of doing things may induce institutional effects over the longer term (Adler & Kwon, 2013; Lawrence et al., 2011; Rao, Monin, & Durand, 2003). Based on the present study, intentionality and institutional work should be understood as intentionality in relation to individual actors' performing their work (Andersson & Liff, 2012; Martin et al., 2017; Smets & Jarzabkowski, 2013; Zilber, 2013), but not necessarily intentionality regarding *institutional work*.

The present study has affirmed the strong position of physicians in healthcare and how it affects their social interactions with other actors. Physicians' strong adherence to their professional institutional logic makes them engage primarily in maintaining institutional work, while preventing institutional work from going further. Therefore, physicians are the main barriers to change, which probably explains the lack of social interactions characterized by 'granting following claiming'. Thus, physicians illustrate the paradox of social embeddedness, whereby the actor who holds the power to change a situation is also the actor who has the least interest in doing so (Battilana & D'Aunno, 2009; Currie et al., 2012). By maintaining their home logic, physicians also uphold the power of their position. We do not see the central position of physicians' professional logic as an example of sole domination, but rather as one of hierarchization (see Arman et al., 2014; Gadolin & Wikström, 2016) in the coexistence of different institutional logics. Nonetheless, this hierarchization has implications for how social interaction forming institutional work can occur (cf. Topal, 2015), because it gives preference to meaning frameworks related to the professional logic of physicians, forcing other actors to frame interaction accordingly.

Therefore, our empirical examples of institutional work beyond maintaining usually began with actors committed to other institutional logics granting physicians influence. This situation seems to be the

starting point of social interactions that reconfirm a reciprocal relationship, which supports institutional work that modifies or challenges established practices. Implicitly, physicians have the option to veto any institutional work that challenges the current institutional setting in healthcare. Their power position in interpersonal relationships (cf. Topal, 2015) enables them to initiate or prevent any institutional work beyond maintaining.

Previous healthcare research has examined how managers can approach physicians and thereby bridge divergent institutional logics. Bååthe and Norbäck (2013) described how managers must appreciate physicians' identities, while Styhre, Roth, and Roth (2016) examined how managers must support physicians in avoiding decisive trade-offs between their medical expertise and leadership positions. Reay, Goodrick, Casebeer, and Hinings (2013) emphasized that managers must support physicians' attempts to try new practices. The present study adds to those mentioned above by explaining the mechanisms in social interactions behind bridging managerial and professional logics. The empirical examples of granting-of-influence approaches from both managers and improvement workers in social interaction are examples of appreciating and helping physicians, which creates fertile ground for reciprocal social interaction and institutional work that goes beyond maintaining and enables small changes that bridge the two often-competing logics.

9. Conclusion

The present study describes and explains how social interactions that feature both claiming and granting between individual actors who adhere to distinct institutional logics can form institutional work that maintains current institutional constellations or goes beyond maintenance in healthcare organizations. Healthcare organizations are characterized by institutional complexity created by several often competing institutional logics, although the present study shows how individual actors usually reduce the effects of this institutional complexity by avoiding reciprocal social interaction involving actors adhering to institutional logics other than their home logic. On the other hand, when reciprocal social interaction occurs, it also allows for the effects of institutional complexity that may form institutional work beyond maintaining.

According to our results, less projective institutional work can occur in the everyday social interactions of individual actors, but it takes less salient forms toward modifying, improvising, and challenging than it does in creating or attacking (cf. Battilana & D'Aunno, 2009). Our data confirms the well-known power position of physicians in healthcare but extends the literature by examining how this position influences social interaction and institutional work through this interaction – specifically, how it makes physicians who are less willing to grant actors representing other institutional logics any influence on their practices. In fact, physicians' frequent denials to grant influence to any institutional logics other than their own manifests as maintaining institutional work. Actors who follow less powerful institutional logics still play a central role in institutional work beyond maintaining current institutions. Their active approaches to granting influence create fertile ground for reciprocal social interaction. However, if physicians are unwilling to become involved in such social interactions, the conditions for institutional work beyond maintaining are poor.

It follows that the granting of actions to actors who conform to the strongest institutional logics – the physicians' professional logic in healthcare – is central for institutional work going beyond maintaining. We contend that individual actors finding new approaches to each other through social interactions beyond their home logics (or as new routines and practices evolve, unconnected to just one institutional logic) exemplifies how the finer-grained mechanisms of institutions are modified and challenged through social interaction in everyday work. Institutional work is a relational phenomenon. In other words, social interactions are required to enable actors from different institutional

logics to 'work' with each other, which then facilitates influence from other institutional logics. Therefore, our study explains the importance of reciprocal and dialogical interaction in producing change in complex organizations like healthcare because it allows for the effects of institutional complexity, which would otherwise be decreased by avoiding influence by other institutional logics and one's home logic. The strong attachment to certain institutional logics among individual actors in healthcare organizations creates compartmentalization, which is likely to make social interactions particularly important in decompartmentalization. Therefore, we suggest that further research should investigate the role of social interaction as an enabler of institutional work beyond maintenance in settings where individual actors display a lesser degree of adherence to given institutional logics.

CRedit authorship contribution statement

Thomas Andersson: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing - original draft, Writing - review & editing. **Christian Gadolin:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Resources, Validation, Visualization, Writing - original draft, Writing - review & editing.

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References

- Adler, P., & Kwon, S.-W. (2013). The mutation of professionalism as a contested diffusion process: Clinical guidelines as carriers of institutional change in medicine. *Journal of Management Studies*, 50, 930–962. <https://doi.org/10.1111/joms.12003>.
- Andersson, T. (2015). The medical leadership challenge in healthcare is an identity challenge. *Leadership in Health Services*, 28, 83–99. <https://doi.org/10.1108/LHS-04-2014-0032>.
- Andersson, T., & Liff, R. (2012). Multi-professional cooperation and accountability pressures – Consequences of a post-new public management reform in a new public management context. *Public Management Review*, 14, 835–855. <https://doi.org/10.1080/14719037.2011.650053>.
- Andersson, T., & Liff, R. (2018). Co-optation as a response to competing institutional logics: Professionals and managers in healthcare. *Journal of Professions and Organization*, 5, 71–87. <https://doi.org/10.1093/jpo/joy001>.
- Andersson, T., Cäker, M., Tengblad, S., & Wickelgren, M. (2019). Building traits for organizational resilience through balancing organizational structures. *Scandinavian Journal of Management*, 35, 36–45. <https://doi.org/10.1016/j.scaman.2019.01.001>.
- Arman, R., Liff, R., & Wikström, E. (2014). The hierarchization of competing logics in psychiatric care in Sweden. *Scandinavian Journal of Management*, 30, 282–291. <https://doi.org/10.1016/j.scaman.2014.01.001>.
- Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *The Academy of Management Review*, 14, 20–39. <https://doi.org/10.5465/amr.1989.4278999>.
- Bååthe, F., & Norbäck, L.-E. (2013). Engaging physicians in organisational improvement work. *Journal of Health Organization and Management*, 24, 479–497. <https://doi.org/10.1108/JHOM-02-2012-0043>.
- Battilana, J., & D'Aunno, T. (2009). Institutional work and the paradox of embedded agency. In T. Lawrence, R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organizations* (pp. 31–58). Cambridge: Cambridge University Press.
- Bejerot, E., & Hasselbladh, H. (2013). Forms of intervention in public sector organizations: Generic traits in public sector reforms. *Organization Studies*, 34, 1357–1380. <https://doi.org/10.1177/0170840613477639>.
- Bévort, F., & Suddaby, R. (2016). Scripting professional identities: How individuals make sense of contradictory institutional logics. *Journal of Professions and Organization*, 3, 17–38. <https://doi.org/10.1093/jpo/jov007>.
- Blomgren, M., & Waks, C. (2015). Coping with contradictions: Hybrid professionals managing institutional complexity. *Journal of Professions and Organization*, 2, 78–102. <https://doi.org/10.1093/jpo/jou010>.
- Buchanan, D., Addicott, R., Fitzgerald, L., Ferlie, E., & Baeza, J. (2007). Nobody in charge: Distributed change agency in healthcare. *Human Relations*, 60, 1065–1090. <https://doi.org/10.1177/0018726707081158>.
- Chreim, S., Langlely, A., Comeau-Vallée, M., Huq, J.-L., & Reay, T. (2013). Leadership as boundary work in healthcare teams. *Leadership*, 9, 201–228. <https://doi.org/10.1177/1742715012468781>.
- Cloutier, C., & Langlely, A. (2013). The logic of institutional logics: Insights from French pragmatist sociology. *Journal of Management Inquiry*, 22, 360–380. <https://doi.org/10.1177/1056492612469057>.
- Currie, G., & Lockett, A. (2011). Distributing leadership in health and social care: Concertive, conjoint or collective? *International Journal of Management Reviews*, 13, 286–300. <https://doi.org/10.1111/j.1468-2370.2011.00308.x>.
- Currie, G., & Spyridonidis, D. (2016). Interpretation of multiple institutional logics on the ground: Actors' position, their agency and situational constraints in professionalized contexts. *Organization Studies*, 37, 77–97. <https://doi.org/10.1177/0170840615604503>.
- Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. (2012). Institutional work to maintain professional power: Re-creating the model of medical professionalism. *Organization Studies*, 33, 937–962. <https://doi.org/10.1177/0170840612445116>.
- Dacin, M. T., Munir, K., & Tracey, P. (2010). Formal dining at Cambridge colleges: Linking ritual performance and institutional maintenance. *The Academy of Management Journal*, 53, 1393–1418. <https://doi.org/10.5465/amj.2010.57318388>.
- DeRue, S., & Ashford, S. (2010). Who will lead and who will follow? A social process of leadership identity construction in organizations. *The Academy of Management Review*, 35, 627–647. <https://doi.org/10.5465/amr.35.4.zok627>.
- Dobbin, F. (2010). Review of Thomas B. Lawrence, Roy Suddaby, and Bernard Leca, eds., *Institutional Work: Actors and Agency in Institutional Studies of Organizations*. *Administrative Science Quarterly*, 55, 673–676. <https://doi.org/10.2189/asqu.2010.55.4.673>.
- Empson, L., Cleaver, I., & Allen, J. (2013). Managing partners and management professionals: Institutional work dyads in professional partnerships. *Journal of Management Studies*, 50, 808–844. <https://doi.org/10.1111/joms.12025>.
- Ernst, J. (2019). The curse of bureaucratization or the blessings of professionalisation? Nurses' engaged adoption of quality management in hybrid managerial positions. *Scandinavian Journal of Management*, 35(3), 101050. <https://doi.org/10.1016/j.scaman.2019.101050>.
- Finn, R., Currie, G., & Martin, G. (2010). Team work in context: Institutional mediation in the public-service professional bureaucracy. *Organization Studies*, 31, 1069–1097. <https://doi.org/10.1177/0170840610376142>.
- Fitzgerald, L., Ferlie, E., McGivern, G., & Buchanan, D. (2012). Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *The Leadership Quarterly*, 24, 227–239. <https://doi.org/10.1016/j.leaqua.2012.10.012>.
- Gadolin, C. (2018). Professional employees' strategic employment of the managerial logic in healthcare. *Qualitative Research in Organization and Management*, 13, 126–143. <https://doi.org/10.1108/QROM-02-2016-1359>.
- Gadolin, C., & Andersson, T. (2017). Healthcare quality improvement work: A professional employee perspective. *International Journal of Health Care Quality Assurance*, 30, 410–423. <https://doi.org/10.1108/IJHCQA-02-2016-0013>.
- Gadolin, C., & Wikström, E. (2016). Organizing healthcare with multi-professional teams: Activity coordination as a logistical flow. *Scandinavian Journal of Public Administration*, 20, 53–72. <http://ub016045.ub.gu.se/ojs/index.php/sjpa/article/view/3136/3054>.
- Glouberman, S., & Mintzberg, H. (2001). Managing the care of health and the cure of disease – Part I: Differentiation. *Healthcare Management Review*, 26, 56–69. <https://doi.org/10.1097/00004010-200101000-00006>.
- Goodrick, E., & Reay, T. (2010). Florence Nightingale endures: Legitimizing a new professional role identity. *Journal of Management Studies*, 47, 55–84. <https://doi.org/10.1111/j.1467-6486.2009.00860.x>.
- Goodrick, E., & Reay, T. (2011). Constellations of institutional logics: Changes in the professional work of pharmacists. *Work and Occupations*, 38, 372–416. <https://doi.org/10.1177/0730888411406824>.
- Hallett, T. (2010). The myth incarnate: Recoupling processes, turmoil, and inhabited institutions in an urban elementary school. *American Sociological Review*, 75, 52–74. <https://doi.org/10.1177/0003122409357044>.
- Hsieh, H. F., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277–1288. <https://doi.org/10.1177/1049732305276687>.
- Jansen, L. (2008). Collaborative and interdisciplinary health care teams: Ready or not? *Journal of Professional Nursing*, 24, 218–227. <https://doi.org/10.1016/j.profnurs.2007.06.013>.
- Kraatz, M. (2009). Leadership as institutional work: A bridge to the other side. In T. Lawrence, R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organizations* (pp. 59–91). Cambridge: Cambridge University Press.
- Kristiansen, M., Obstfelder, A., & Lotherington, A. T. (2015). Nurses' sensemaking of contradicting logics: An underexplored aspect of organisational work in nursing homes. *Scandinavian Journal of Management*, 31, 330–337. <https://doi.org/10.1016/j.scaman.2015.04.003>.
- Lawrence, T., & Dover, G. (2015). Place and institutional work: Creating housing for the hard-to-house. *Administrative Science Quarterly*, 60, 371–410. <https://doi.org/10.1177/0001839215589813>.
- Lawrence, T., & Suddaby, R. (2006). Institutions and institutional work. In S. Clegg, C. Hardy, T. Lawrence, & W. R. Nord (Eds.), *Handbook of organization studies* (pp. 215–254). (2nd ed.). Thousand Oaks: Sage.
- Lawrence, T., Leca, B., & Zilber, T. (2013). Institutional work: Current research, new directions and overlooked issues. *Organization Studies*, 34, 1023–1033. <https://doi.org/10.1177/0170840613495305>.
- Lawrence, T., Suddaby, R., & Leca, B. (2009). Introduction: Theorizing and studying institutional work. In T. Lawrence, R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organizations* (pp. 1–27). Cambridge: Cambridge University Press.

- Lawrence, T., Suddaby, R., & Leca, B. (2011). Institutional work: Refocusing institutional studies of organization. *Journal of Management Inquiry*, 20, 52–58. <https://doi.org/10.1177/1056492610387222>.
- Liff, R., & Wikström, E. (2015). The problem-avoiding multi professional team – On the need to overcome protective routines. *Scandinavian Journal of Management*, 31, 266–278. <https://doi.org/10.1016/j.scaman.2014.12.001>.
- Lindberg, K. (2014). Performing multiple logics in practice. *Scandinavian Journal of Management*, 30, 485–497. <https://doi.org/10.1016/j.scaman.2013.12.007>.
- Llewellyn, S. (2001). 'Two-way windows': Clinicians as medical managers. *Organization Studies*, 22, 593–623. <https://doi.org/10.1177/0170840601224003>.
- Lok, J. (2010). Institutional logics as identity projects. *The Academy of Management Journal*, 53, 1305–1335. <https://doi.org/10.5465/amj.2010.57317866>.
- Lounsbury, M. (2007). A tale of two cities: Competing logics and practice variation in the professionalizing of mutual funds. *The Academy of Management Journal*, 50, 289–307. <https://doi.org/10.5465/amj.2007.24634436>.
- Lounsbury, M., & Crumley, E. (2007). New practice creation: An institutional perspective on innovation. *Organization Studies*, 28, 993–1012. <https://doi.org/10.1177/0170840607078111>.
- Macintosh, R., Beech, N., & Martin, G. (2012). Dialogues and dialectics: Limits to clinician-manager interaction in healthcare organizations. *Social Science & Medicine*, 74, 332–339. <https://doi.org/10.1016/j.socscimed.2011.03.014>.
- Marchiondo, L. A., Myers, C. G., & Kopelman, S. (2015). The relational nature of leadership identity construction: How and when it influences perceived leadership and decision-making. *The Leadership Quarterly*, 26(5), 892–908. <https://doi.org/10.1016/j.leaqua.2015.06.006>.
- Martin, G., Currie, G., Weaver, S., Finn, R., & McDonald, R. (2017). Institutional complexity and individual responses: Delineating the boundaries of partial autonomy. *Organization Studies*, 38, 103–127. <https://doi.org/10.1177/0170840616663241>.
- McCann, L., Granter, E., Hyde, P., & Hassard, J. (2013). Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work. *Journal of Management Studies*, 50, 750–776. <https://doi.org/10.1111/joms.12009>.
- McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L., & Waring, J. (2015). Hybrid manager-professionals' identity work: The maintenance and hybridization of medical professionalism in managerial contexts. *Public Administration*, 93, 412–432. <https://doi.org/10.1111/padm.12119>.
- McPherson, C. M., & Sauder, M. (2013). Logics in action: Managing institutional complexity in a drug court. *Administrative Science Quarterly*, 58, 165–196. <https://doi.org/10.1177/0001839213486447>.
- Pisek, P., & Wilson, T. (2001). Complexity, leadership and management in healthcare organizations. *British Medical Journal*, 323, 746–749. <https://doi.org/10.1136/bmj.323.7315.746>.
- Rao, H., Monin, P., & Durand, R. (2003). Institutional change in Toque Ville: Nouvelle cuisine as an identity movement in French gastronomy. *The American Journal of Sociology*, 108, 795–843. <https://doi.org/10.1086/367917>.
- Reay, T., & Hinings, C. R. (2005). The recomposition of an organizational field: Health care in Alberta. *Organization Studies*, 26, 351–384. <https://doi.org/10.1177/0170840605050872>.
- Reay, T., & Hinings, C. R. (2009). Managing the rivalry of competing institutional logics. *Organization Studies*, 30, 629–652. <https://doi.org/10.1177/0170840609104803>.
- Reay, T., Goodrick, E., Casebeer, A., & Hinings, B. (2013). Legitimizing new practices in primary health care. *Health Care Management Review*, 38, 9–19. <https://doi.org/10.1097/HMR.0b013e31824501b6>.
- Reay, T., Goodrick, E., Waldorff, S. B., & Casebeer, A. (2017). Getting leopards to change their spots: Co-creating a new professional role identity. *The Academy of Management Journal*, 60, 1043–1070. <https://doi.org/10.5465/amj.2014.0802>.
- Sartirana, M., Currie, G., & Noordegraaf, M. (2018). Interactive identity work of professionals in management: A hospital case study. *Public Management Review*, 21, 1191–1212. <https://doi.org/10.1080/14719037.2018.1549269>.
- Scott, R. (2008). Lords of the dance: Professionals as institutional agents. *Organization Studies*, 29, 219–238. <https://doi.org/10.1177/0170840607088151>.
- Scott, R., Ruef, M., Mendel, P., & Caronna, C. (2000). *Institutional change and healthcare organizations: From professional dominance to managed care*. Chicago: University of Chicago Press.
- Seo, M.-E., & Creed, D. (2002). Institutional contradictions, praxis, and institutional change: A dialectical perspective. *The Academy of Management Review*, 27, 222–247. <https://doi.org/10.5465/amr.2002.6588004>.
- Sirris, S. (2019). Coherent identities and roles? Hybrid professional managers' prioritizing of coexisting institutional logics in differing contexts. *Scandinavian Journal of Management*, 35, 101063. <https://doi.org/10.1016/j.scaman.2019.101063>.
- Smets, M., & Jarzabkowski, P. (2013). Reconstructing institutional complexity in practice: A relational model of institutional work and complexity. *Human Relations*, 66, 1279–1309. <https://doi.org/10.1177/0018726712471407>.
- Smets, M., Jarzabkowski, P., Burke, G., & Spee, P. (2015). Reinsurance trading in Lloyd's of London: Balancing conflicting-yet-complementary logics in practice. *The Academy of Management Journal*, 58, 932–970. <https://doi.org/10.5465/amj.2012.0638>.
- Styhre, A. (2014). Gender equality as institutional work: The case of the church of Sweden. *Gender, Work and Organization*, 21, 105–120. <https://doi.org/10.1111/gwao.12024>.
- Styhre, A., Roth, A., & Roth, J. (2016). Who will lead the physicians unwilling to lead? Institutional logics and double-blind situations in health care leadership. *Leadership & Organizational Development Journal*, 37, 325–340. <https://doi.org/10.1108/LODJ-10-2012-0137>.
- Suddaby, R. (2010). Challenges for institutional theory. *Journal of Management Inquiry*, 19, 14–20. <https://doi.org/10.1177/1056492609347564>.
- Sztompka, P. (2008). The focus on everyday life: A new turn in sociology. *European Review*, 16, 23–37. <https://doi.org/10.1017/S1062798708000045>.
- Thornton, P., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective: A new approach to culture, structure and process*. Oxford: Oxford University Press.
- Topal, C. (2015). A relational perspective of institutional work. *Journal of Management & Organization*, 21, 495–514. <https://doi.org/10.1017/jmo.2015.13>.
- Vossen, E., & van Gestel, N. (2019). Translating macro-ideas into micro-level practices: The role of social interactions. *Scandinavian Journal of Management*, 35, 26–35. <https://doi.org/10.1016/j.scaman.2018.12.001>.
- Wankhade, P., Heath, G., & Radcliffe, J. (2018). Cultural change and perpetuation in organisations: Evidence from an English emergency ambulance service. *Public Management Review*, 20, 923–948. <https://doi.org/10.1080/14719037.2017.1382278>.
- Waring, J., & Currie, G. (2009). Managing expert knowledge: Organizational challenges and managerial futures for the UK medical profession. *Organization Studies*, 30, 755–778. <https://doi.org/10.1177/0170840609104819>.
- Weber, M. (1991). *From Max Weber: Essays in sociology*. Oxon: Routledge.
- Wright, A., Zammuto, R., & Liesch, P. (2017). Maintaining the values of a profession: Institutional work and moral emotions in the emergency department. *The Academy of Management Journal*, 60, 200–237. <https://doi.org/10.5465/amj.2013.0870>.
- Zilber, T. (2013). Institutional logics and institutional work: Should they be agreed? In M. Lounsbury, & E. Boxenbaum (Eds.), *Institutional logics in action, part A (Research in the sociology of organizations, Volume 39 Part A)* (pp. 77–96). Bingley: Emerald.

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