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1 **Institutional complexity and individual responses: delineating the boundaries of partial**

2 **autonomy**

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

17 **Abstract**

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

34 **Keywords**

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

37 **Introduction**

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

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

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

73 We begin by reviewing the institutional logics literature, including its propositions on
74 how logics co-exist, and how actors respond to this. We highlight the disconnection between
75 macro- and micro-level studies, and argue that, while micro-level studies have gone some
76 way to fulfilling their promise of returning neo-institutionalism to its 'microfoundations'
77 (Powell & Colyvas 2008), the methodological approaches predominant in this literature mean
78 that in aggregate it risks overstating the "avenues for partial autonomy" (Thornton et al. 2012,
79 p.7) available to individual actors. Then we briefly describe our empirical setting, a
80 particularly complex institutional field in terms of the dimensions set out by Greenwood et al.
81 (2011). After accounting for our methods, we explore the dynamics of institutional change
82 and the divergent consequences for our four cases through time. We then discuss our findings
83 and their implications for theory and future research.

84 **Institutional logics: coexistence and its consequences**

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

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

95 Formative research within the institutional logics approach focused primarily on the
96 dominance of given logics: how this was created, maintained and challenged (e.g. Scott et al.
97 2000). Increasingly, however, research has found that many fields are characterized by the
98 co-existence of a plurality of logics—often with no single logic dominant in determining
99 actors’ disposition and behaviour. Rather than representing a temporary, transitional phase
100 between epochs of dominance by a single logic, “some fields are better portrayed as leaning
101 towards the ‘relative incoherence’ of enduring, competing logics” (Greenwood et al. 2011,
102 p.323). Greenwood et al. (2011, p.332) note that research on institutional complexity has
103 tended to assume that coexisting logics are “inherently incompatible,” but more recent studies
104 have challenged this assumption. Several have found that contradictory logics may coexist in
105 an organizational field, often in a kind of ‘creative tension’ which means that their influences
106 affect actors simultaneously (e.g. Reay & Hinings 2005; 2009; Lounsbury 2007; Greenwood
107 et al. 2010; Goodrick & Reay 2011; self-citation). The plurality of institutional prescriptions
108 available means that a diversity of actor behaviours is often in evidence: for example,
109 Lounsbury (2007) finds that different fund managers operate according to ‘trustee’ and
110 ‘performance’ logics concurrently, depending on their geographical location.

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

112 as signalling greater actor autonomy. The influence of logics, studies have found, is often
113 ‘segmented’, such that different groups of actors are affected differentially by logics’
114 prescriptions (Reay & Hinings 2009; Pache & Santos 2010; Goodrick & Reay 2011). Reay
115 and Hinings (2009, p.646), for example, find that the rivalry between an incumbent logic of
116 medical professionalism and an increasingly powerful logic of business-like healthcare is
117 managed by collaboration between physicians and administrators, with each group
118 maintaining its independence but engaging “in collaborations that result in mutually desirable
119 outcomes and thus sustain the co-existing logics.” Often, therefore, studies of sustained
120 institutional complexity find that carriers of different logics—for example, professional and
121 managerial groups—remain bound to their ‘home’ logics and referent audiences, and are able
122 to continue to act in accordance with their expectations. Alternatively, the same group of
123 actors may have to satisfy the expectations of more than one audience for legitimacy, such
124 that different aspects of their practice are governed by different logics (e.g. Smets et al.
125 2015).

126 To observe that multiple logics are available within a field, therefore, is not to imply
127 that individuals are able to pick and choose freely from their prescriptions. Due to their prior
128 socialization, the expectations of their referent audiences, and other structural determinants,
129 actors continue to face the constraints presented by the need for legitimacy, as identified by
130 the earliest exponents of neo-institutionalism. The most recent developments in our
131 understanding of the consequences of institutionally complex fields for actor autonomy
132 arguably retain this structural focus. A promising recent line of inquiry is the consequences of
133 the specific configuration of logics in a field: the ‘constellation’ in which they are formed
134 (Reay & Hinings 2009; Goodrick & Reay 2011; Waldorff et al. 2013). The same logics may
135 be configured differently in different fields, with important consequences for actor behaviour,
136 as Waldorff et al. (2013) demonstrate with a comparison of Danish and Canadian healthcare.

137 A similar set of logics existed in each setting, but they were arranged in rather different
138 constellations, so that a complementary relationship between market and professional logics
139 in Canada led to changes in behaviour that did not arise in Denmark, where the relationship
140 was more antagonistic. Waldorff et al. (2013, p.125) claim that “the concept of constellation
141 of logics [offers] a new way of understanding agency. We see that it is the arrangement and
142 relationship among logics that helps to explain how action can be both constrained and
143 enabled.” Yet their analysis remains at the level of the field: the constellation of logics is a
144 product of field-level dynamics (most notably, in this example, incentive structures and
145 regulatory regimes), and these determine the repertoires available to different actors. There is
146 less sense in such analyses of the way, as Smets and Jarzabkowski (2013, p.1301) have it,
147 “constellations are constructed rather than given, and which dimensions of agency drive their
148 construction.”

149 Partly in response to the shortcomings of the macro-level focus of much of the work on
150 institutional logics, another—largely separate—body of literature considers the micro-level
151 enactment of logics by individuals at the ‘coalface’ (Barley 2008) of everyday work—that is,
152 the unremarkable, day-to-day interactions of actors in institutionalized fields, far removed
153 from the battles between institutions and high-level institutional entrepreneurs. Scholars in
154 this line argue that much neo-institutional research neglects “interpretation and subjectivity,
155 which [...] offers considerable degrees of agency and freedom to reinterpret and even change
156 institutional templates” (Bévort & Suddaby 2015). Where institutionalists have considered
157 agency, they have focused disproportionately on what Smets et al. (2012, p.878) call
158 “‘hypermuscular’ institutional entrepreneurship”: the work of “heroic actors” (Powell &
159 Colyvas 2008, p.277) with unusual levels of individual or collective clout, who feed back into
160 the constitution of institutional logics themselves (e.g. Greenwood et al. 2002; Murray 2010).
161 What this neglects, critics argue, is the everyday work of lower-profile actors who

162 nevertheless are active in their interpretation and application of institutional logics.

163 Accordingly, work on ‘inhabited institutions’ (Hallett & Ventresca 2006) has examined
164 the lived experience of actors in institutionalized fields, and the practices they pursue,
165 consciously or unconsciously, that reproduce or challenge institutional expectations. Often
166 deploying ethnomethodological approaches, these studies highlight the interpretive, non-
167 deterministic processes that translate situations of institutional complexity into day-to-day
168 reality (e.g. Heimer 1999; Binder 2007; Hallett 2010; Everitt 2013; McPherson & Sauder
169 2013; Smets & Jarzabkowski 2013; Smets et al. 2015). They vividly demonstrate Powell and
170 Colyvas’s (2008, p.277) assertion that a division between “heroic actors and cultural dopes
171 [is] a poor representation of the gamut of human behavior.” For example, Binder (2007)
172 shows how professionals in different parts of the same organization meld together
173 institutional demands, personal beliefs and localized meaning systems in the way they enact
174 their organization’s mission. Everitt (2013) looks at the professional socialization of teachers
175 as agentic and active, combining institutional prescriptions with social influences and
176 personal preferences. Such work focuses above all on the everyday work of actors who are
177 not in the business of “intentionally pursuing a clear institutional ‘vision’” (Smets &
178 Jarzabkowski 2013, p.1300): they are not seeking to transform the rules of the game in an
179 institutional field, but to forge a legitimate path through complex organizational settings
180 characterized by a profusion of prescriptions, power relationships and personal interests
181 (Smets et al. 2015).

182 Taken together, these studies provide an important corrective to neo-institutionalism’s
183 focus on the power of institutional logics. Yet their key methodological advantage—detailed
184 examination of practice as it takes place in real-life environments—also creates a limitation.
185 With few exceptions, these papers offer in-depth understanding of single organizations or
186 even single organizational sub-units, rather than cross-sectional comparisons. This means that

187 they are unlikely to reveal organizational-level contingencies in the way that, for example, a
188 comparative case-study approach might. They also tend to ascribe a remarkable degree of
189 autonomy to individual actors—perhaps in consequence of case selection, or of a desire to
190 challenge the structuralist predictions of macro-level studies, or of the preferences of journals
191 for studies that indicate new or unexpected findings. In aggregate, these studies suggest that
192 actors enjoy a great deal of latitude, in contradiction to the findings of the macro-level
193 institutionalist literature. If a macro-level focus fetishizes structure, then a risk of a micro-
194 level focus is fetishizing agency. Thus, echoing Hardy and Maguire’s (2008, p.199) critique
195 of the institutional entrepreneurship literature, we need to “ensure that the efforts of
196 institutional theorists to incorporate agency—in order to move beyond an over-emphasis on
197 the constraining effects of institutions—do not swing too far in the opposite direction.”

198 What has been less prominent in the literature is examination of the circumstances in
199 which such agency is possible. With this in mind, our study considers the consequences of
200 institutional complexity, and rapid institutional change, in four organizations in the same
201 field, which exhibited divergent outcomes in terms of the room for manoeuvre achieved by
202 the central actors, each of whom sought to maintain a novel service intervention that became
203 misaligned with the prescriptions of the dominant logic within the field. We sacrifice the
204 ethnomethodological depth of the ‘inhabited institutions’ tradition for comparative breadth,
205 but nevertheless offer a detailed, qualitative, longitudinal study covering seven years of
206 change. Our approach is not without precedent: the work of Reay and Hinings (2005; 2009)
207 similarly combines field-level analysis with qualitative interviews with key actors, but
208 whereas their focus is the consequences for the composition of the field, ours is the
209 consequences for the autonomy of everyday actors (not muscular institutional entrepreneurs)
210 at the coalface. Whereas the success of institutional entrepreneurs is often attributed to the
211 power deriving from their social position or to exceptional creative vision (Hardy & Maguire

212 2008), we address the question of what enables or constrains these ‘coalface’ actors, who
213 cannot rely on such attributes, in acting autonomously. We ask: what are the conditions that
214 precipitate and inhibit actors’ ability to defy changing institutional prescriptions in defence of
215 their own beliefs and interests?

216 **Institutional logics in English healthcare, 2005-2011**

217 The field of healthcare is quintessentially institutionally complex. It has offered a fertile
218 ground for the development of institutional theory, with key contributions arising from
219 analysis of healthcare systems globally (e.g. Scott et al. 2000; Reay & Hinings 2005). As
220 Pache and Santos (2010) note, healthcare is a fragmented field where stakeholders from a
221 wide range of logics co-exist, but is also dependent on a small number of resource providers
222 (in England’s case, the state). “The most complex fields for organizations to navigate,” argue
223 Pache and Santos (2010, p.458), “are moderately centralized fields” of this kind,
224 “characterized by the competing influence of multiple and misaligned players whose
225 influence is not dominant yet is potent enough to be imposed on organizations.” Besharov
226 and Smith (2014) conceptualize such fields as combining ‘high centrality’ (with multiple
227 logics central to organizational functioning) with ‘low compatibility’ (because the logics’
228 prescriptions are contradictory), and suggest that such fields produce ‘contested’
229 organizations characterized by extensive conflict.

230 In common with healthcare systems worldwide (e.g. Scott et al. 2000), the NHS is the
231 site of long-term conflict among logics. Of particular note is the influence of the professional,
232 corporate and market logics. The professional logic in healthcare can be characterized as the
233 dominance of professionals over not just clinical but organizational decision-making, and
234 deference among others (managers, patients and lower-status clinicians) to (medical)
235 professional knowledge (Reay & Hinings 2009). The market and corporate logics are
236 sometimes conflated (e.g. [self-citation]), but we follow Thornton (2002) in distinguishing

237 between them as two potentially complementary, but conceptually separate, institutional
238 logics. The corporate logic is realized through managerial techniques for controlling
239 professionals' activity, for example performance-management regimes, standardization of
240 clinical care, and development of capacity for surveillance and audit. The market logic
241 represents a shift towards use of competition among providers and market signals to induce
242 improvement and contain costs. Traditionally dominated by medical professionalism, the
243 English system was subject to increasing managerial and market influences from the 1980s
244 onward, as the state sought to challenge professional jurisdictions and provider monopolies as
245 part of wider 'new public management'-style reforms (Ferlie 1996). Within this longer-term
246 shift in the balance of logics, the period of our study, 2005-2011, can be seen as a particularly
247 turbulent period of change, marking as it did the end of an unprecedented increase in
248 healthcare spending in England, followed by a rapid retrenchment into austerity. Government
249 funding for healthcare rose rapidly in the early 2000s (at a real-terms rate of 7% per annum)
250 before plateauing and finally declining slightly relative to GDP (OECD 2014). The
251 exogenous jolt of the global financial crisis from 2008 was partly responsible for this
252 transition, but by this point the government had already begun to shift its focus from
253 increasing capacity to increasing productivity (Secretary of State for Health 2008). In 2006
254 the government required that the NHS's £520-million deficit be transformed into a £250-
255 million surplus by 2008 (Day 2006), and as the financial situation became straitened, in 2009
256 the NHS chief executive called for efficiency savings of 20% within five years (Nicholson
257 2009).

258 This turnaround in the financial environment translated into pronounced shifts in the
259 organizational field, with the government seeking to increase the influence of market and
260 corporate logics. Firstly, in line with the corporate logic, there was an increased emphasis on
261 more managerial approaches to improving quality (e.g. care pathways, skill-mix

262 reconfiguration) (Secretary of State for Health 2008). Secondly, again following the
263 corporate logic, the government introduced a more intensive regime of performance
264 management of NHS provider organizations, including a pledge to reduce waiting lists to 18
265 weeks, backed by the ability to invoke Draconian sanctions against ‘failing’ organizations
266 (Lewis & Appleby 2006). Thirdly, following the market logic, the government took renewed
267 steps to increase competition in the NHS. Although an internal market for acute healthcare
268 services had existed since the early 1990s, further steps were taken from 2006 to extend the
269 scope of the market, by increasing service provision outside traditional hospitals (Secretary of
270 State for Health 2006), increasing the power of ‘commissioners’ (holders of healthcare
271 budgets for a locality, responsible for paying for the healthcare needs of the local population)
272 over providers (Ham 2008), and removing all responsibility for providing care from
273 commissioning organizations, known as primary care trusts (PCTs), so that services were
274 tendered competitively rather than offered ‘in house’. Thus there was a sustained effort to
275 ensure that the logic of the market pervaded the entire healthcare system, including areas that
276 had previously been immune to its influence.

277 This period, then, was characterized by particularly intensive change, as government
278 sought to adapt to the end of a period of sustained increases in funding by introducing
279 evermore extensive market and managerial policies into the NHS system. Of course, changes
280 in policy do not instantaneously give rise to a shift in the logics governing actors’ behaviour;
281 nevertheless we can detect in these policies an attempt to strengthen the market and corporate
282 logics—and correspondingly weaken the professional logic. At the start of the period, the
283 NHS was enjoying unprecedented real-terms increases in funding; by the end, it was facing
284 unprecedented levels of efficiency savings. A system of performance management that was
285 emerging at the start had grown into a fully-fledged set of central-government prescriptions
286 by the end, accompanied by the ability to ‘punish’ non-compliant or ineffective organizations

287 with sanctions or wholesale replacement of management. At the beginning, only secondary-
288 care services provided by hospitals were subject to a competitive system of resource
289 allocation, but by the end all community-based services, previously provided in-house by
290 PCTs, were exposed to the same expectation. The period was thus characterized by great
291 institutional turbulence, with increasing centralization and formalization (Greenwood et al.
292 2011; Pache & Santos 2010) of the market and corporate logics.

293 **Setting and methods**

294 Our paper follows the trajectory of four new service developments over this period, through a
295 longitudinal understanding over the period 2005-2011 of how those responsible for leading
296 the development of these services—the ‘focal actors’—and other stakeholders responded to
297 the changing institutional environment. The four services in question had their roots in a
298 national government initiative in 2004 which aimed to encourage the ‘mainstreaming’ of
299 clinical-genetics knowledge across the English NHS. This initiative (Secretary of State for
300 Health 2003) provided pump-priming funding to 27 pilot services, each of which sought to
301 introduce a new approach to delivering genetics services in its locality—for example by
302 changing the way risk assessment or counselling was provided—but maintaining professional
303 control over this. Our team evaluated the initiative, studying the changes attempted in a
304 theoretical sample of 11 of the services. The initiative ran on the basis that successful services
305 would be sustained using local monies, and host organizations committed to this as a
306 condition of funding. However, in the event, when pilot funding ended in 2007, only a
307 minority of services were sustained, including just four of the 11 we studied (see Table 1).
308 The challenges inherent in sustaining organizational innovations are an area of significant
309 policy interest in the UK (e.g. Buchanan et al. 2007), and we therefore developed, and
310 succeeded in obtaining external funding for, a follow-up study that revisited the four
311 sustained services post-pilot, to examine in more detail what had made a difference in their

312 successful continuation. This paper derives from both the original evaluation and the follow-
313 up study, offering a longitudinal analysis of the work of actors involved in the four services
314 covering the seven-year period 2005-2011. While we lack the data from the seven
315 discontinued services to consider them in detail in this paper, Table 1 shows how they
316 resemble and differ from our sample of four according to key variables, and briefly
317 summarizes the reasons for their termination.

318 [TABLE 1 ABOUT HERE]

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

336 [TABLE 2 ABOUT HERE]

337 Table 2 summarizes the four cases. Of particular note in the composition of our sample
338 are the similarities and differences in two dimensions: professional allegiance of focal actor;
339 and organizational host. Whereas Ashover's focal actor was a nurse by training who had
340 more recently become involved in a managerial capacity in her organization, the other three
341 cases were led by physicians of varying backgrounds. The focal actor in Bolbourne was a
342 general practitioner (family physician), while Carsridge was led by a clinical geneticist and
343 Dovington by a specialist physician in the 'mainstream' clinical area into which genetics
344 provision was being incorporated (we leave this unspecified to protect participant
345 anonymity). Nurses are of lower status than doctors in English healthcare as worldwide
346 (Battilana 2011); the intraprofessional hierarchy within medicine tends to place specialists
347 above generalists, although the changes afoot in the English system explicitly sought to raise
348 the standing of general practitioners and increase their influence on resource allocation
349 (Secretary of State for Health 2006). The host organizations in Ashover and Bolbourne were
350 both primary care organizations: PCTs responsible for budget-holding and resource
351 allocation, but which also at the start of the period provided some services in-house,
352 including these genetics services. Carsridge and Dovington's services were hosted by acute
353 hospital trusts: large hospital organizations providing services to the populations covered by
354 several PCTs.

355 Both studies used a combination of qualitative methods, drawing primarily on in-depth
356 interviews with key actors (e.g. focal actors, others involved in service delivery, those in key
357 decision-making and budget-holding roles beyond the services), supplemented by
358 observational data and document collection and analysis. In total, across the two studies, we
359 undertook 83 interviews over four time points, broken down as shown in Table 2. For the
360 original evaluation, we undertook the majority of interviews in 2005-6 (hereafter referred to
361 as T₁), with follow-up interviews in 2008 (T₂). For the second study, we undertook further

362 interviews in 2010 (T₃) and 2011 (T₄). Thus our data offer a longitudinal perspective on the
363 trajectories of the four cases spanning seven years, albeit with data collection unevenly
364 distributed across the period. Interviews ranged from approximately 30 to 130 minutes, with
365 an average length of around one hour. Our topic guide in the original evaluation covered a
366 wide range of issues, most notably for this paper the rationale for the service, how it related
367 to and modified existing provision, relationships with key stakeholders and organizations,
368 plans for the future, and (at T₂) progress towards maintaining provision post-pilot. In the
369 follow-up study our topic guide focused more specifically on the trials and tribulations of
370 sustaining these small service innovations in a changing environment, the degree to which
371 they had evolved in their service models, and the organizational, financial and relational work
372 that had been done and was anticipated to maintain their existence.

373 All interviews were transcribed in full. They were analysed using an approach informed
374 by the constant-comparative method (Charmaz 2007), with specific attention directed
375 towards certain ‘sensitizing concepts’—ideas that had informed our thinking in developing
376 the study, derived from prior conversations, analysis of policy documents, and the existing
377 literature on healthcare and organizational change—covering the social, professional,
378 organizational and policy influences on service innovation and sustainability. We thus
379 developed themes both inductively and deductively, to cover issues derived from existing
380 conceptual frameworks, but also issues that emerged from close, repeated readings of the data
381 sources. GPM and SW both read the source materials several times over, and GPM then led
382 coding and analysis using NVivo software. This involved an initial ‘broad-brush’ coding of
383 all documents to identify portions that offered potential insights for the purpose of this paper
384 (since a substantial proportion of the material from the original evaluation was not relevant),
385 informed by our existing knowledge. In discussion with the other authors, GPM then
386 undertook several rounds of more refined, inductive coding, firstly coding items in terms of

387 the actions described by interviewees in relation to the development and sustaining of the
388 services (Charmaz 2007), and then a further round of more theoretically oriented coding that
389 sought to identify the influence and enactment of different logics in the activities
390 interviewees described and the way they justified them. He then developed case histories
391 describing the trajectories of the four cases over the period studied, which he discussed with
392 co-authors before returning for a final round of coding, merging some existing codes and
393 disaggregating others.

394 **Findings**

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

406 Professionally led services and shifting institutional logics

407 When originally designed and initiated in 2004 through central government funding, all four
408 services embraced a model premised on professional ownership and accountability. The
409 white paper that announced the initiative had emphasised the role of clinical professionals in
410 devising new genetics services (Secretary of State for Health 2003), and accordingly, all the

411 projects funded were led by clinicians, not managers—primarily clinical geneticists, but also
412 other physicians, and nurses. Focal actors emphasised the centrality of a professional ethic in
413 their approaches to delivering the new services, though in slightly different ways. In
414 Carsridge and Dovington, they stressed the importance of ensuring that genetic knowledge
415 was mainstreamed in a way that maintained or enhanced specialist involvement, rather than
416 reducing it to a protocolized approach that might be more in line with the corporate logic. In
417 the two primary-care cases, Ashover and Bolbourne, the emphasis was on integrating
418 genetics into a generalist model of care, emphasising holism and the wider public health:

419 “We were aware right from the early stages that patients really didn’t get a terribly
420 good deal in terms of any kind of comprehensive service. There was very little
421 continuity and I thought we could do a better job.” (Focal actor (mainstream
422 physician), Dovington, T₁)

423 “Anybody who’s concerned that they’ve got a family history of cancer and are at risk
424 can be referred into our service. [...] We also do a lot of health promotion so we don’t
425 actually just talk about cancer, we also talk about things related to cancer like diet,
426 like giving up smoking, sunbathing, those types of things.” (Focal actor (nurse-
427 manager), Ashover, T₁)

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

432 Each focal actor had obtained agreement in principle from their host organization to
433 continue to fund the service following the pilot period. The shift in the policy landscape from
434 2005, however, threw such plans into disarray. An increased emphasis on markets and
435 targets, and the organizational changes that accompanied it, had a marked effect on genetics

436 service developments, and meant that commitments made years earlier counted for little:

437 “We’ve gone from a position of completely unprecedented investment in the health
438 service, where it was attractive to invest money in bits of the service which had not
439 previously had large amounts of money invested in them. [... But now] we’re in a
440 position where it’s not clear how we’re going to continue to provide what everybody
441 would regard as core NHS services, [so] slightly unusual developments are much less
442 easy to make.” (Director, genetics service, Bolbourne, T₃)

443 There was a tangible shift in the language of those in decision-making positions in all four
444 cases, towards an acknowledgement of the need for parsimony and demonstrable value.
445 Professionally led services, in the view of these stakeholders, needed to address changing
446 expectations around, for example, consumer-responsiveness in a competitive environment
447 that mirrored the market logic:

448 “The mistake I’ve seen a lot of services make is that they try really, really hard to
449 establish because they think there’s a need to convince people, there’s a need to get
450 funded, and they start seeing stakeholders, but then it stops. [...] Products don’t
451 survive in the market very long unless they inhabit the environment they’re in, learn
452 from it and modify based on their clients’ continuously changing needs. And that’s
453 what differentiates successful products from not-successful products.” (Director of
454 Commissioning, Ashover, T₃)

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

461 The outcomes: domination; resistance; transformation
462 Focal actors in all four cases worked hard to defend the services they had built, and secure
463 continued funding for them in this changing environment, while ensuring they remained true
464 to the professional logic on which the services had been founded. As noted above, all four
465 succeeded initially in obtaining ongoing funding, in contrast to their peers. But beyond this,
466 their success varied.

467 At one extreme, in Bolbourne, despite the focal actor's extensive efforts, local budget-
468 holders decided six months later to terminate their funding for the service. The focal actor, a
469 family physician, made robust arguments for the continued importance of her service and the
470 holistic understanding of the place of genetics in wider primary care that it promoted.
471 Alongside a costed business case, her efforts included compiling evidence of impact in the
472 form of "e-mails, comments from other GPs saying, 'This is great, the website's fantastic,
473 really good about having the advice line'," "pictures in the [local] newspapers saying what a
474 wonderful thing," and lobbying commissioners and genetics specialists: "I think we covered
475 most avenues really." But as she bluntly reflected in her final (T₄) interview:

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

479 Essentially, she found that arguments premised on a logic of professionalism failed to hold
480 sway in an environment now dominated by concerns around efficiency and throughput
481 ("seeing all these patients"). Her view was confirmed by the decision-makers themselves.
482 The director of the genetics service felt that the focal actor was "selling something which [...]
483 commissioners didn't want to buy" (T₃). Another decision-maker was even franker:

484 "It isn't going to release huge savings, [...] so when commissioners are prioritizing, it
485 will not tick all the boxes I'm afraid. It's undeniable that well informed GP specialists

486 able to support their GP colleagues can have an impact both on improving resources
487 but more importantly making sure that patients get the right service at the right time,
488 but I think in the current economic situation it's going to be difficult to see many
489 primary-care genetics services being established.” (Primary care commissioning lead,
490 T₃)

491 Further work undertaken by the focal actor to resurrect her service following termination of
492 funding was unsuccessful, and by the end of the study period she was resigned to the fact that
493 “it's just gone back to how it was. The website is the only lasting legacy” (T₄).

494 At the other extreme, in Carsridge and Dovington, focal actors were much more
495 successful in defending the professional logic in the changing field, such that their services
496 remained in place, largely unaffected by the wider environment and the rise of the market
497 logic for the duration of the period studied. As the focal actor in Dovington put it, with some
498 surprise, “actually to move us into the whole commissioning process and to make it
499 sustainable was a far more fraught process potentially than it actually was” (T₃). The model
500 of service delivery continued to follow a professional logic, with patient-centredness taking
501 precedence over throughput or efficiency savings:

502 “Patient satisfaction is high, clinic sizes are relatively small although efficient, and
503 time spent with medical staff and nursing staff is higher and so we get a much better
504 patient experience and outcome with all of that. We're always going to be able to be
505 criticized on the basis that we're providing a luxury service as opposed to an economy
506 service, but they're a very vulnerable group of patients.” (Clinical geneticist, T₄)

507 Similarly, in Carsridge, ongoing funding was secured and the service remained faithful to the
508 original design, without any challenge to the professionally determined service model: “I
509 don't think there was ever any major problems: it just seemed to happen” (Genetic
510 counsellor, T₃). Only minor changes were instigated, such as adjustment of the skill mix to

511 enhance the professional responsibilities of the clinical staff: “the function of the team is
512 exactly the same, but we have up-skilled one of the administrators to take some of the more
513 mundane activities from [the clinicians]. And I suppose that’s the biggest change actually”
514 (Focal actor (clinical geneticist), T₃). Whereas in Bolbourne, adherence to the professional
515 logic meant that the service was seen as anachronistic by budget-holders (“selling something
516 which [...] commissioners didn’t want to buy”), the services in Carsridge and Dovington
517 retained legitimacy with key decision-makers despite their avowedly professionally driven
518 ethos:

519 “To me it’s actually really pretty streamlined, a very efficient service. [...] What
520 they’ve done in terms of bringing things up into the twenty-first century is of value to
521 the population, so I think they provide a valuable service.” (Clinical director,
522 Carsridge, T₃)

523 Between the contrasting experiences of Bolbourne, and Carsridge and Dovington, lay
524 Ashover’s. Here, funding was sustained throughout the period, but achieving this required
525 fundamental changes to the ethos and delivery model of the service. At the behest of local
526 decision-makers, the original holistic, public-health focus of the service gave way to
527 something much narrower in remit, and better aligned with corporate and market expectations
528 around efficiency and performance against specific measures. The focal actor was expected
529 to agree to a “service specification” with “specific key performance indicators” developed
530 with managers, “which I disagreed with but had to put them forward anyway” (T₄). The
531 service was incorporated into a managed care pathway, with a much more tightly defined
532 service-level agreement that focused on triaging patients at possible risk of inherited cancer.
533 Alongside this, more forensic examination of the service’s activities was introduced: “we
534 have now a scoring of interventions, sort of whether it’s a low intervention or a high
535 intervention, [...] and they’re now reviewing that data collection as well, so there’ll be a

536 whole new system coming out” (Focal actor (nurse-manager), T₄). The positioning of the
537 service within a managed pathway, along with this extra scrutiny and oversight for managers
538 and commissioners, gave the service legitimacy with key decision-makers. It was now
539 aligned with normative conceptualizations of how to deliver efficient and well managed
540 healthcare, as part of a defined pathway that offered a cheaper alternative to hospital-based
541 care:

542 “Community services we know are darn site cheaper than secondary and tertiary care
543 services. [...] It’s a community-led service, you know, and necessarily, it’s broken
544 down the boundaries between primary care and secondary care. So it’s a pathway-
545 driven service from the community which ticks all the boxes at the moment of things
546 being community-driven, closer to home.” (Associate medical director, T₃)

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

552 “When we first started in the pilot phase, it was very much self-referrals that
553 outweighed any professional referrals. Whereas now I would say that’s reversed and
554 self-referrals probably come at the bottom of the referral rate and it’s secondary-care
555 and GP referrals that probably top. [...] I don’t know how GPs will feel about patients
556 referring themselves in, because they’re not going to have control of that budget.
557 (Focal actor (nurse-manager), T₄)

558 This process of adaptation to the new realities of the market continued through time. Between
559 T₃ and T₄, as part of its continued funding, the service was incorporated into a different
560 organization with much greater managerial capacity than its original host, and with a strong

561 market orientation:

562 “[New host organization] have an operating model which they would apply to all of
563 their products. So [...] they’ll have to change certain aspects of the way they just run
564 the service to fit in with their corporate model. [...] If they can’t robustly describe the
565 value this service would have on the whole of cancer care, then the more likely the
566 risk that this service won’t be commissioned.” (Commissioner, T₃)

567 The future for the service looked more secure—it had reinvented itself as part of an
568 integrated care pathway with a tightly defined remit and expectations around efficient
569 resource use—but this had meant fundamental changes to its service-delivery model. From
570 her original affiliation with the professional logic, the focal actor had been forced to
571 fundamentally realign herself to the corporate and market logics, in terms of both the
572 discursive justification, and the service provided.

573 Making sense of the contrasting outcomes

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

580 [TABLE 3 ABOUT HERE]

581 In all four cases, hard evidence about the efficiency or effectiveness of the services was
582 in short supply (see self-citation). Evidence of this nature was difficult for focal actors to
583 generate—partly because they had never devised their services with such a crudely economic
584 calculus in mind, but also because generating such evidence was difficult in genetics with its
585 long-term, not short-term, outcomes: “it’s difficult to demonstrate their value or the amount

586 of money they're saving," as a manager in Carsridge acknowledged (T₃). Explanations for the
587 divergent outcomes premised on a rationalistic understanding of organizational decision-
588 making can therefore be discounted.

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

596 First, it might be argued that the divergent outcomes were down to the differential skill
597 of the focal actors in making the case for their services. Other micro-level studies have noted
598 the importance of actors who are "highly reflexive and somewhat creative in interpreting the
599 pressures for institutional change" (Bévort & Suddaby 2015; cf. Smets & Jarzabkowski 2013;
600 self-citation), and going against the 'institutional grain' clearly requires capacity for lateral
601 thinking and persuasive ability. There was some support for this notion in our data. One
602 decision-maker in Bolbourne intimated that the focal actor did not have "the right personality
603 to go out there and engage people and get people stirred up" (T₃). However, it was clearly not
604 the case that any of the focal actors was naïve about the changing environment they were
605 facing: over the course of our four interviews with each of them, they demonstrated an astute,
606 reflexive understanding the changing healthcare system and the risks this posed to their
607 services. And of course, unlike the seven other services sampled in our original evaluation,
608 these focal actors had at least obtained initial local funding beyond the pilot monies provided
609 by central government.

610 A second plausible explanation is that the status and power enjoyed by the focal actors

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

622 A more convincing and comprehensive explanation is possible if we focus on neither
623 actors' social position nor their creative capacity per se, but on the consequences for these of
624 the wider changes taking place in the field at the time. While the rise of the market logic over
625 the period of the study applied equally across the English healthcare field, its effects at an
626 organizational level were unequal. For the primary-care organizations that hosted the services
627 in Ashover and Bolbourne, the rise of the market was unprecedented, and brought significant
628 structural changes. As commissioning organizations (budget holders for the healthcare needs
629 of the local population), they were required to relinquish their responsibility for service
630 provision to enable competition for services that had been provided in-house. The services
631 that had been a part of these organizations, including Ashover's and Bolbourne's genetics
632 services, had to be reconstituted as financially independent standalone bodies, or incorporated
633 into existing provider organizations. Consequently, the focal actors in Ashover and
634 Bolbourne found themselves in the midst of a complicated process of organizational
635 disengagement, and were cut adrift from their organizational sponsors. The focal actor in

636 Ashover found that her new managers “didn’t have as much insight into the service and were
637 less committed to seeing it expand” (T₃), while in Bolbourne, the service’s manager had “less
638 direct involvement” in the service, “although because there was not really anyone else to do it
639 I did carry on to an extent” (T₃). Further, and more critically, the focal actors were exposed to
640 a range of expectations associated with the market logic that were foreign to them—and
641 lacked the managerial support necessary to coherently argue their case in response.

642 On the face of it, this challenge also applied to Carsridge and Dovington. However,
643 here the services were hosted by hospitals with long experience of participating in a
644 competitive market—and this equipped them much better to deal with the changing
645 expectations of the new regime. The primary-care organizations in which Ashover’s and
646 Bolbourne’s focal actors worked had only ever encountered the competitive market as budget
647 holders, choosing between competing bids: making a business case as a potential contractor
648 was not something they had experienced before. As hospitals, the organizations in Carsridge
649 and Dovington had long experience of a competitive market for secondary care that stretched
650 back into the 1990s. Thus while the market-oriented shifts were just as dazzling to the focal
651 actors themselves, they were surrounded by an established managerial infrastructure that was
652 adept at managing such demands, and did not have to contend with rapid organizational
653 change. They could rely instead on extensive managerial support—an instantiation of the
654 corporate logic with its focus on the monitoring, audit and justification of professional
655 activity—to deal with such shifts.

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

659 “Just after the pilot finished once we’d secured ongoing funding there was the
660 commissioner-provider split, so the service went into mainstream services in the

661 provider arm. [...] I don't mean to sound derogatory, but I suppose the senior
662 managers within the provider arm didn't have as much insight in to the service and
663 were less committed to seeing it expand.” (Focal actor, Ashover, T₃)

664 “My final line manager, essentially he and I put together a business plan very much
665 on our own, and we met with the medical director and the deputy medical director and
666 we put our case.” (Focal actor, Bolbourne, T₃)

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

669 “The key relationship going forward [...] is the relationship between our service, the
670 business planning directorate, and their relationship with whatever commissioner
671 organization exists after that, because we as a clinical service can't keep up with
672 changes in commissioning. But the business planning section do. And it's that
673 relationship that's really important.” (Focal actor, Carsridge, T₂)

674 “We have had no direct dealings with commissioners at any stage, because we are
675 part of [a wider funding] envelope, from the point of view of the service that's
676 provided, it's completely embedded in [the wider service].” (Focal actor, Dovington,
677 T₄)

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

685 “What we've been doing is pulling together our experience and our outcomes in a

686 brief report that we can send to the business-planning department of this hospital, so
687 that they can use that in their negotiations.” (Focal actor, Carsridge, T₃)
688 In the absence of such support, Ashover and Bolbourne faced greater challenges. Bolbourne’s
689 focal actor floundered, but in Ashover the focal actor was able to draw on her experience as a
690 manager—her dual embeddedness in the professional and corporate logics (Pache & Santos
691 2013)—to reframe her service. As we have seen, though, this came at the cost of
692 transforming the service model itself, so that it was premised not on a professional logic but
693 on notions of efficiency and throughput. For all four focal actors, however, the ability and
694 opportunity to invoke and make advantageous use of logics was heavily shaped—one might
695 even say structured—by influences beyond their capacity and social position as individual
696 agents, but below the level of the field as a whole. Organizational context and the nature of
697 their relationship with other agents—themselves affiliated with other logics—were crucial
698 mediators of the relationship between field-level configuration of logics and individual-level
699 autonomy.

700 **Discussion**

701 Our paper seeks to bridge macro-level and micro-level work on responses to institutional
702 complexity by using comparative, longitudinal analysis to examine the conditions under
703 which actors are able to defy changing institutional prescriptions. In particular, we show that
704 a common ‘constellation’ of institutional logics (Goodrick & Reay 2011; Waldorff et al.
705 2013) could give rise to divergent outcomes at the level of practice. Constellations are thus
706 not just ‘celestial’ features of the field-level ‘sky’: the relationship between logics was also
707 realized through the work of actors on the ‘ground’. Most notably, whereas the corporate
708 logic aligned, as the literature predicts (Thornton 2002; [self-citation]), with the market logic
709 in some cases, in others it proved a remarkably robust defence for the professional logic
710 against the market logic. But none of the actors had free rein to pick and choose from the

711 plurality of logics present in this complex field. Rather, influences above the level of the
712 actor but below that of the field were important mediators and shapers of autonomy.

713 As noted above, much of the micro-level work on the enactment of institutional logics
714 ‘at the coalface’ has focused on the ‘hypermuscular’ work of institutional entrepreneurs with
715 unusual degrees of power, deriving from their social position, their “reflexivity or insight”
716 and “their superior political and social skills” (Hardy & Maguire 2008, p.211). But even
717 where studies have looked at the day-to-day work of lower-profile actors, they have often
718 found a high level of autonomy, and attributed this to the creative capacity or social position
719 of the individuals studied. For example, Bévort and Suddaby (2015) suggest that liberation
720 from institutional prescriptions “appears to rest in the differential ability of some individuals
721 in a common field to interpret the phenomenological fragility of logics and to be somewhat
722 immune to their ‘totalizing’ cognitive influence.” Greenwood et al. (2011, p.349),
723 summarizing the state of the field, submit that the ability to advance the prescriptions of one
724 logic over others is in part “a function of how logics are given voice within the organization;
725 but the ability of a voice to be heard is linked to the influence of that logic’s field-level
726 proponents over resources.” One way or another, these studies suggest that the ability to
727 selectively enact logics derives primarily from some combination of status and creativity. But
728 as Hallett (2010, p.67) acknowledges, this ability is produced (and denied) at a “supra-
729 individual,” social level. And a key level at which this process takes place, we argue, is the
730 organizational level, and particularly the way in which logics are configured and represented
731 in organizational processes and personnel.

732 Others have shown how organizations can act as ‘filters’, whereby different
733 organizational units are subject to different institutional logics. Binder (2007, p.562), for
734 example, finds that actors in different sections of the community organization she studied
735 enact different logics, since different constellations of logics predominate: those in the

736 housing department follow a more corporate logic, since “there are no countervailing
737 institutional logics that staff in this department draw on.” This reflects the findings of others
738 about how in some fields, institutional complexity is ‘segmented’: some prescriptions apply
739 to one group of actors; others to another (e.g. Pache & Santos 2010). In other settings,
740 collaboration across logics may be a prerequisite for organizational functioning (e.g.
741 McPherson & Sauder 2013; Smets et al. 2015). What we witness in this study, however, is a
742 combination of what Besharov and Smith (2014) call high centrality and low compatibility: a
743 field characterized by multiple institutional logics which must all be adhered to, and yet are
744 mutually conflicting. This results in what they term ‘conflicted’ organizations, and they
745 recount many examples from the literature of where this has led to organizational dysfunction
746 or even disintegration. Yet, as Besharov and Smith (2014) argue, centrality and compatibility
747 are not determined only at the field level: they are also a function of organizational form.
748 Since ‘structurally differentiated hybrids’—in which the influences of different logics sit
749 side-by-side, in different units in the same organization (Greenwood et al. 2011)—are
750 especially vulnerable to dysfunction (e.g. Battilana & Dorado 2010; Greenwood et al. 2011),
751 Besharov and Smith suggest two organizational interventions to mitigate this: recruiting
752 personnel without prior institutional affiliations (to move from a structurally differentiated
753 hybrid towards a blended hybrid, thereby reducing logic incompatibility), or reducing
754 resource dependency by shifting strategic focus (to diminish the number of logics that must
755 be accounted for, thereby reducing logic centrality). But these are not options for all
756 organizations, particularly in the public services, where structural differentiation is itself
757 necessary for legitimacy (and so blending is difficult to achieve) (see Greenwood et al. 2011,
758 p.355), and organizational objectives are externally dictated (and so shifting strategic focus is
759 not tenable). Logics’ influence cannot always be reduced in this way.

760 What our findings suggest is how the tension between logics can be managed even

761 where structural differentiation, so prone to disintegration, is necessary. What appears
762 crucial is the internal configuration of structurally differentiated units. Thus in Carsridge and
763 Dovington, the presence of carriers of the corporate logic in a separate unit—who could
764 intervene actively to moderate its influence on their professional colleagues—paradoxically
765 helped to secure latitude for the focal actors; the lack of such a buffering influence in
766 Ashover and Bolbourne resulted in constraint.⁶ We suggest, therefore, that at least in public-
767 service organizations, efforts to hire or socialize ‘non-affiliated’ staff to create blended
768 hybrids that increase compatibility, or realign mission to reduce logic centrality, are likely to
769 be forlorn or even counterproductive: attention might be more appropriately addressed to
770 developing a cordial, interdependent and mutually beneficial relationship between carriers of
771 logics in structurally differentiated units. Indeed, in Ashover the focal actor’s socialization (or
772 dual embeddedness) within both the professional and the corporate logic proved a mixed
773 blessing, enabling the service to continue but only through transformation in its character.
774 Boxenbaum and Battilana (2005, p.359) echo Besharov and Smith’s (2014) contention that
775 staff with multiple institutional affiliations can help to reduce incompatibility and increase
776 autonomy: “the more contexts individuals are embedded in, the more options they have
777 available for transposing practices.” But while this helped Ashover’s focal actor avoid the
778 termination of the service that occurred in Bolbourne, it offered her substantially less
779 discretion than that enjoyed by the focal actors in Carsridge and Dovington. Dual
780 embeddedness may then improve actors’ access to different logics, but it does not necessarily
781 give them freedom of choice in enacting them. The configuration of organizations and the
782 carriers of logics within them, not just their composition, matters, and as such structurally

⁶ It might be noted in passing that of the seven services included in the original evaluation which did not obtain post-pilot funding, three had organizational set-ups involving collaboration between two or more host organizations (see Table 1). This may have added complication to the relationship among logics and their carriers, accounting in part for their failure to secure post-pilot funding, though we do not have the data to sustain this argument.

783 differentiated hybrid arrangements have the potential, at least, to reconcile conflicting logics
784 as effectively as blended hybrids.

785 Understood this way, the findings of other micro-level studies that have emphasised the
786 ingenuity of individual actors might be seen in a slightly different light. For example, Murray
787 (2010, p.379) sees the response of scientists to unfamiliar commercial pressures arising from
788 the patenting of the genetic modification of ‘OncoMouse’ as the “sophisticated [production]
789 of new hybrids,” in which the “expertise that allows [key actors] to transpose elements from
790 each logic” to protect the autonomy of science was crucial. Yet it is also evident from her
791 study that the privileged access to a wider, supportive, infrastructure—including “lawyers,
792 TTO professionals, university counsel, and corporate executives”—was also critical to this
793 endeavour: it was not expertise or status alone that enabled autonomy. McPherson and Sauder
794 (2013, p.186) show that actors in a drugs court draw relatively freely upon a “shared toolkit”
795 of logics in pursuit of their interests, but some actors are better placed than others to do so:
796 the relational position of probation officers means they occupy a position of ‘brokerage’ that
797 allows them privileged access to the ‘home’ logics of others, even though they lack the status
798 of other professional groups in the court.⁷ Heimer (1999, p.61) argues that in disputes about
799 the care of neonates in intensive care, doctors’ arguments tend to overpower those of other
800 actors because they are on their home turf, with greater knowledge of “how to get problems
801 onto the agenda, how to propose their solutions in a persuasive way” and so on. She thus
802 concludes that “the ranking of various professions [will shape] outcomes” of such disputes;
803 “laws that are useful to high status professionals like physicians are more likely to be
804 incorporated into NICU routines than laws that might be useful to lower status staff” (Heimer
805 1999, p.62). But our findings show that it is more than simple professional hierarchy that is
806 important here: in itself, it is no guarantee of greater legitimacy, as the contrasting

⁷ We thank an anonymous reviewer for drawing this connection to our attention.

807 experiences of Ashover’s nurse and Bolbourne’s physician indicate. It was perhaps not then
808 physicians’ position as “high status professionals” per se that was important in Heimer’s
809 study, but the privileged access to wider resources and networks that this afforded.

810 We suggest, then, that organizations—and specifically the way organizations instantiate
811 relationships between multiple logics—thus contribute crucially not just to the availability of
812 logics at individual level, but also to the manner in which they become available: the degree
813 to which the appearance of a logic constrains or enables autonomy. Broadly, we propose
814 three overarching alternative ways organizations might mediate the influence of logics,
815 deploying a physics-based metaphor that we hope helps to convey the means by which
816 different organizational forms may intervene in the transmission of logics. First,
817 organizations may deflect logics, protecting those within them from the need to align with
818 logical prescriptions. We did not see this in our study, but other studies (Binder 2007; Pache
819 & Santos 2010; Jones 1999), where organizations have the power to defy institutional
820 expectations or buffer their members from the influence of competing logics, might be
821 conceptualized in this way. Second, they may simply transmit logics, so that prescriptions are
822 largely unmediated and it is left to individual-level actors to resolve (or fail to resolve) the
823 contradictions between competing logics. We see this in Ashover and Bolbourne, where the
824 professional actors were left exposed to the vagaries of new prescriptions from the market
825 logic in the absence of an effective corporate buffer. Third, they may refract logics, altering
826 or refocusing their influence and thereby offering some shield to individuals and opportunity
827 for autonomy. We see this in Carsridge and Dovington, where a functional relationship
828 between carriers of the corporate and professional logics saw the former shield the latter from
829 some aspects of new institutional prescriptions, such that they retained autonomy. The notion
830 of refraction has some similarities with one of the oldest concepts in the institutionalist
831 repertoire, that of decoupling (Meyer & Rowan 1977). However, as our choice of metaphor

832 indicates, we consider this to be more than a simple matter of one organizational unit
833 providing legitimacy in the terms of the corporate logic, while another, decoupled unit
834 continues its own work untainted. Rather, by refraction we mean that the institutional logic,
835 like white light passing through a prism, is slowed, bent or even dispersed into its component
836 parts. Thus in the cases of Carsridge and Dovington, staff in business-planning units were
837 able to translate the requirements of the market and corporate logics into terms
838 comprehensible to the services' professional leads, and then reframe the professional leads'
839 cases back into terms that would satisfy the expectations of the corporate and market logics.
840 This was not so much a decoupling, then, as a conscious, selective coupling. Though carriers
841 of the corporate logic, the relationship between these business-planning units and
842 professional clinicians was organized in a way that encouraged co-operation, enabling this
843 refraction to take place—in stark contrast to the situation in Ashover and Bolbourne. The
844 notions of deflection, transmission and refraction represent a tentative typology requiring
845 validation and further development, but might serve as an initial touchstone for further
846 investigation of the organizational-level mediation of institutional logics.

847 For all four focal actors, then, creative capacity, professional status and embeddedness
848 in the rules and norms of different logics were only as good as the organizational setting and
849 social relationships they enjoyed. Autonomy was constrained where these were lacking and
850 enabled when these were favourable. Over the period studied, institutional prescriptions were
851 consolidated, with greater centralization of logics and the ascendancy of market and
852 corporate logics that seemed incompatible with the professional logic. Both of these changes
853 should work to constrain actors' autonomy. Nevertheless, meso-level features of
854 organizations within the field made a significant difference to the consequences for actors,
855 maintaining latitude for some while others faced constraint (cf. Besharov & Smith 2014). We
856 contend that attending to these features could go a long way towards explaining the

857 disjuncture between macro- and micro-level findings about the partial autonomy afforded to
858 professionals at the coalface.

859 Our analysis offers several suggestions for future research. In particular, we suggest
860 that more attention to the meso-level mediators of agency, perhaps building on the typology
861 we outline above, would help to understand how the prescriptions and openings for discretion
862 at the field level do or do not translate into opportunities at the individual level. Further work
863 that combines a detailed, phenomenological understanding of micro-level activity with
864 comparison of similar or divergent contexts would be helpful. Relatedly, further conceptual
865 development of Thornton et al.'s (2012, p.7) notion of "avenues for partial autonomy" would
866 be helpful in reconciling macro- and micro-level work in the field of neo-institutionalism. As
867 noted above, while many macro-level studies claim to show how institutional complexity
868 affords opportunities for autonomy, they often remain steadfastly structuralist in the way they
869 describe these (e.g. Waldorff et al. 2013). Finally, we strongly endorse Greenwood et al.'s
870 (2011) call for research that embraces the impact of the coexistence of more than two logics,
871 and Thornton and Ocasio's (2008) point that what constitutes a logic needs to be carefully
872 considered by those seeking to study their effects. The market and corporate logics appear, on
873 the face of it, to present a concerted threat to the professional logic in rapidly changing fields
874 such as healthcare. Indeed, others have analysed their impact collectively: for example Reay
875 and Hinings' (2005, p.358) logic of 'business-like healthcare' combines elements of both.
876 But we show that the experience of the two logics can diverge in different contexts, and that
877 they do not necessarily operate synergistically in practice. We therefore recommend careful
878 disaggregation of logics (and perhaps their constituent elements) in future studies.

879 **Conclusion**

880 Through comparative study of the trajectories of four change initiatives in a complex
881 organizational field, we have sought in this paper to contribute to the institutional logics

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

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

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

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Table 2: Summary of the four cases

	Service model	Profession of focal actor	Initial host organization	Number of interviews				
				T ₁	T ₂	T ₃	T ₄	Total
Ashover	Implemented a national model to provide cancer-genetics risk assessment and triage using primary care-based staff, and wider health-promotion advice aimed at high-risk groups	Nurse	Primary care organization	12	2	12	2	28
Bolbourne	General practitioner with a special interest: provides training and advice to other GPs to inform proper management and referral of patients with suspected genetic conditions	Physician	Primary care organization	5	2	7	1	15
Carsridge	Implemented a national model to provide cancer-genetics risk assessment and triage provided by secondary care-based staff, replacing <i>ad hoc</i> provision by oncologists and surgeons	Physician	Hospital organization	12	2	10	2	26
Dovington	New multidisciplinary clinic, incorporating mainstream and specialist consultant-led care, for a group with a genetic disorder previously seen in separate clinics	Physician	Hospital organization	6	2	5	1	14

Table 3: The differential translation of institutional change across cases

	Time	Ashover	Bolbourne
Focal actor		Nurse/manager	Physician
Organizational host		PCT (T ₁); PCT provider arm (T ₂ -T ₃); community provider organization (T ₄)	PCT (T ₁); PCT provider arm (T ₂ -T ₃)
Original logic espoused by focal actors	T ₁ (2005-6)	Professional Emphasis on ensuring holistic care and addressing public health, rather than providing a narrow care pathway delivered by deskilled occupational group	Professional Emphasis on utilizing broad skills of a family physician to facilitate holistic care, rather than replicating work done by lower-status occupational groups.
Impact of rise of market logic	T ₂ -T ₃ (2008-10)	Market logic conflicts with professional logic; corporate logic exacerbates	Market logic conflicts with professional logic; corporate logic exacerbates
Response of focal actors	T ₂ -T ₃ (2008-10)	Focal actor adapts behaviour to comply with market and corporate logics	Focal actor defends alignment with professional logic
Outcome	T ₃ -T ₄ (2010-11)	Service is transformed in character: reflects market and corporate logics	Service is discontinued: focal actor's defence fails to deflect market logic