The Logics of Healthcare

- In Quality Improvement Work

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Abstract

Quality improvement (QI) has become a cornerstone in contemporary healthcare organizations with the aim of enabling management that facilitates efficiency and effectiveness, while providing a consistent correlation between health spending and indicators of access to and quality of care. However, despite years of reform which have attempted to change healthcare professionals' practice, traditional professional modes of working remain relatively stable and entrenched. Previous research has highlighted the fact that healthcare professionals' active involvement in quality improvement work (QIW) is often lacking. Such a lack is often explained by professionals' scepticism towards management, managers, and organizationally related improvement initiatives. Yet, there is a shortage of studies which focus on analysis at the level of the actor when studying healthcare professionals' involvement in QIW.

This dissertation presents a qualitative case study of the QIW undertaken by a multi-professional diabetes care team. It enables a description and analysis of healthcare professionals' involvement in QIW at the actor level of analysis. A theoretical framework, consisting of the combination of institutional logics and institutional work, is applied in order to focus on varied and complementary aspects of institutional dynamics while simultaneously emphasizing the embeddedness of actors' actions and interactions.

The study shows that healthcare professionals' identification with and adherence to the professional logic in general impairs their involvement in QIW. Adherence entails perceiving professional judgments and discretion as legitimate in guiding practice and work. However, the study emphasizes that adherence to the professional logic varies amongst professionals representing different professions. This means that healthcare professionals' acceptance of the bureaucratic control of work as legitimate differs - enabling diverse approaches and practices in QIW. Furthermore, the study illustrates that the physicians' relative dominance hinders the utilization of multiple perspectives in the multi-professional team. This finding elucidates how dominance and hierarchization of logics enable healthcare professionals' practice to remain relatively stable, despite managerial attempts to change and alter it. Finally, the study delineates the interactions needed in order to bridge institutional logics at the actor level of analysis. Such interactions are characterized by reciprocal acts of claiming and granting influence that constitute creative/disruptive institutional work, enabling actors to find new approaches to each other and further facilitate healthcare professionals' involvement in QIW.

Keywords: quality improvement; quality improvement work; healthcare organizations; healthcare professionals; institutional logics; institutional work.

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Introduction

The aim of the research conducted for this dissertation is to describe and analyse the active involvement of healthcare professionals in quality improvement work (QIW) in healthcare organizations at the actor level of analysis. In emphasizing work, QIW places the focus on what people actually do; encompassing the effort and/or concrete activities of healthcare professionals in realizing stipulated outcomes of managerially imposed Quality improvement (QI) interventions and initiatives. As such, the dissertation places the focus on professional employees' perspectives of QIW in practice, rather than focusing on the strategies, methodologies, and tools traditionally associated with QI.

The dissertation consists of four papers, each addressing a specific research question, which will be summarized and synthesized in the following chapters in order to develop the contributions of the individual papers to a unified whole, thus fulfilling the purpose of the dissertation.

The origins and challenges of Quality improvement in healthcare

The decades since the end of World War II have been characterized by rapid technological development and changes that have enabled the emergence of a previously unprecedented range of improved diagnostic and therapeutic technologies (Gelijns & Rosenberg, 1995; IOM, 2001), giving rise to new ways to practice medicine incorporating ground-breaking methods to both detect and resolve health problems (Gossink & Souquet, 2006; Socialstyrelsen, 2009a). Consequently, what were previously untreatable and undetectable conditions may now be treated successfully (SKL, 2005a). However, the ability to offer new treatments and improved care has resulted in immense and rapid increases in health expenditure around the world. On average, total expenditure on healthcare systems in the OECD countries in 2013 constituted 15% of total government expenditure (OECD, 2015). In the same year in Sweden, total expenditure on the healthcare system reached an all-time high in relation to GDP, equivalent to 11%, and constituting 17% of total government expenditure (OECD, 2015). The rapidly increasing spending has given rise to discussions concerning the limits of viable monetary allocation for healthcare provision (SKL, 2005b). However, most attention has been paid to delivering effective management enabling rational use, and best value, of the available resources while providing a consistent correlation between health spending and indicators of access to and quality of care (IOM, 2014; OECD, 2015).

In order to achieve effective management and enable rational use of resources in health systems, it is proposed that old systems of care have to be replaced (IOM, 2001). As such, the previously unprecedented discretion of physicians to control their own professional work (see Freidson, 1988; Freidson, 2001) is being challenged by a new form of managed care (Scott *et al.*, 2000; Kirkpatrick *et al.*, 2005), inspired by the widespread notion of formal auditing (Power, 1997) and further strengthened by consumerism and managerialism which claim that professional actors are unable and/or unwilling to make judgments that ensure the quality of their professional work (Freidson, 2001). The previous social mandate of physicians to judge and manage the quality of care (Blumenthal, 1996) is consequently opposed by the belief that they are ill-suited to exercise autonomous discretion. Hence, the proposed effective management of healthcare does not solely originate from an economic imperative, but also reflects the perceived necessity of diminishing professional discretion through standardizing the provision of care to counteract what has been described as "the disabling impact of professional control over medicine" (Illich, 1976, p. 3) in order to make rational use of the available resources.

It has been argued that Quality improvement (QI), including concepts and methodologies such as plan-do-study-act, six sigma, and lean strategies (Varkey *et al.*, 2007) is pivotal in attaining the effective management and 'transformation' of healthcare (Batalden & Davidoff, 2007) that is sought in order to achieve quality and reduced costs, enabling efficiency and effectiveness while providing qualitative care (Berwick, 1989; Chassin & Galvin, 1998; Bevan, 2010; Chassin *et al*., 2010). However, despite a large body of research and the current perception of its vitality, major difficulties have been reported in relation to achieving implementation of QI methodologies as well as in substantiating their actual effect on care outcomes, efficiency, and quality (Schouten *et al.,* 2008; Kaplan *et al.*, 2010; Perla *et al.,* 2013). The evidence that quality improvements actually improve quality has been questioned (Choi *et al.,* 2011; Nicolay *et al.,* 2012). It has even been proposed that ideas and methods associated with healthcare QI have caused more harm than good following their repeated, often shallow, interventions in established practice (Walshe, 2009).

The lack of, and inconsistency in, the results of QI interventions in healthcare that are sought are often attributed to the failure to understand complexity and context in relation to planned, management-initiated approaches to development and change (cf. Hood & Peter, 2004; Nyland *et al.*, 2009; Ohemeng, 2010; Pollit & Dan, 2011; Pedersen & Löfgren, 2012). In healthcare organizations the elements of complexity and context are often manifested in the general contradictions and conflicts between healthcare professionals (primarily

physicians) and managers regarding who holds the mandate to dictate practice (Scott *et al.*, 2000; Kitchener, 2002; Reay & Hinnings, 2005; Reay & Hinnings, 2009; Arman *et al.,* 2014; Broek *et al.*, 2014), incorporating different perceptions of what denotes 'quality of care' (Blumenthal, 1996), and how it should be improved (Batalden & Stolz, 1993). As a consequence, there is often a lack of healthcare professionals' involvement in quality improvement work and/or it is not aligned with what is managerially expected (Cabana *et al.*, 1999; Dijkstra *et al.*, 2000; Grol & Wensin, 2004; Audet *et al.,* 2005, Powell *et al.,* 2009; Tummers, 2012; Bååthe, 2015; Eriksson *et al.*, 2016). Healthcare professionals' active involvement is emphasized as pivotal in both the theory/conceptualization of QI (e.g., Batalden & Stolz, 1993; Bataladen & Davidoff, 2007; Riley *et al.*, 2010), and the involvement of physicians in particular is promoted as a prime success factor in empirical studies (see Powell *et al.*, 2009; Kaplan *et al.*, 2010). In studying QIW in healthcare organizations, the tensions and conflicts between healthcare professionals and managers consequently remain the focal point – especially in understanding why healthcare professionals do not engage in it. QIW places the focus on what people actually do, which encompasses the efforts and/or concrete activities of healthcare professionals in realizing the stipulated outcomes of managerially imposed QI interventions and initiatives. This understanding of QIW follows Barley and Kunda's (2001) emphasis on "concrete activities" (p. 76) and places the focus on "what people actually do" (p. 90) in studying work, in combination with the Oxford dictionary definition of work which emphasizes that work consists of "effort done in order to *achieve a result*" (Soanes & Stevenson, 2008, emphasis added). Studying the QIW of healthcare professionals, and going beyond the notion that they constitute either passive actors or active resistors that have to be convinced or otherwise managed (e.g., Landaeta *et al*., 2008; Graban, 2012), holds the potential to address the increasingly voiced concern that management-driven reform initiatives fail to address the importance of interpretations and understanding of healthcare professionals (cf. Ackroyd *et al.*, 2007; Jun, 2009). Furthermore, such an approach holds the potential to achieve an increased understanding of the nature and prerequisites of development and change in the healthcare sector, hopefully enabling better preparation to tackle future challenges.

As noted, QI in healthcare organizations is not a phenomenon that should be understood in isolation. It is interconnected with a broader political and economic agenda (cf. Gruening, 2001; Styhre, 2014), and is directly linked to the major reform efforts collected under the umbrella term of New Public Management (NPM), which has swept through public sector organizations since

the late 1970s. Understanding the aversion of healthcare professionals to QI, and the concomitant lack of involvement in QIW, must be related to the efforts to decrease autonomy and alter the practices of healthcare professionals. The following section will therefore describe the fundamentals of NPM and the effects it has had on the public sector[1] at large, but in particular on healthcare organizations, through its contrasting attributes in relation to traditional – professional – steering mechanisms. The post-NPM countermovement will subsequently be briefly discussed, with an emphasis on the critique that has been aimed towards both NPM and post-NPM in their failure to appreciate that organizational changes are ultimately composed of changes amongst individual actors. In other words, the lack of focus on what happens *within* organizations in order to understand how the perceptions of actors and their behaviour are interconnected with the outcomes of reform efforts and associated change initiatives. Thereafter, the next subchapter addresses the notion of professionalism, and its relationship to managerialism in general and healthcare organizations in particular, in order to outline why the shift of control in healthcare organizations may instigate conflict between actors and the varied subsets of different professional groups in accepting managerial control of their work. The rationale behind QI, its impact on practice, and the often displayed aversion of healthcare professionals towards it, resulting in the lack of active involvement in QIW, will subsequently be presented in more detail. Based on this background, specific research questions will be outlined in order to address the aim behind the research carried out for the dissertation. The last subchapter presents the dissertation's arrangement.

New Public Management

New Public Management (NPM) has been proclaimed one of the most striking international trends in public administration, championing principles such as hands-on professional management, standardization, output control and disaggregation, in order to achieve public sector reforms[2] which cut costs and enable greater resource utilization in public sector organizations (Hood, 1991). NPM can be described as a shift from old forms of public sector administration, which emphasized the necessity of distinguishing the public sector from the private sector while keeping managerial influence and discretion at bay, towards making the difference between the sectors less distinct, and altering public accountability from process towards results - shifting the focus from inputs

[1] "The public sector can be characterized as a service sector consisting distinctively of public service organizations." (Ferlie *et al.*, 1996, p. 165)

[2] Public sector reforms are commonly defined as "deliberate changes in the structures and processes of public sector organizations with the objective to getting them (in some sense) to run better" (Pollit & Bouckaert, 2004, p. 8).

(budget) towards outputs – facilitated by increased managerial power and performance indicators (Dunleavy & Hood, 1994; Hood, 1995; Almqvist *et al.*, 2011). As such, supervision and evaluation of public sector professionals, and their ability to achieve preset goals, became the cornerstone in NPM associated reforms (Hood, 1995), resulting in management control[3] systems and performance management practices[4] emphasizing output (results) control (Verbeeten, 2008). A frequent criticism of NPM is that it is an ambiguous concept (Hood, 1991; Hood, 1995). However, the changes that public sector organizations have gradually undergone from the late 1970s and early 1980s onwards share the belief that private sector administrative practices, and a concomitant marketization of the public sector, should be adopted by public sector organizations; qualifying NPM to constitute the, academically designated umbrella term for these changes (Hood, 1991; Power, 1997; Gruening, 2001; Modell, 2005; Almqvist, 2006; Pedersen & Löfgren, 2012). Pollitt and Dan (2011) propose that NPM can be understood as a two-level phenomenon. At the higher level it represents a general theory or doctrine that the public sector can be improved by adopting business concepts, techniques and values. At the more mundane level, the authors propose that NPM is a bundle of specific concepts and practices reflecting its overarching rationale.

However, the difficulties in implementing the concepts and practices of NPM and achieving the promises of increased performance through reform initiatives inspired by NPM, were soon acknowledged (Hood & Peters, 2004). The conceptual critique of NPM as abstract, sweeping, ambiguous and instrumental, while being unable to facilitate explanation and understanding of the actions of organizational actors (Dunleavy & Hood, 1994; Dunn & Jones, 2007) were reflected in empirical studies, which frequently concluded that policy makers were failing to acknowledge the interventional influence of context and complexity – falling victim to the idea of "one best way" and "one-size-fits-all" methods of public sector management reforms – which often resulted in no change in, or even a diminished, performance of public sector organizations, in terms of outputs and outcomes after NPM reforms were introduced (Ohemang, 2010; Pollit & Dan, 2011; Pedersen & Löfgren, 2012).

In the wake of NPM, a substantial amount of reform initiatives have been introduced in healthcare organizations. However, actual practice has often

[3] Management control has traditionally been defined as "the process by which managers ensure that resources are obtained and used effectively and efficiently in the accomplishment of the organization's objectives." (Anthony, 1965, p. 17) and more recently as "the process by which managers influence other members of the organization to implement the organization's strategies" (Anthony & Govindarajan, 2007, p.17).

[4] Performance management "can be defined as the process of defining goals, selecting strategies to achieve those goals, allocating decision right, and measuring and rewarding performance" (Verbeeten, 2008, p. 430).

remained relatively stable as "older professional modes of working remain entrenched despite years of reform and untold disruption to staff and users" (Ackroyd *et al*., 2007, p. 21-22). As such, the necessity of acknowledging the actor perspective (i.e. acknowledging the agency of actors) has been particularly required in healthcare organizations in order to recognize that changes ultimately concern cognition and perception, and entail the actions and behaviour of healthcare professionals (cf. Nyland *et al.*, 2009).

This notion – the necessity of understanding the outcomes of NPM-inspired reform initiatives from, and as a result of, the perspective of healthcare professionals – is further elaborated by Tummers (2012) in his doctoral thesis. Tummers highlights the fact that multiple researchers have demonstrated that public professionals often have difficulties identifying with NPM-inspired reforms and policies as these reforms tend to focus on efficiency and financial transparency, championing an 'economic logic' which is in conflict with traditional professional standards and values. However, Tummers also highlights that little effort has been put into theorizing this occurrence. He thus studies the phenomenon utilizing the concept of 'policy alienation' defined as "a general cognitive state of psychological disconnection from the policy program to be implemented, by a public professional who, on a regular basis, interacts directly with clients" (p.14). Utilizing this concept, studying an NPM-inspired reform as part of a larger agenda to marketize the Dutch healthcare system, Tummers found that healthcare professionals were indeed under pressure to conform to policies that were alien to them, and they thus often chose not to implement them. Tummers identified several factors to which this behaviour could be attributed: as Tummers had hypothesized the policies, understood as manifestations of NPM reforms, often championed an 'economic logic' which was incoherent with their professional traditions/norms/values/beliefs, and what they believed to be their job (e.g., offering the best care), making them distance themselves from them. Moreover, if the autonomy and dominance of the healthcare professionals were perceived to be threatened by the policy, or its implementation, it often faced the same fate. However, Tummers also found that some healthcare professionals decided not to implement a policy as they perceived it be meaningless; unable to achieve the business goals of efficiency and effectiveness. As such, it was not the goals, rationale or logic of the policy *per se* that was challenged, but rather the ability of the policy, if implemented, to achieve the outcomes it sought.

Tummers' (2012) study is important as it connects the classical ideas and notions found in sociological literature concerning autonomous, self-regulated and peer-managed professions with the interventions in healthcare professionals'

work which reforms associated with NPM have come to entail. However, what is of particular interest in Tummers' study is that it goes beyond traditional variables – such as autonomy, self-regulation and peer-management – in explaining why healthcare professionals often choose not to implement NPM policies. Tummers highlights that the choices, and concomitant actions, of healthcare professionals are intricate and cannot be attributed solely to stubbornness or professional traditions and norms. The cognition and perception of healthcare professionals seems to be a more complex inquiry than that. It therefore seems that future research would benefit from utilizing theoretical concepts that are able to address in depth both the static and dynamic nature of, and influences on, the agency of healthcare professional actors in order to understand the effects and outcomes of NPM ideas, reforms, and policies in practice. After all, while the dichotomies between traditional and modern styles of public management have their uses, they obscure the prospects of understanding intermediate possibilities (Dunleavy & Hood, 1994) and hence the ability to capture the complexity at the actor level of analysis.

In summary, it is argued that implementation (or lack thereof) of NPM-inspired reforms, associated concepts and proposed practices ultimately depends upon the professional actors *within* healthcare organization. In their review of the outcomes of NPM reforms in practice, Hood and Peters (2004) pinpoint that what was missing was empirical research at the actor level of analysis, i.e. that research had hitherto overlooked the actor level of analysis in explaining and understanding the outcomes of the introduction of such reforms. It appears that since then researchers have started to pay attention to the actor level of analysis in relation to healthcare organizations in understanding the failure of NPM reforms to achieve their intended purpose and effects in practice. However, there are indications that reforms, and reformers, are still disregarding the profound notion that organizational change is ultimately composed of changes among the people in the organization (cf. Robertson *et al.*, 1993; Kotter, 1996), while utilizing the same rationale and instrumentalist approach towards overcoming the unforeseen, and often paradoxical, outcomes of NPM reforms that have been critiqued as causing them.

Post-New Public Management

As NPM-inspired reforms have often resulted in paradoxical and unintended outcomes, the post-NPM movement came to encompass coordination and integration, collaboration and shared goals as key to reducing the fragmentation of public sector organizations and activities in efforts aiming to achieve increased capacity, effectiveness, and efficiency in and of the public sector

(Christensen & Lægreid, 2007). However, key aspects of NPM remain institutionalized (Goldfinch & Wallis, 2010), resulting in elements from different reform 'generations' being blended in a complex interplay due to the inability of organizations and institutions to change rapidly (Christensen & Lægreid, 2008; Lodge & Gill, 2011). It has been illustrated that post-NPM concepts in healthcare organizations, which have the aim of facilitating collaboration between healthcare professionals and managers, have had difficulties in introducing new values due to previously institutionalized practices (Liff & Andersson, 2012).

Moreover, despite being described as a counter-movement to NPM with the intent to address a variety of challenges facing public sector management, post-NPM has been criticized. Jun (2009) argues that both NPM and post-NPM, regardless of their diversity of content, incorporate management-driven reform initiatives with the embedded idea and belief that improved management is the solution to the complex problems of the public sector. As such, Jun argues, they are both grounded in the same paradigmatic traditions of positivism and functionalism. These foundations are reflected in the assumptions that people's actions and behaviour can be modified through structural, functional and regulatory organizational change, meaning that members of the organization are expected to act rationally in correspondence with political and managerial initiatives.

Jun (2009) claims that such expectations present a deterministic view of human nature as well as a one-dimensional explanation of organizational phenomena that is not coherent with the complexity of reality. Members of an organization make interpretations and create their own understanding of any given situation; such interpretations and understanding are what precede action and behaviour. As such, they are not passive entities who solely conform to external demands (e.g., hierarchical orders, rules and regulations, goals and tasks). Thus, credence to structural integration alone will not ensure effective human relationships and organizational performance. In addition to the aforementioned simplifications, Jun states that both NPM and post-NPM contain the expectation that members of an organization are motivated by the external variables included in management goals and initiatives to effect change. Such expectations, Jun claims, are problematic due to the intrinsic nature of commitment. Hence, there is a need to critically examine and go beyond the fundamental assumptions of the instrumental modes of governance imposed by both NPM and post-NPM.

Expressing similar thoughts and critiques of current public sector management, Osborne (2006) argues that the logic and assumptions of NPM have been

perceived to be inadequate in capturing the complexity of, and contributing efficiently to, the development of public sector organizations. NPM emphasizes economy and efficiency, reflecting its reliance on economic theory, traditional management theory and new institutionalism (Jun, 2009). In contrast, the sort of post-NPM research proposed by Osborne ought to aim to incorporate notions of contemporary management theory, focusing on pluralistic and relational aspects of organizations and their members, with the intent of addressing the realities and complexities of public sector organizations.

Notwithstanding the aforementioned shortcomings of NPM and post-NPM, these reform ideals have had a significant impact on public sector organizations concerning their intended working practices and policies (Hasselbladh *et al.*, 2008), legislation and other rules (Goldfinch & Wallis, 2010), efforts to achieve financial results, accountability, and transparency (Ackroyd *et al.*, 2007), and the position of management as an established strong ideology (Diefenbach, 2009). The institutionalized presence of management and managers aiming to influence the rationale of professionals' everyday work, as they push for the implementation of NPM-inspired reforms and policies in practice, has been found to be particularly troublesome for healthcare professionals - especially physicians - often resulting in conflicts concerning priorities and the jurisdiction of managers to supervise their work (Ferlie *et al.,* 1996). As a result, the logic of professionalism and the logic of managerialism now co-exist in healthcare organizations, both exerting influence (Reay & Hinnings, 2009). However, whilst both these logics are present at the actor level of analysis, the sustained top-down pressure for healthcare professionals to conform to the new logic has entailed a decline in professional autonomy and clinical professionals now being directly involved in decisions concerning how scarce resources should be utilized (Ferlie *et al.,* 1996). As such, the governing ideals that have spread across public sector organizations during the last four decades have resulted in contestation of healthcare professionals' autonomy and professional values, and of their control of professional work. In order to better understand the conflicts often arising between healthcare professionals (particularly physicians) and managers in relation to QI, and why they are often reluctant to involve themselves in QIW, the next subchapter will address what it means for an occupation to be a "profession", the perceptions of legitimate control of work it entails, and how the logic of professionalism relates to the many occupations present in healthcare organizations.

Why professions and professionalism in healthcare matters

As previously noted, while it is necessary to refrain from explaining the outcomes of NPM associated reforms in healthcare organizations as solely the result of contradictions between traditional (professional) and new styles of (managerial) public management (Dunleavy & Hood, 1994; Tummers, 2012), the concept of professionalism is important in understanding the perspectives of healthcare professionals on managerial interventions and hence their outcomes. However, what defines a profession, and the differences in relation to an occupation, or what denotes a professional (i.e. the member of a profession) are not undisputed matters. Seminal works, indulging in the inquiry, have focused on diverse characteristics and aspects of professions, professionalism, and professional work (e.g., Johnson, 1972, Freidson, 1986, Abbott, 1988, Freidson, 2001).

Freidson (1986) attempted to outline the rise of professions and delineate the fundamental characteristics of workers who should be labelled as professionals. In doing so, Freidson identifies 'professionals' as the agents, or carriers, of formal knowledge. He argues that formal knowledge is associated with the notion of rationalization; the rise of modern science and the application of scientific methods to technical and social problems. However, formal knowledge is not part of everyday knowledge, which makes it an elite knowledge as well as an instrument of power. As such, Freidson proposed that *professionals are distinguished from other occupations due to their possession of, specialized, formal knowledge.*

Freidson (1986) argues that professionals' ability to claim jurisdiction over a body of formal knowledge is reflected in their positions as employees. In contrast to the proletariat, professional employees have "the freedom to employ discretion in performing work in the light of personal, presumably schooled judgment that is not available to those without the same qualifications" (p. 141). Hence, *control of work and self-regulation is what separate professionals from other workers and is a defining characteristic of professional employees*. As a consequence, Freidson argues, professionals do not perceive administrative rank to be of importance when their work is directed by others, or an attempt is made to do so. Instead, *professionals perceive expertise to be the viable mode of authority* and only accept guidance and supervision by others when it is perceived to be carried out by a respected peer. However, not all professions are able to exercise professional judgments to the same extent. Freidson proposes that a higher degree of discretion when exercising specifically professional

judgments, and hence withstanding attempts by others to influence their work, are what distinguishes strong from weak professions.

The nature of professional work and the positions of professional employees are what Freidson (1986) argues fuel the classic conflict between professionals and managers. Professionals and managers have different aims and interests, with managers being "concerned with the preservation of the integrity of the organization (or organizational unit) as a whole in the light of the general policy of its governing board, while the rank and file [the professionals] are concerned with the preservation of the integrity of their specialized pursuit of a discipline or a profession" (p. 152). Moreover, Freidson argues that it is this diametric difference between professionals and managers which creates such tension that not even managers with a professional background are considered peers. Instead, they are perceived to be "another breed" (p. 153), focusing on the aims of the organization while championing managerial interests rather than professional virtues and fulfilment. In summary, Freidson claims that the conflict between professionals and managers is ultimately a conflict over control and concomitantly which logic should be legitimate in structuring work and guiding practice.

In a later contribution, Freidson (2001) developed the idea of understanding professionalism and managerialism as two opposite logics in controlling and organizing work[5], accentuating their antagonistic relation in underscoring that "freedom of judgement and discretion in performing work is intrinsic to professionalism, which directly contradicts the managerial notion that efficiency is gained by minimizing discretion" (p. 3). Although, Freidson (2001) emphasizes that both logics are intellectual constructs, not portraying any real occupation or actual organizational conflicts, the ideal-typical (see also Weber, 1978) logics of professionalism and managerialism are intrinsically at odds due to their inherently dichotomized ideological axioms concerning how work ought to be organized and controlled (see also Thornton, 2004). In other words, the professional logic represents occupational control of work whereas the managerial logic represents managers' bureaucratic control of work. Analogously, as occupations come closer to the ideal-typical construct of a profession and hence identify with the professional logic and its premises of occupational control of work as legitimate, occupations are more likely to resent managerial and administrative rules that constrain discretion (cf. Freidson,

[5] Freidson (2001) also outlines the logic of the market as a third logic for controlling and organizing work, nonetheless emphasizing that when services are complex, as in the case of medicine, it is the role of managers, who understand consumers' needs and who are devoted to efficiency in serving those needs, to facilitate consumers' choice rather than the consumer him-/herself through the competition generated by the market.

1986). It is thus not unexpected that managerial interventions with the aim of altering healthcare practices are often met with scepticism by healthcare professionals, with physicians at the fore.

Medicine (implying physicians in general) is often referred to as the prototypical profession (Freidson, 1986; Freidson, 1988; Abbott, 1988). Historically, it has, "almost completely realized ideal typical professionalism" (Freidson, 2001, p. 181) and, while the nature of professional work and its contingencies have changed (cf. Evetts, 2011; Noordegraaf, 2013), it is currently still closer to the ideal type than any other occupation (Freidson, 2001). As such, if any group of professionals is prone to be sceptical towards managerial control of work, it is physicians. However, it is not only the unprecedented control over their own professional work that makes medicine unique, it is also the fact that, historically, medicine has dominated the division of labour[6] within healthcare (Freidson, 1986; Abbott, 1988, Freidson, 2001). In focusing on interprofessional relations in understanding the development of professionals and their interdependency, Abbott (1988) underlines the dominance of physicians as supreme in controlling a complex division of labour in which a number of subordinate groups (e.g., nurses, laboratory technicians, X-ray technicians etc.) occupy their allotted places. As such, the profession of medicine has had an exclusive claim over jurisdiction, i.e. the exclusive ability to not only classify and provide reasoning in relation to a problem, but also to prescribe effective action for it, with the concomitant subordination of a host of professional groups (Abbott, 1998). Moreover, medicine has been singularly effective in creating subordinate groups to handle clearly demarcated tasks (e.g., pharmacists), as a consequence of the expanding demands of health services, without losing too much jurisdiction (Abbott, 1998). As such, while the subordination of other occupations to medicine (e.g., dietitians, psychologists and physiotherapists etc.) is no longer as evident (Freidson, 2001), physicians have a distinct, and unprecedented, tradition of controlling their own, and other occupations', professional work.

This distinction is striking when contrasting the ability of the profession of medicine to control their own work in relation to the other primary profession in healthcare in terms of numbers (WHO, 2015): nursing. Nurses have traditionally been firmly subordinated to physicians, even "unable to perform their work without authorization by physicians" (Freidson, 2001, p. 182). As such, physicians have been able to fully direct the work of nurses, even though they lacked the formal authority to hire, fire, or promote them (Freidson, 1986).

[6] Division of labour "represent the structure of social relationships that organizes and coordinates the work of related specializations and occupations" (Freidson, 2001, p. 41).

However, nursing has recently undergone significant professionalization which has expanded the jurisdiction and autonomy of nurses (Salavage, 1988; Keogh, 1997; Boling, 2003; Yam, 2004; Råholm *et al.*, 2010; Beedholm & Frederiksen, 2015). Nonetheless, the difference and subordination of nurses' status to physicians is still widespread in healthcare organizations (Currie & Spyridonidis, 2016). As such, nurses are not, and have never been, able to fully and freely exercise specific professional discretion. From this it follows that physicians in general will have a different starting point than nurses in relation to, and perceptions of, managerial interventions aimed at influencing their control over, and the content of, their work. Due to their stronger identification with and adherence to the professional logic, physicians are more likely to perceive managerial interventions as illegitimate, as accepting them would entail waiving the right of exclusive control over their own work – the control that is "*the essential characteristic of ideal-type professionalism from which all else flows*" (Freidson, 2001, p. 32, emphasis in original). Hence, due to differing identification with and adherence to the professional logic, the two primary professions in healthcare organizations are predisposed to react differently towards managerial interventions.

As stated, the logic of professionalism and the logic of managerialism are mutually exclusive in their different prescriptions of how work ought to be controlled and organized. Whereas professionalism "stresses the lack of uniformity in the problems its work contends with, therefore emphasizing the need for discretion" (Freidson, 2001, p. 111), managerialism "denies authority to expertise by claiming a form of general knowledge that is superior to specialization because it can organize it rationally and efficiently" (Freidson, 2001, p. 117). As such, the managerial logic exalts managers to rise above professionals as they possess the power, in line with their general knowledge, to "see the bigger picture", rather than getting stuck in insignificant details. Hence, their antagonistic state does not only incorporate inherent prescriptions concerning who (professionals or managers) should decide, but also the legitimate basis for the decisions they make. NPM has introduced the basis for decision-making, focusing on efficiency and effectiveness rather than professional discretion, inherent to the managerial logic in healthcare organizations. This is particularly evident in QI interventions, as they manifest the managerial logic at the actor level of analysis in requiring that treatment and care must follow certain procedures – making the individual healthcare professional's judgment secondary. QI interventions interfere profoundly with the professionals' control of their work as it limits their ability to fully exercise choices in regard to how tasks are organized (cf. Freidson, 2001). As such,

through instigating QI, managers stress that it is not solely up to the individual healthcare professional to define and resolve the problems that they face. Consequently, the idea that quality is defined and achieved through the ability of the individual professional to exercise just judgments is opposed, challenging the dominance of the healthcare professionals, most notably physicians, and their monopoly to exercise power in order to socially organize the division of labour (cf. Freidson, 2001). The next subchapter will present the idea and concept of QI more thoroughly, before reviewing studies addressing professional employees' perspectives on and involvement in QIW.

Quality improvement in healthcare

The QI concept originates from the private industrial sector, focusing on enabling continuous improvements, with the argument that quality is created through understanding and revising the production process based on the data which the process itself generates (Berwick, 1989). Berwick argued in 1989 that QI is pivotal for achieving quality and reducing costs in healthcare. Since then, QI has gained in appeal and is often proposed to enable a transformation of healthcare systems, enabling them to achieve the necessary changes imposed by the contemporary demands for efficiency and effectiveness while providing qualitative care (Chassin & Galvin, 1998; Bevan, 2010; Chassin *et al.*, 2010). Following Pollit and Dan's definition (2011) that NPM can be understood as a two-level phenomenon – both at the higher level as a general theory or doctrine and in everyday work as a set of specific concepts and practices – QI in healthcare is understood in this thesis as a manifestation of an overarching managerial and economic rationale with the aim of altering the everyday work and practice of healthcare professionals.

In order to start outlining the concept it is important to understand that what is considered 'quality' in healthcare organizations has come to be a complex matter. Blumenthal (1996) states that "just a few years ago, physicians could be confident that they alone had a social mandate to judge and manage the quality of care" (p. 891). However, as detailed in the previous sections, physicians no longer enjoy such autonomy and self-regulation. Blumenthal (1996) argues that, beside the classical and traditional sense of 'quality of care' derived from a healthcare professionals' perspective, i.e. as "the attributes and results of care provided by practitioners and received by patients" (p. 892), there are three other major perspectives of quality which, as manifested in recent years, have become cornerstones in defining quality. The first one is the *consumer perspective*; that individuals' opinions and perceptions regarding the care provided is a measurement of its quality. The second one Blumenthal (1996) labels *health*

care plans and organizations and it incorporates the idea that quality of care must take into account the (aggregated) health of the population served, and functional organizational systems which enable optimization of the output of scarce resources. The third perspective, *organized purchasers*, reflects the creation of (internal/quasi) markets in numerous healthcare systems where quality is evaluated using certain established standard measurements which the purchaser may use to evaluate the performance of the healthcare providers.

It is important to be aware of these new perspectives on what is deemed 'quality of care' in order to understand what is aimed to be improved (i.e. the aspects that denote quality) but also how improvements are proposed to be achieved. In an effort to outline a framework for achieving continual improvement in healthcare organizations, Batalden and Stolz (1993, p. 425) highlight the difference which the new aspects of quality have brought about in relation to how improvement has traditionally been achieved:

> Improvement in health care has traditionally resulted from advance in professional knowledge, which consists of knowledge of subject and discipline as well as professional values. A new body of knowledge – improvement knowledge – consists of knowledge of a system, knowledge of variation, knowledge of psychology (in particular, psychology of work and psychology of change), and theory of knowledge. Joining professional knowledge with improvement knowledge makes possible the continual improvement of health care, characterized by more improvements of a different kind and at a faster pace than before.

Obviously, QI incorporates new ways of understanding and measuring quality, but also new ways (with the help of a new form of knowledge: improvement knowledge) of achieving it; physicians no longer hold the monopoly to dictate what is 'quality of care', nor decide how quality is supposed to be achieved.

However, there is not one single, universally accepted, definition of Quality improvement in healthcare (Riley *et al.*, 2010), and multiple concepts are often used interchangeably (e.g., improvement science, improvement work, continuous improvement, quality assurance) to denote its inherent core attributes (Andersson, 2013). Batalden and Davidoff (2007) aim to answer the questions of "what is 'quality improvement' and how can it transform healthcare?". They propose that QI should be defined as "the combined and unceasing efforts of everyone - healthcare professionals, patients and their families, researchers, payers, planners and educators - to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)" (p.2). However, the authors argue that

there are certain prerequisites for achieving this *substantial shift* in healthcare: *change making* needs to be an intrinsic part of everyone's everyday work, implying *accurate and powerful measurements of what is happening* and specific *tools and methods* - in order for healthcare to realize its full potential. Batalden and Davidoff (2007) describe the vision of QI in healthcare organizations, however, they are vague in describing the impact of QI in practice. Riley *et al.* (2010) follow suit, stating that QI entails distinct management processes and a set of tools and techniques which allow for continuous and ongoing efforts to achieve *measureable improvements* concerning *efficiency*, *effectiveness*, *performance*, *accountability*, and *outcomes*. In turn, these measureable improvements help in *eliminating inefficiency*, *error* and *redundancy* which result in *improved critical processes* and *reduction of cost associated with poor quality*. While Riley *et al.* (2010) are as vague as Batalden and Davidoff (2007) concerning the actual manifestations of QI in practice, it is clear that QI is something alien and new in healthcare organizations, as it promotes the importance of the formal management of healthcare professionals and reflects the phraseology associated with contemporary public sector reforms (e.g., efficiency, effectiveness, and outcomes). As such, the interconnection between QI and the new managerial logic of organizing and steering healthcare organizations is further established.

In order to go beyond the visions and slogans of Bataladen and Davidoff (2007) and Riley *et al.* (2010), and outline the intended interventions that QI would entail in practice, it is worthwhile revisiting the framework for achieving continual improvement suggested by Batalden and Stolz (1993). They propose that the number of tools and methods available for achieving continual improvement (i.e. QI) are almost endless, but that they can be grouped in four major categories: 1) process and system, 2) group process and collaborative work, 3) statistical thinking, and 4) planning and analysis. The first category, *processes and systems*, includes tools with the intention of making visible the stages in the conduct of work as well as their relationships. At the systems level, this includes outlining and visualizing the components (e.g., community need, suppliers, core processes, and customers) that need to be taken into account in the "production" of healthcare as well as the relationship between these components. At the process level, the most frequently used tool for process analysis is the flowchart. The flowchart enables the visualization of each stage in a process; it contains information concerning who does what and why, and enables non-optimal flows to be identified and non-value adding steps to be eliminated. Batalden and Stolz (1993) liken the flowchart to the catwalk above a factory floor – aiming to provide an overview of all activities in the process at

once. The second category, *group process and collaborative work*, incorporates tools and methods that aim to facilitate people working together. This includes techniques that focus on enhancing group performance in that they enable multiple perspectives and different points of views to be combined, enabling better decisions and judgements to come to fruition. The third category, *statistical thinking*, includes tools which underline the importance of numbers and measurements (e.g., Pareto charts, time plotting or run charts, and scatter diagrams) in order to create and analyse data, which enables improvements to be carried out. Moreover, they are proposed to enable testing and evaluation of improvement and performance, and to track and keep longitudinal records of both. The fourth and last category, *planning and analysis*, is described as tools and methods enabling the processing and use of qualitative data (e.g., various diagrams, benchmarking methods and quality function deployment) in order to achieve improvement. In a more recent effort to evaluate the activities and interventions associated with QI in healthcare, Powell *et al.* (2009) highlight some strategies/methods/tools as most notable: Total Quality Management (TQM)/Continuous Quality Improvement (CQI), Business Process Reengineering (BPR), The Institute for Healthcare Improvement (IHI)'s rapid cycle change, Lean thinking and Six Sigma.

Batalden and Stolz (1993) set out the fundamental array of tools and methods QI aims to bring forth, while Powell *et al.* (2009) illustrate their manifestation in contemporary practice. As far back as 1993, Batalden and Stolz firmly advise against the belief that these tools and methods *per se* will lead to improvement and warn that a certain improvement model should not be adhered to 'just for the sake of it'. Moreover, they underline the centrality of recognizing professional knowledge and values when aiming to achieve continual improvement and that the improvement knowledge needs to be merged with professional knowledge in order to be meaningful. They conclude that "if we get focused on using the 'QI approach' or the 'QI tools', then *doing improvements, not improving what we do, becomes the goal*" (p. 438, emphasis added). In 2009 many of their concerns seem to have proven to be legitimate: in a substantial review of Quality improvement models in healthcare, Powell *et al.* (2009) conclude that multiple QI interventions failed to realize the notion of continuous improvements in their efforts, instead they often consisted of ill-composed mixtures of multiple, often contradictory and/or fashionable, tools or methods while failing to incorporate elements of forethought, adaptability, and endurance. As a result, it was established that QI interventions as a whole have had little impact on actual practice, limited influence in achieving change, and,

while some of the studies reviewed showed remarkable improvements, inconclusive success in achieving positive outcomes.

However, Powell *et al.* (2009) further concluded that the QI interventions which resulted in positive outcomes showed that certain 'necessary, but not sufficient' antecedents needed to be fulfilled in order for the positive outcomes to be achieved: provision of the practical and human resources to enable quality improvement, the active engagement of health professionals, particularly doctors, sustained managerial focus and attention, the use of multi-faceted interventions, coordinated action at all levels of the healthcare system, substantial investment in training and development, and the availability of robust and timely data through supported IT systems. Apparently, certain antecedents are necessary for achieving improvements though they are not sufficient for establishing strict causality.

In elaborating the failure of QI interventions to continuously and systematically achieve improved outcomes, and further developing the contextual factors which may influence them, in a systematic review of QI interventions (including 47 articles and concepts such as Plan-Do-Study-Act (PDSA), Plan-Do-Check-Act (PDCA), Total Quality Management (TQM), Continuous Quality Improvement (CQI), Six Sigma, and Lean Management), Kaplan *et al.* (2010) conclude that the QI interventions demonstrated mixed results in terms of outcomes, and that contextual factors probably constitute a major component in explaining this variance. Furthermore, Kaplan *et al*. (2010) showed that a substantial amount of contextual factors may (or in some cases may not) influence the success of QI: 66 factors were identified in their initial categorization. These factors were later categorized into broader categories (e.g., organizational structure, QI team leadership and physicians' involvement in QI), however they underline the great complexity involved in trying to outline and define the contextual factors which influence the outcomes of QI interventions and that universal approaches towards implementation are bound to fail. The findings of Kaplan *et al.* (2010) echo the conclusions of Powell *et al.* (2009, p. 13):

> Importing quality improvement techniques from outside health care may have the benefit that the tools and approaches have been tested to some degree, but the complexity of health care and the contingencies of the particular local and organisational circumstances can combine to overwhelm these potential advantages.

As a consequence, Powell *et al*. (2009) propose that it is vital to acknowledge the emerging notion that IQ initiatives/programmes should be understood as complex interventions imposed upon and introduced in already complex and

diverse 'social worlds'. However, while factors both facilitating (e.g., Øvretveit & Gustafson, 2002; Schouten *et al*., 2008; Nicolay *et al*., 2012) and hindering (e.g., McNeil, 2001; Esain *et al*., 2012) the success of QI interventions are fairly well studied at an aggregated/systems level, there is a lack of studies embracing, albeit often acknowledging, the complexity of such interventions as well as in-depth empirical studies of the antecedents and hindrances to the active involvement of healthcare professionals in QIW. The dearth of studies that employ a professional employee perspective in understanding QI as interventions in already established practice from the healthcare professionals' point of view is remarkable as their involvement is emphasized as pivotal in both the theory/conceptualization of QI (e.g., Batalden & Stolz, 1993; Bataladen & Davidoff, 2007; Riley *et al.*, 2010) and, in particular, the involvement of physicians, is promoted as a prime success factor in empirical studies (see Powell *et al.*, 2009; Kaplan *et al.*, 2010). In other words, while the complexity of QI interventions in practice is often acknowledged, it is seldom a prerequisite when conducting research. As a result, there is a lack of research focusing on the continuous interplay between the enduring presences of QI interventions and previously established professional practices when studying healthcare professionals' perspectives on and involvement in QIW. In order to progress research on QI in practice there is a need to go beyond pretentious conceptualizations and grand success factors and for the focus to be placed on the actor level of analysis. This entails concentrating on the healthcare professionals' perspectives on and attitudes towards QI, being aware that prior to the institutionalization of the managerial logic in healthcare, physicians exercised full professional autonomy and discretion in deciding what was deemed 'quality of care', as well as solely responsible for improving it. The next sub-chapter will review research addressing professional employees' perspectives on QI and the factors/conditions facilitating their involvement in QIW.

Quality improvement work: professional employees' perspectives

As previously mentioned, a perspective on QI interventions in healthcare organizations emanating from professional employees is lacking, and knowledge concerning the antecedents for the involvement of healthcare professionals in QIW is limited. However, healthcare professionals' aversion (though healthcare professionals often solely incorporate physicians) towards QI has long been acknowledged. This aversion is partly attributed to the new perspectives on what is construed as quality, "the very language of current discussions about the quality of care leaves many physicians tongue-tied and uncomprehending"

(Blumenthal, 1996, p. 891), as well as the removal of professional autonomy in determining how improvements should be carried out, interwoven with the introduction of a new, and to physicians alien, 'improvement science' and its associated tools and methods. Moreover, interrelated with the new perspectives on quality, physicians' unfamiliarity with perceiving themselves to be a part of a grander healthcare 'system' or 'organization', is proposed to constitute a cultural barrier as physicians "seem to have difficulty seeing themselves as participants in processes, rather than as lone agents of success or failure" (Berwick, 1989, p. 55).

However, as previously outlined, since healthcare professionals and managers are deemed to be distinctly guided by antagonistic logics, the aversion of healthcare professionals towards QI interventions and their lack of involvement in QIW interconnects with a broader conflict concerning whether professionals or managers are mandated to control professional work. This phenomenon, highlighting the discrepancies and conflicts it instigates between healthcare professionals and managers, has been diligently studied using the institutional logics concept (see Thornton *et al.*, 2012). The logic of medical professionals has been found to coexist with the new logic of business-like healthcare (e.g., Scott *et al.*, 2000; Doolin, 2001; Kitchener, 2002; Reay & Hinings, 2005; Kirkpatrick *et al.,* 2009; Bovenkamp *et al*., 2014), which often impinges on collaboration between healthcare professionals and managers as they perceive that different set of values should be guiding practice (Reay & Hinnings, 2009; Arman *et al.*, 2014; Currie & Spyridonidis, 2016).

These studies highlight the fact that the institutionalization of the managerial logic in healthcare has engendered significant difficulties in practice, particularly concerning the viability of collaboration between actors identifying with and adhering to different institutional logics. Notwithstanding its potential, the institutional logics concept has not been extensively utilized in researching the aversion of healthcare professional towards QI and relatively few studies have utilized it in studying the involvement of healthcare professionals in QIW. Broek *et al.* (2014) is a notable exception, illustrating the lack of willing involvement of healthcare professionals (nurses in this case) in QIW if it is not perceived to be aligned with professional fulfilment and values inherent in their professional logic. In the study, focusing on the implementation of an innovative practice to organize the work of nursing staff at a Dutch hospital, the business-like/managerial logic was perceived by the nurses to be given precedence as the focus was on increasing productivity rather than quality of care. As a result, there was a lack of involvement and commitment on the part of the nurses, due to the fact that the QIW was not aligned with their professional logic. The

viability of understanding the contradictions amongst and between healthcare professionals and managers – with an emphasis on the applicability of studying healthcare professionals' perception of QI and involvement in QIW – utilizing institutional logics is thus further underlined as constructive.

However, acknowledging that organizational actors primarily adhere to and identify with distinct institutional logics, and that this affects their perception of QI and their involvement in QIW, is not the same as attributing logic identification and adherence to solely encompass all aspects which contribute to the individual healthcare professional's perception of QI, nor his/her involvement in QIW. As previously outlined, healthcare organizations are inhabited by a multiplicity of professional actors with diverse inter-professional relationships, as well as different points of departure in perceiving the professional logic, and the professional control of work it prescribes, as legitimate in guiding professional work. Analogously, it is thus unwise to diminish healthcare professionals' aversion towards QI interventions, and their lack of involvement in QIW, to a simplistic dichotomist construct consisting of professionals versus managers, or as "old versus new" forms of defining and achieving quality of care, while being aware that their inherent differences are vital. However, as underscored in studies aiming to delineate the antecedents for successful QI interventions, such interventions are imposed upon complex and diverse 'social worlds' (see also Glouberman & Mintzberg, 2001; Llewellyn, 2001), requiring that healthcare professionals' attitudes towards and cognition of QI interventions must also be understood as complex. There is consequently a need to embrace the notion that "resistance to change" does not capture the complexity of the individual healthcare professional's responses to QI interventions and proposed organizational changes, as such responses are multi-dimensional (cf. Piderit, 2000), in order to progress beyond denoting healthcare professionals as either passive actors or active resistors that have to be convinced or otherwise handled by management (e.g., Landaeta *et al*., 2008; Graban, 2012).

Whereas institutional logics has rarely been utilized explicitly in addressing the involvement of healthcare professionals in QIW, studies addressing the lack of healthcare professionals' involvement in QIW have been conducted. In reviewing the barriers for physicians to follow guidelines for clinical practice (i.e. guidelines describing appropriate courses of action, for specific circumstances, aiming to improve quality and decrease variation in clinical practice), Cabana *et al.* (1999) conclude that multiple barriers exist that may often – intertwined – be attributed to the fact that physicians do not adhere to such guidelines. A multiplicity of barriers affecting attitudes and behaviours was

identified: lack of awareness, lack of familiarity, lack of agreement, lack of outcome expectancy, inertia of previous practice, external barriers, guideline-related barriers, patient-related barriers and environment-related barriers. In the paper the authors endeavour to answer the question, "Why don't physicians follow clinical practice guidelines?", and they conclude that a universal answer is unlikely as barriers to their adoption by physicians vary. As such, the authors reject the notion of generalizable means to achieve physicians' "compliance" towards clinical guidelines – highlighting interventions to modify work practices as a complex and contextually entangled matter. However, while complexity and context must be acknowledged, the conclusions of Cabana *et al.* (1999) support the notion, and reveal how it is manifested, that healthcare professionals value their autonomy and the belief that their own professional judgments should be given credence in the execution of their professional work, rather than guidelines that are often perceived to be imposed by management, dictating how it should be carried out.

In a similar attempt to understand physicians' lack of adherence to clinical guidelines, a study by Dijkstra *et al.* (2000) of the perceived barriers to physicians implementing diabetes care guidelines, found that organizational barriers such as a heavy workload, insufficient managerial support and lack of necessary personnel were generally perceived to be more common than personal barriers such as resistance to imposed activities (i.e. being told what do to by management), insufficient knowledge of diabetes complications, inability to treat patients as individuals, and a perception that the guidelines were based on insufficient evidence. Dijkstra *et al.* (2000) thus concluded that organizationally-related barriers to accepting clinical guidelines were more prominent than personal/individual barriers. As the findings of Dijkstra *et al.* (2000) are based on a survey study, with internists with a specific interest in diabetes as responders, there is a need to critically reflect upon the nature of the barriers identified, particularly the lack of barriers reflecting 'shortcomings' and an unwillingness among physicians to change practice. Nonetheless, the conclusion establishes the importance of understanding the active, self-elected, involvement in QWI by healthcare professionals as a complex phenomenon, while underscoring the necessity of acknowledging diverse perceptions and cognitions amongst different social actors in outlining the factors that are attributed to the lack of such involvement. Moreover, as barriers are found at both an organizational and a personal level, the study, albeit implicitly, highlights the necessity for future research to approach the phenomenon of healthcare professionals' active involvement in QIW with theoretical perspectives that

enable the macro-, meso-, and micro level of analysis to be taken into consideration.

To sum up, similarly to Tummers' (2012) findings in relation to healthcare professionals' adherence and conformity to policies, Cabana *et al.* (1999) and Dijkstra *et al.* (2000) show that the lack of healthcare professionals' active involvement in QIW is a more complex inquiry than simply a matter of delineating the universal factors that hinder it, overcoming resistance towards it, and in turn being able to overthrow the remnants of institutionalized professional autonomy and its resulting persistent and ineffective ways of providing care. Moreover, these studies further underline the fact that the interplay between the logic of professionalism (i.e. that professional judgments and competence should be given credence in QI initiatives) and the logic of managerialism (i.e. that managers should be given a mandate to direct, lead, and organize the forms and goals of QI in order to promote a systems/organizational perspective) is a prominent feature in understanding healthcare professionals' perceptions of QI and involvement in QIW.

In a similar study reviewing the barriers and incentives for healthcare professionals to change practice through adherence to guidelines, Grol and Wensin (2004) conclude that certain factors are established as antecedents for achieving change. However, the authors underscore that, despite this, there is a lack of in-depth knowledge concerning "which factors are decisive in achieving which changes, in which target group and which setting" (p. 60). In other words, Grol and Wensin (2004) - once again - draw attention to the importance of recognizing complexity and context as vital elements in understanding how QI interventions affect practice, and how healthcare professionals engage in QIW. In line with Powell *et al.* (2009), Grol and Wensin's (2004) conclusions indicate that certain factors seem to be 'necessary, but not sufficient' in achieving changes of practice as well as constructive outcomes of QI interventions – both incorporating the active involvement of healthcare professionals as a pivotal element.

In further exploring the lack of involvement by physicians in QIW, Audet *et al.* (2005) conclude that QI and measurements of physicians' performances are perceived to be fundamental from a range of perspectives (e.g., political, managerial, and consumer), nonetheless, physicians have never accepted either of them as integral parts of practice. In a survey study the authors found that only one third of the responding physicians reported to have engaged in redesign initiatives to improve the performance of the system of care in which they practiced. As such, the conception that physicians are reluctant to involve

themselves in QIW is further established through the physicians' own responses. In addition, the authors found that the likelihood that physicians would involve themselves in QI activities (i.e. QIW) was reduced if the physician was a specialist as opposed to being a primary care physician. Moreover, Audet *et al.* (2005) highlighted the fact that the physicians demonstrated a varying degree of willingness to share information concerning their clinical performance with the medical leadership of the health system in which they worked, scepticism towards making such data available for patients, and even greater scepticism towards making it available for the general public. The unwillingness of physicians to share information concerning their clinical performance, which would enable other parties to perform their own reviews and evaluations based on data associated with QI, indicates that the judgment of 'what is considered quality' is still perceived to be - first and foremost - an intra-professional matter. Furthermore, as expected, the authors highlight the fact that QI data was not routinely used by the physicians in evaluating their own performance – further underlining their perception of QI as not being an intrinsic part of their professional work. As such, the authors add to the multiplicity of research, underlining the fact that QI has not become an integral part of physicians' practices and indicating that professional specialization further decreases the perceived necessity of involvement in QIW.

In an effort to embrace both the unique contextual factors of healthcare – particularly the professional identity of physicians – as well as the complexity of achieving physicians' active involvement in QIW, Bååthe (2015) further elaborates upon the differences between the logic of professionalism and the logic of managerialism and its intricate role in obstructing physicians from engaging in QIW. Bååthe (2015) argues that physicians and managers live in separate worlds, speak different languages, and have different mindsets, with physicians focusing on their work with the patient 'here-and-now', while valuing professional autonomy and independence, and managers promoting the standards and principles of contemporary public sector reforms, all of which obstruct physicians from engaging in QIW, which is perceived to be derived from the 'world' (i.e. the logic) of management and managers. However, Bååthe (2015) goes beyond iterating specific factors which would enable the managerial logic, or the managerial world, to overcome resistance or shatter the autonomy of physicians. Instead, the author argues that the primary component in achieving active involvement is that "managers need to be appreciative of the mindset of physicians, and physicians need to better understand the mindset of managers" (p. 34), and that everyday human interaction is key to achieving such mutual appreciation. Following Bååthe's (2015) line of reasoning, it appears that

the relational aspects between different social actors are pivotal in 'bridging the worlds' of physicians and managers and achieving the active involvement of physicians in QIW, enabling QI interventions to emerge into fruition. Moreover, the conclusions underscore the necessity of mutuality in allowing such relations to emerge; it is not the sole responsibility of – or even possible for – one party/actor to achieve it. However, the conclusions have further implications for the process of managing and leading QI initiatives, as the focus ought to be shifted towards creating and maintaining the prerequisites for constructive relationships, i.e. relationships which facilitate everyday interactions and enable mutual appreciation and reciprocal influence to emerge, rather than meticulously identifying 'barriers to change' in the hope of trying to overcome them, as solely placing confidence in such an approach would be deemed unproductive considering the complexity of the task at hand (i.e. achieving involved healthcare professionals). Bååthe's (2015) study is an important contribution as it establishes the importance of understanding the differences between the 'worlds' of physicians and managers (i.e. the inherent content and distinct prescriptions of the logic of professionalism in contrast to the logic of managerialism) as serious obstacles to achieving the active involvement of physicians in QIW, but also through acknowledging the complexity of the matter. In doing so, Bååthe progresses beyond the idea that structural arrangements will, through causal mechanisms, enable organizational performance to be achieved (cf. Jun, 2009). Instead, derived from the author's conclusions, the focal point ought to be the relational aspects, and prerequisites for relations being and becoming constructive, of actors' interactions at the actor level of analysis, in overcoming and bridging the diverse points of departure resulting from the identification and adherence to the distinct logics (i.e. different worlds) in healthcare organizations.

Most studies detailed describe a set of barriers, as well as enablers for physicians to involve themselves in QIW. Perhaps this focus is unsurprising. As outlined, physicians have had the most power in controlling professionals' work and their great capacity to implement changes, as long as they are willing, is acknowledged by managers (Reay & Hinings, 2009). However, it is important to underline that there is a multiplicity of healthcare professionals, and it is nurses who actually constitute the major profession in terms of numbers (WHO, 2015). As such, it is important that healthcare professionals' perspectives on QI and involvement in QIW does not solely incorporate physicians. Broadening the research agenda does not lessen the importance of physicians' perspectives on QI initiatives and involvement in QIW, it simply accentuates the fact that outcomes are not solely dependent one profession. In an important contribution

to further widening the discourse of healthcare professionals' involvement in QIW, Eriksson *et al.* (2016) illustrate that the factors driving the involvement of physicians and nurses are diverse. Physicians are, more so than nurses, engaged by factors that are related to their professional work, professional traditions, and professional values (i.e. aligned with their professional logic), and factors that strengthen the position of their own profession within the organization (i.e. increasing professional autonomy and control over their work), while being generally sceptical towards tools and methods associated with managerially instigated QI interventions. Nurses, on the other hand, generally revealed more positive attitudes towards such tools and methods. As a result, their inherent qualities and the skills through which they were implemented had a more prominent role in involving nurses in QIW. The research by Eriksson *et al.* (2016) makes a distinct contribution in demonstrating that the presence of multiple professional groups within healthcare organizations adds to the contextual and complex elements that must be acknowledged in understanding QIW involvement, as the factors which influence physicians' involvement in QIW cannot simply be extrapolated to be applied to all professional groups. As such, different professions (e.g., physicians and nurses) must be understood as, at least partly, unique in this regard. This insight is well aligned with the historic, and contemporary, conditions for physicians and nurses to control their own work, and the likely attitudes towards managerially instigated QI interventions which these conditions entail. Hence, the study suggests that it is not sufficient to conceptualize the often negative attitudes towards QI initiatives and lack of involvement in QIW as depending on identification with and adherence to a static latent professional logic by healthcare professionals. In addition, if combined with the conclusions of Bååthe (2015), the findings of Eriksson *et al.* (2016) imply that there are more 'worlds', or at least variations of them, that need to be bridged. The suggestion is therefore that the importance of creating and maintaining constructive relationships, which facilitate interactions characterized by actors' reciprocal influence, is not solely to be attributed to the relationships between managers and physicians. Instead, constructive relationships, which enable variations of the professional logic to be bridged, are seemingly vital between and among all of the different social actors in healthcare organizations, if inclusive involvement by multiple groups of healthcare professionals in QIW is the desired outcome. These insights ought to become integral in research aiming to further address the involvement of healthcare professionals in QIW and its contextual and complex elements.

To sum up, the perspective of professional healthcare employees, which entails studying healthcare professionals' perspectives on QI and involvement in QIW,

has placed the focus on their aversion towards QI and their lack of engagement in QIW. Physicians have been the professionals most exposed to scrutiny, and studies often attribute their laissez-faire attitudes to be a consequence of QI introducing new ways to denote quality, as well as how it ought to be achieved, in relation to the previously unchallenged social mandate of physicians to judge and manage quality. However, following the inherent conflict between the professional and the managerial logic, and the augmented opposition towards managerial influence on professional work that increased identification and adherence to the professional logic brings about, the hesitation of physicians in relation to QI and involvement in QIW is interlinked with a broader, general, conflict between physicians and managers over who, and on what basis, holds the mandate to dictate practice. The conflicts resultant on identification and adherence to diverse logics in healthcare have been empirically established as frequent and beneficially studied utilizing the concept of institutional logics. However, thus far little attention has been given to utilizing the institutional logics concept in studying healthcare professionals' perspectives on QI and involvement in QIW. However, research addressing these topics often focuses on the barriers that hinder physicians from involving themselves in QIW, and in so doing often, at least implicitly, highlight the inherent conflict between physicians and managers as vital in understanding the lack of such involvement. Nonetheless, the findings of the fairly comprehensive studies which address these barriers are often congruent in their conclusions: that there is little hope of finding universal, linear, and static barriers that once overcome would expedite the involvement of physicians in QIW. Comprehending the effects of QI initiatives at the actor level seems to be far too complex and contextually tangled for such universal barriers to be identified. In an effort to go beyond conceptualizing the lack of involvement in QIW by physicians as a set of factors that needs to be identified and barriers that need to be overcome, Bååthe (2015) argues that the most vital component in achieving the involvement of physicians in QIW, and making QI initiatives more constructive, is relationships that facilitate interactions characterized by mutual appreciation and understanding between physicians and managers. However, as previously noted, it is important to underline the fact that physicians are not the only professionals in healthcare. In outlining the diverse factors influencing the views of QI initiatives by physicians and nurses, Eriksson *et al.* (2016) suggest that the starting point for different professional groups to involve themselves in QIW, and their propensity to accept managerial attempts to control professional work, must be understood as partly unique. Perhaps more importantly, the findings of Eriksson *et al.* (2016) imply that intra-professional differences entail that it is not only the relationships between physicians and managers that matter; constructive

relationships seem to be important across professional boundaries as well. If involvement in QIW is contingent on constructive relationships, this surely applies to some degree to all social actors within healthcare organizations in order to achieve the inclusive involvement of multiple professions in QIW. In proceeding to provide a rationale for the research purpose and outline the research questions, indulging in further research aimed at outlining the distinctive barriers to involvement in QIW appears questionable. Instead, it seems pivotal when studying the prerequisites for healthcare professionals' involvement in QIW at the actor level of analysis to address constructive relationships which facilitate interactions between different professional groups and managers alike that enable them to understand, appreciate, and influence each other despite the different logics, the different 'worlds' that affect their perspectives.

Research purpose and research questions

Quality improvement (QI), a manifestation of the managerial logic concomitant upon reforms associated with NPM, has not achieved the desired results and outcomes in healthcare organizations, despite healthcare being the subsector that has been the target of the majority of initiatives to effect change in the public sector. Instead, healthcare organizations have been viewed as notoriously difficult to change, and it is argued that actual practice has remained relatively stable as institutionalized professional modes of working remain entrenched (Ackroyd *et al*., 2007). The failure of QI and contemporary reform efforts in general to achieve the desired change is primarily attributed to the inability of its initiators to comprehend the means through which people's actions and behaviour are modified - failing to adequately address contextual and complex elements at the actor level of analysis (cf. Dunleavy & Hood, 1994; Cabana *et al.*, 1999; Dijkstra *et al.*, 2000; Grol & Wensin, 2004; Hood & Peter, 2004; Osborne, 2006; Dunn & Jones, 2007; Jun, 2009; Nyland *et al.*, 2009; Powell *et al.,* 2009; Ohemeng, 2010; Pollit & Dan, 2011; Pedersen & Löfgren, 2012; Tummers, 2012; Bååthe, 2015; Eriksson *et al.,* 2016). In studying healthcare professionals' involvement in QIW, placing the focus on the actor level of analysis thus becomes integral. The aim of this dissertation is to address the lack of such a focus.

> *The research purpose of this dissertation is to describe and analyse the active involvement of healthcare professionals in quality improvement work (QIW) in healthcare organizations at the actor level of analysis.*

Previous research aiming to overcome the obstructions to healthcare professionals involving themselves in QIW has highlighted the fact that universal barriers are unlikely to be found. However, they have also shown that aversion towards QI and lack of involvement in QIW are linked to a broader and more general conflict between healthcare professionals and managers concerning who holds the mandate to dictate practice. This conflict originates from the distinct prescriptions inherent in the professional logic and the managerial logic in relation to the legitimate basis for controlling and organizing professional work, whose effects have been studied extensively utilizing the institutional logics concept. However, there is a lack of research utilizing the institutional logics concept which focuses on the actor level of analysis when studying healthcare professionals' perspectives on QI and involvement in QIW. This scarcity means that the explanatory value in explicitly framing the lack of healthcare professionals' involvement in QIW as resulting from the incompatibility between the professional logic and the managerial logic, and the distinct "worlds" and mindsets their identification and adherence entail, is untapped. Perhaps more importantly, the lack of explicitly utilizing institutional logics prevents a conceptualization of the involvement of healthcare professionals in QIW as successful efforts to bridge different logics and hence hinders the systematic outlining of the preconditions for the often irreconcilable perspectives to constructively function in symbiosis. Consequently, utilizing the institutional logics concept is a cornerstone in addressing research question 1:

> *How do the professional and managerial logics affect healthcare professionals' involvement in QIW?*

As previously discussed, it is mainly the lack of physicians' involvement in QIW that has been addressed in research. While physicians certainly are influential and powerful actors within healthcare, this unilateral perspective is inadequate in embracing the contextual and complex elements of healthcare organizations that are often highlighted. Paying attention to context entails addressing the diverse ability of different healthcare professions to exercise control over professional work, healthcare organizations' distinct division of labour, and inter-professional power discrepancies. All these aspects affect identification with and adherence to the professional logic and its inherently axiomatic view that professional control of work is legitimate. Embracing complexity entails acknowledging the effects of this contextual idiosyncrasy in practice. As such, it is vital that

research concerning the involvement of healthcare professional does not solely include physicians, but also includes other healthcare professions. Perhaps it is most pressing to address the lack of inclusion of nurses in studies concerning healthcare professionals' involvement in QIW; a profession which has not enjoyed the attention it deserves in relation to its vast numbers and their concomitant impact on practice. However, it is important that the professions' discrepancies are acknowledged and the nursing profession is partly addressed as uniquely juxtaposed to physicians in relation to involvement in QIW. In an effort to make the differences between physicians and nurses explicit and to further broaden the research agenda of healthcare professionals' involvement in QIW to incorporate nuances, research question 2 is:

> *How does physicians' and nurses' identification with and adherence to the professional logic constrain and enable diverse approaches and practices in QIW?*

Previous research argues that QI has not become an intrinsic part of healthcare professionals' everyday work, which Batalden and Davidoff (2007) claim is a prerequisite for healthcare to realize its full potential, and QI is certainly not perceived as "business as usual", which has been argued as pivotal for QI to truly penetrate the culture of healthcare organizations (Riley *et al.*, 2010). Despite the fact that QI has not achieved this state, its presence and impact is unquestionable following its institutionalization in practice, with it now co-existing with traditional professional values and beliefs (Audet *et al.*, 2005). Consequently, the professional logic and the managerial logic now both constitute strong institutionalized presences in healthcare. However, how practice at the actor level of analysis is affected by the continuous presence of these two logics, beyond the fact that it often generates conflict between professionals and managers, is often omitted. Whereas studies have highlighted the fact that professional practice often remains stable and entrenched (e.g., Audet *et al.*, 2005; Ackroyd *et al.*, 2007), some aspects of QI have achieved the status of mandatory parts of contemporary care provision. The QI underpinning that the provision of care should be provided utilizing a combination of multiple perspectives and different points of views (Batalden & Stolz, 1993) has become a contemporary organizing principle following the widespread application of the multi-professional team (MTP) in healthcare (Grumbach & Bodenheimer, 2004). The idea that multiple professionals are engaged, and are equally

important, in creating quality of care contradicts the traditional division of labour in healthcare organizations (Freidson, 1986; Abbott, 1988, Freidson, 2001), where physicians saw themselves as "lone agents of success or failure" (Berwick, 1989, p. 55). Difficulties in achieving MPTs where multiple perspectives are utilized are often noted (e.g., Atwal & Caldwell, 2005; Sargeant *et al.*, 2008), albeit it being uncommon that these difficulties are studied rigorously. Instead, they are often solely attributed distinct professional roles and/or the authoritarian role of the physicians. Moreover, studies often lack in-depth empirical accounts of what *actual* effects the MTP may have in practice and the circumstances engendering these effects. There is consequently a dearth of studies addressing the actor level of analysis in understanding the involvement of healthcare professionals in QIW (teamwork in MPTs being an example of QIW), as affected by the co-existence of the institutionalized presence of QI combined with older, traditional, ways of working, while ultimately dependent on the interactions and actions of actors. In order to address this dearth, research questions 3 is:

> *How may organizing in multi-professional teams affect practice and thereby be of relevance for explaining the conditions for QIW?*

Whereas significant research has been undertaken which addresses the difficulties in achieving healthcare professionals' involvement in QIW, albeit with physicians often remaining in focus, and the multitude of factors that might hinder that involvement being fairly well explored, research addressing the prerequisites for healthcare professionals' involvement in QIW is not as plentiful. The emerging notion that constructive relationships, i.e. relationships that facilitate everyday interactions and which enable mutual appreciation and reciprocal influence, between physicians and managers are pivotal to achieve physicians' involvement in QIW (Bååthe, 2015), needs to be further studied and conceptualized in relation to the multiplicity of social actors within healthcare organizations. As previously noted, it is not only the 'worlds' and mindsets of physicians and managers that need to be taken into account. Moreover, there is a lack of studies addressing and illustrating ways in which constructive relationships are able to bridge the different 'worlds', the different mindsets, that actors who primarily identify with and adhere to a certain logic often take for granted. As a result, analyses regarding *how* interactions might bridge actors' logics and mindsets, as well as the consequences such interactions might have in

facilitating healthcare professionals' involvement in QIW, are left incomplete. Consequently, research question 4 is:

> *How might interactions between individual actors enable logics to be bridged and in turn facilitate healthcare professionals' involvement in QIW?*

In summary*, the research purpose of this dissertation is to describe and analyse the active involvement of healthcare professionals in quality improvement work (QIW) in healthcare organizations at the actor level of analysis.*

This is achieved through addressing the following research questions:

> *RQ1: How do the professional and managerial logics affect healthcare professionals' involvement in QIW?*
>
> *RQ2: How does physicians' and nurses' identification with and adherence to the professional logic constrain and enable diverse approaches and practices in QIW?*
>
> *RQ3: How may organizing in multi-professional teams affect practice and thereby be of relevance for explaining the conditions for QIW?*
>
> *RQ4: How might interactions between individual actors enable logics to be bridged and in turn facilitate healthcare professionals' involvement in QIW?*

Arrangement

The remainder of this dissertation is structured as follows. The next chapter, chapter 2, presents the theoretical framework, the institutional logics perspective, utilized in its broader sense, incorporating both concepts of institutional logics and institutional work (Thornton *et al.*, 2012), which has served as an inspiration and analytical tool in writing this dissertation and its appended papers. Further, this chapter includes a discussion concerning the viability and necessity of combining concepts, institutional logics and institutional work in order to study both the rigidity of institutional arrangements as well the circumstances and prerequisites for them to be loosened. The utilization of the institutional logics perspective in healthcare organizations, in its broader sense, enables an in-depth understanding of, and elaboration upon, the contradictions between, and among, social actors, contradictions that often inhibit the involvement of healthcare professionals in QIW, as well as

contributing to the emerging, both empirical and theoretical, body of knowledge aiming to understand the relational aspects of overcoming such contradictions, enabling them to be bridged. Chapter 3 then presents the methods utilized and the study's setting. This chapter addresses the research approach and strategy, design, data collection, data analysis, and the generalizability and validity of the study, as well as the pre-study which was undertaken in order to identify a suitable case for the study. In addition, chapter 3 further explores global healthcare systems' expansions and challenges (with an emphasis on the Swedish situation) before outlining the specific empirical setting of the case studied. Chapter 4 presents the results of the study in addressing each of the specific research questions in relation to the findings of the papers; each research question is addressed specifically in one paper. The dissertation is then brought to a close in chapter 5, with the individual contributions of each individual paper synthesized in order to address the overarching research purpose in outlining the study's conclusions and contribution, while additionally addressing theoretical reflections and contributions, practical implications and suggestions for future research.

Theoretical framework

As previously noted, the institutional logics concept has been utilized in order to place the focus on the multifarious basis that influences the actions and behaviour of social actors in healthcare, whereas conflicts are often attributed logic incompatibility. However, the explicit utilization of the institutional logics concept in studies addressing healthcare professionals' involvement in QIW is modest – despite lack of involvement often being attributed to diverse perspectives of social actors, incorporating different mindsets concerning what denotes quality of care as well as how it ought to be achieved. This chapter commences by briefly presenting contemporary criticism directed at institutional theory in order to contextualize the origins of institutional logics and institutional work, both concepts included in the institutional logics perspective, and the problem areas these concepts aim to address. Thereafter, the institutional logics concept is presented in depth, along with its utilization in studies addressing healthcare. The chapter then presents the institutional work concept and concludes with an elaboration of the potential of utilizing the institutional logics perspective in its broader sense, incorporating both concepts of institutional logics and institutional work in relation to the research purpose of the dissertation as it enables illumination of both the elements that contribute to the rigidity of institutional arrangements in healthcare organizations as well as small deviations from such that may potentially, in the prolonging, induce organizational as well as institutional change.

Actors and change – what is missing in institutional theory

The institutional logics perspective has its theoretical roots in institutional theory (Thornton *et al.*, 2012). The rise of neo institutional theory originated with the seminal research of Meyer and Rowan (1977) and DiMaggio and Powell (1983) who instituted a revival of institutionalism in organization studies - a revival that has led to institutionalism still exerting a major influence in organization studies (Scott, 1987; Tolbert & Zucker, 1996; Scott, 2014). However, the expansion of institutional theory has entailed its widespread application to a broad range of organizational and institutional phenomena – an expansion that has been critiqued. Clegg (2010) criticizes institutional theory for being mechanical and mechanically adopted, characteristics entailing a lack of sufficient attention to the micro-level of analysis. Clegg argues that in order to address this lack, institutional theory and its adversaries must reduce its inherent functionalism and improve the ontological depth of institutional accounts while bringing agency, practice, and structure to the forefront of its analysis. Following suit, Suddaby (2010, p. 15) asks critically: "If the central puzzle of institutional

theory is to understand why and how organizations adopt processes and structures for their meaning rather than their productive value, why has 'meaning' disappeared from institutional theory?", simultaneously pointing out the worrying lack of attention paid towards individual actors in institutional research, a lack that it is argued renders a picture of organizations as "uninhabited" (Bévort & Suddaby, 2016). As Suddaby (2010) points out, in order to address the micro-level of analysis it is important that the individual actor is perceived as a vital component in understanding organizations, to be able to undertake an internal perspective that focuses less on organizational products and more on the organizational and individual processes of handling institutional pressure and complexity. To sum up, by disregarding the micro-level of analysis and the individual actors inhabiting it, institutional theory is critiqued for being unable to focus on the basis for reasoning and sensemaking in everyday work. The suggested outcome is that institutional theory is unable to adequately address agency, and explain organizational and institutional change - as the intentions, actions, and rationales of actors are strictly and solely conditioned by the institutions to which they belong.

Albeit the prospect of change and the necessity of acknowledging the potential impact of individual actors has been given moderate attention in institutional theory, for instance in studies categorized under the constructivist approach that is often referred to as Scandinavian institutional theory (see Czarniawska & Joerges, 1996; Sahlin & Wedlin, 2008; Eriksson-Zetterquist, 2009), the call to shift focus from outcomes and products of institutional influences to its internal processes (Suddaby, 2010) has mainly been addressed in mainstream research utilizing one of the concepts of *institutional entrepreneurship* (Hardy & Maguire, 2008), *institutional logics* (Thornton *et al.*, 2012) or *institutional work* (Lawrence & Suddaby, 2006). However, institutional entrepreneurship, which refers to the "activities of actors who have an *interest in particular institutional arrangements* and *who leverage resources* to create new institutions or to transform existing ones" (Maguire *et al.*, 2004, p. 657, emphasis added), which further allows these actors – these institutional entrepreneurs – to "*create a whole new system of meaning* that ties the functioning of disparate sets of institutions together" (Garud *et al.*, 2002, p. 196, emphasis added), has been critiqued to emphasize a narrow spectrum of strong – or even heroic – individuals with the cognizant interest to gather resources in order to exert power to overthrow existing institutions (e.g., Delmestri, 2006; Meyer, 2006; Lawrence *et al.*, 2013). Consequently, the suggestion is that the paradox of embedded agency remains unsolved in studies of institutional entrepreneurship (Leca *et al.*, 2008), as the concept "offers us a world designed by farsighted and

clever humans that is as implausible as it is attractive" (Aldrich, 2011, p. 1). It is therefore argued that institutional entrepreneurship is poorly equipped to place the focus on the everyday, mundane work of actors as well as organizational and institutional emergence in its attempt to reintroduce change and agency in institutional theory.

It has been proposed that institutional logics, on the other hand, is able to meaningfully bring "down" the effects of institutions to the individual actor level of analysis, while simultaneously being able to maintain the importance of the agency of actors within organizations (Clegg, 2010; Suddaby, 2010). However, whereas the concept of institutional entrepreneurship is critiqued for overrating the potential of, at least certain, individuals to exercise agency seemingly regardless of institutional constraints and arrangements, it has been insinuated that the concept of institutional logics deprives individual actors of agency, depicting them as trapped by institutional arrangements and unable to transcend them in any way, shape, or form (Lawrence *et al.*, 2009). This insinuation is seemingly not uncalled for. In reviewing institutional logic studies, Zilber (2013) concludes that they are predominantly focused on macro-level processes, often highlighting logic transformations over long periods of time, whereas there are few studies focusing on the effects of institutional logics on the ground – the day-to-day experiences and behaviour of individual actors. Such singular approaches do not enable focus to be placed on the micro-level of analysis, nor do they facilitate studying the, albeit constrained, agency of individual actors, their interactions, or the interrelated emergence of organizational and institutional change. Consequently, studies conducted during the initial stages of the proliferation of the institutional logics concept did not sufficiently address the primary critique of institutional theory.

However, there has recently been an increase in efforts aiming to address these shortcomings as studies focusing on the individual actor level have been performed (e.g., Empson *et al*., 2013; McPherson & Sauder, 2013; Pache & Santos, 2013a; Arman *et al*., 2014; Kristiansen *et al*., 2015; Smets *et al.*, 2015; Wright *et al.*, 2015; Bévort & Suddaby, 2016; Reay *et al.*, 2016; Styhre *et al.,* 2016). These studies highlight the effects of institutional logics "on the ground", while conversely illustrating the potent agency of individual actors to manoeuvre institutional complexity in their mundane day-to-day work as they, for instance, employ different institutional logics to achieve desired outcomes (McPherson & Sauder, 2013), establish new organizational routines through sensemaking processes instigated by diverse demands prescribed by distinct logics (Kristiansen *et al*., 2015), or even exercise a considerable degree of freedom in reinterpreting logics (Bévort & Suddaby, 2016).

As these studies relate to the micro-foundations of institutional logics, and subsequently to the micro-foundations of institutions (cf. Powell & Colyvas, 2008; Cloutier & Langley, 2013), the recent developments within institutional logics studies reveal scholarly convergence towards another interrelated concept proclaimed to focus on the processual aspects of institutions: institutional work (Lawrence & Suddaby, 2006; Lawrence *et al.*, 2009). While both concepts of institutional logics and institutional work are included in the broader institutional logics perspective, when comprehended as a perspective that "provides an overarching meta-theory that can contribute to wider scholarly interest in practice by emphasizing the embeddedness of individuals in society and institutional fields and providing a theoretical architecture that makes contribution to knowledge more visible" (Thornton *et al.*, 2012, p. 180), they have come to explore varied and complementary aspects of institutional dynamics, making their combined efforts generative in offering a more nuanced and balanced view of institutional processes (cf. Zilber, 2013). Before elaborating upon the concepts' inherent tension, and the rationale as to why their combination is deemed to be beneficial and productive in this dissertation, the fundamentals of both concepts will be individually presented.

Institutional logics

The concept of institutional logics was first introduced by Friedland and Alford (1991), who defined institutions as "supraorganizational patterns of human activity by which individuals and organizations produce and reproduce their material substance and organize time and space. They are also symbolic systems, ways or ordering reality, and thereby rendering experience of time and space meaningful" (p. 243). Each institution provides and makes available a corresponding institutional logic, which organizations and individuals are able to employ in order to rationalize actions and behaviour - incorporating both material practices as well as symbolic constructions. In introducing the concept of institutional logics, Friedland and Alford (1991) make visible the connection between the individual, organizational and institutional level of analysis, while emphasizing their interconnectedness.

> Individual action can only be explained in a societal context, but that context can only be understood through individual consciousness and behavior (p. 242).

Moreover, the authors underscore that individuals and organizations are institutionally constrained, entailing that institutions, and hence institutional logics, constrain action and behaviour, however, they do not determine them. Instead, organizations and individuals have a certain capability to

"elaborate" (p. 248) upon the institutional logics available to them. In addition, Friedland and Alford (1991) underscore that contradiction between institutional logics – and the contradiction between the individuals adhering to diverse logics – is key in understanding how organizations and individual actions are shaped.

> Some of the most important struggles between groups, organizations, and classes are over the appropriate relations between institutions, and by which institutional logic different activities should be regulated and to which categories of persons they apply (p. 256).

In a later definition, Thornton and Ocasio (1999, p. 804) denote institutional logics as "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality", underlining the notion that the core assumption of the institutional logics framework is that individual agency and action, which are embedded, are enabled and constrained by prevailing institutional logics (Thornton & Ocasio, 2008). In an effort to express the core of the institutional logics perspective Greenwood *et al.* (2011, p. 318) state that institutional logics "provide guidelines on how to interpret and function in social situations".

As previously mentioned, it has been proposed that institutional logics is able to meaningfully bring 'down' the effects of institutions to the actor level of analysis, while maintaining the importance of the agency of actors within organizations (Clegg, 2010; Suddaby, 2010). Institutional logics may thus be understood as a retort to the critique aimed at neo-institutionalism, encompassing the perceived failure to address the micro-level of analysis – the agency and practice within organizations – while suffering from inherent functionalism, applying theory mechanically, and lacking the ontological depth of institutional accounts (Clegg, 2010). As noted, acknowledging the significance of, and studying, individual actors is important in addressing the aforementioned critique as it enables an internal perspective that facilitates focusing on the individual and organizational processes of handling institutional pressure and complexity (Suddaby, 2010). In addition, institutional complexity, understood as the incompatible demands prescribed by multiple institutional logics (Greenwood *et al*., 2011), is often claimed to characterize healthcare organizations (e.g., Scott *et al.*, 2000; Ferlie & Shortell, 2001; McDaniel & Driebe, 2001; Plsek & Wilson, 2001; Begun *et al.*, 2003; Dopson & Fitzgerald, 2006; Rouse, 2008; Reay & Hinings, 2009; Waring & Bishop, 2010; Greenwood *et al.,* 2011; Hanson & Ford, 2011).

As such, utilizing the institutional logics concept in healthcare enables the study of practice, where practice is understood as the intertwined impact of institutional constraints and individual agency in shaping actions and behaviour, at the actor level of analysis. The interest in understanding what actors do, and why, through utilizing institutional logics is aligned with that of the turn to practice (Schatzki, 2001), where practices are understood as "embodied, materially mediated arrays of human activity centrally organized around shared practical understanding" (Schatzki, 2001, p. 11), and more specifically to the turn to practice in organizational research, with the common denominator that practice is understood as a combination of structural preconditions and individual agency (Whittington, 2011). However, the explicit connection between institutions and institutional logics enables the study of practice without explaining empirical phenomena on their own merits, letting the collective nature of practice remain obscure (cf. Whittington, 2011). Institutional theory is commended for its well-established theoretical approach, with strong empirical and theoretical foundations, but often critiqued as lacking satisfactory understanding of the actor level of analysis (see Suddaby *et al.*, 2013). Hence, utilizing institutional logics when studying the actor level of analysis in healthcare organizations enables this level to be studied with the ability to address the most common critique aimed at studies of practice, i.e. getting stuck in describing empirical phenomena, explaining them solely by their own merits, while lacking theoretical anchorage and failing to achieve cumulative knowledge (cf. Suddaby *et al.,* 2013; Seidl & Whittington, 2014). As previously outlined, healthcare organizations are entrenched in institutionalized norms, which make the explicit connection between these norms and the practice of actors pivotal.

The concept of institutional logics in healthcare

Studies explicitly utilizing the concept of institutional logics are fairly frequent in healthcare settings, often with the aim of explaining and elaborating on the frequently established incompatibility between professionals and managers (cf. Scott *et al.*, 2000). Reay and Hinings (2005) conclude that the logic of medical professionals coexist contemporaneously with a new logic: the logic of business-like healthcare. However, they underline the fact that the previously dominant logic is still very present, guiding a profoundly influential actor in the field: the physicians. This struggle is a reoccurring theme elaborated by most research - the professional logic of physicians versus the managerial logic (i.e. the business-like logic) - inspired by the notion that the new institutional order has not replaced old institutional patterns (e.g., Kitchener, 2002; Bovenkamp *et al.*, 2014). The unwillingness of medical professionals to adhere to the new

managerial logic is further explored by Doolin (2001), illustrating that medical professional identity and autonomy often prevent physicians from adopting a managerial role. Similar findings are presented by Kirkpatrick *et al.* (2009), who highlight that physicians are often unwilling to be involved in the management of the health service due to the incompatibility with their professional logic (see also Llewellyn, 2001).

Reay and Hinings (2009) elaborate how the two logics, "business-like health care" (i.e. the managerial logic) and "medical professionalism" (i.e. the professional logic) co-exist and how they are reflected in everyday activities. Their research found that physicians and managers were able to maintain their individual logics even during mutual collaborations. However, such collaboration occurred on a case-by-case basis, contingent on a perceived, pressing need to achieve a mutually desired goal. Moreover, such collaboration depended upon the physicians' abilities to maintain their own identities. The authors also highlight how the influential physicians may maintain the status quo – by guiding and constraining decision makers – while also acknowledging that managers recognize physicians' ability to facilitate change when willing to do so. Although Reay and Hinings bring the research of institutional logics down to the micro-level of analysis, they clearly denote physicians and managers as being distinctly guided by a single institutional logic. As such, albeit their study is pivotal in acknowledging the continuous interplay between, and presence of multiple, institutional logics in practice, their study does not address the contemporary focus of institutional logics studies, i.e. the organizational emergence and agency of actors in reinterpreting or employing various logics, but rather illustrates a fairly static dynamic of conflicting logics at the actor level of analysis.

A similar relationship between nurses and managers is presented by Broek *et al.* (2014), who utilize institutional logics while studying the implementation of an innovative practice to organize the work of the nursing staff at a Dutch hospital. They found that the new practice initially appeared to apply to both the nursing professional logic, with the aim of achieving a high quality of care, as well as to the business-like logic, in terms of increasing productivity. However, the implementation of the goals associated with the business-like logic was perceived as having been given priority. This resulted in a lack of commitment to implementation on the part of the nurses, as it did not fit what they believed to be of importance (i.e. coherent with their professional logic). Broek *et al.*'s result is not surprising as it specifically underlines the difficulties of multiple co-existing logics in relation to adopting and implementing new practices (i.e. QIW). It also adds to research by taking an explicit approach towards the

nursing professional logic - encouraging future research to take on a more holistic approach towards professional logics in healthcare organizations.

Arman *et al.* (2014) make a significant contribution by elaborating on the co-existence of multiple logics at the actor level. They illustrate the interactions between different actors adhering to different logics; how logics are manifested by individuals and the impact of multiple logics in practice. Arman *et al.* found that the managerial logic was given credence over the professional logic, a result not uniformly found in previous studies. An interesting aspect is that the majority of professionals in the study were not physicians, indicating that hierarchization does not only occur between the managerial logic and the professional logic but also among professional logics and that different professional actors are able to have a varied amount of influence when faced with the managerial logic. As such, the study implicitly underlines the importance of not generalizing professional actors and their ability to handle the contradictory managerial logic. However, the study does not explicitly explore these discrepancies.

As highlighted above, most research on institutional logics in healthcare organizations takes the same stance. The focal point of attention being actors adhering to a specific logic and the conflict between the logics, and consequently between the actors adhering to different logics. Consequently, few studies have focused upon how different logics might influence the actions of an individual actor. As such, their ability and agency in manoeuvring the institutional complexity of healthcare organizations are left unelaborated and the emergence of organizational practices as dependent more nuanced and elaborate interactions of logics than simply attributed to the conflict between the managerial and the professional logics is not sufficiently explored.

These shortfalls have recently begun to be addressed. Kristiansen *et al.* (2015) show how nurses are able to handle the demands prescribed by the managerial logic through sensemaking, establishing new organizational routines incorporating the demands prescribed by their own professional logic, as well as the managerial logic. These findings are vital, establishing that the everyday work of healthcare professionals may incorporate elements prescribed by the managerial logic, and that the conflict between the professional logic and the managerial logic is an inadequate approach to understanding the actions of actors and subsequently insufficiently able to capture the nuances of organizational practice. The possibility for nurses to reconcile the diverse demands prescribed by the distinct logics are further addressed by Currie and Spyridonidis (2016), who highlight that nurses may be able to incorporate the

managerial logic in everyday work – exhibiting agency while doing so – due to their low-status compared to physicians. As such, Currie and Spyridonidis reinforce Arman *et al*.'s (2014) implicit notion that different professional actors in healthcare organizations relate to, and are able to handle, the managerial logic differently. Consequently, while professionals may incorporate elements prescribed by the managerial logic in their everyday work, the preconditions for doing so are diverse. Hence, there is a need to further broaden the conceptualization of "the professional logic" to incorporate variations, or at least nuances, in it in order to capture the distinct characteristics of healthcare organizations and the multiplicity of professionals occupying them in order to understand the involvement of healthcare professionals in QIW as interrelated adherence to and identification with the professionals logic.

In summary, utilizing the institutional logics concept in this study enables the established conflicts between healthcare professionals and managers to be studied, understood and explained as the result of contradictions between distinct institutional logics at the actor level of analysis. Accordingly, the lack of involvement in QIW by healthcare professionals may partly be studied with the point of departure that it depends on adherence to and identification with distinct institutional logics. However, the potential to utilize the institutional logics concept in studying the involvement of healthcare professionals in QIW transcends a focus on static states and reframing conflicts, it also enables a study of the conditions for various social actors to exercise agency, both in employing logics other than their 'home' logic and in exercising significant degrees of freedom in translating logics, and the emergent characteristics of practice in the context of institutional complexity and the dynamics instigated by the QIW. As such, this study takes account of the notion that social actors do not automatically reflect the predetermined content of a specific institutional logic, but nevertheless acknowledges the impact of healthcare's highly institutionalized setting in practice. A more dynamic and nuanced approach towards studying the ability of social actors to handle institutional complexity has begun to emerge (e.g., McPherson & Sauder, 2013; Kristiansen *et al*., 2015; Bévort & Suddaby, 2016; Reay *et al.*, 2016), however, thus far there is a lack of studies embracing this approach in healthcare settings. This dissertation aims to address this lack.

Institutional work

The concept of institutional work was first introduced by Lawrence and Suddaby (2006) in an effort to reorient institutional approaches to organization theory away from focusing upon the governing and constraining effects of

institutions on actions towards how actions can be understood as also affecting institutions. In a later contribution, Lawrence *et al.* (2009) underline the fact that it is the mundane, day-to-day, activities of actors that constitute institutional work in creating, maintaining, and disrupting institutions. Moreover, the authors argue that while institutional work is always contextually embedded, with institutions regularizing and constraining actors, this does not mean that actors are considered to be "cultural dopes", mindlessly reproducing institutional arrangements. Instead, actors are able to act, despite being institutionally embedded. Agency is thus perceived to be something that goes beyond reactions towards institutional pressures and actors are capable of undertaking intentional actions. This entails actors being able to "transcend the totalizing cognitive influence of institutions" (Lawrence *et al.*, 2011, p. 54).

Lawrence *et al.* (2011) establish that institutional work focuses upon the activities of "creating, maintaining, and disrupting institutions", rather than the accomplishments of "creation, maintenance, and disruption of institutions". As such, institutional work places the focus on the processual aspects of practice rather than perceiving practice as a linear process of achieving a certain state. Thus, institutional work enables studying a flux state of becoming, rather than the static state of being, in underlining the - however small - continual movements of institutions, and institutional arrangements. Although institutional work is defined as "*purposive action aimed at* creating, maintaining, and disrupting institutions'" (Lawrence & Suddaby, 2006, p. 217, emphasis added), it is argued that intentionally must be understood as incorporating a wide range of levels (Battilana & D'Aunno, 2009) or even as the intention of actors to accomplish their everyday, mundane, practical work (Smets & Jarzabkowski, 2013). As such, the alternative reading of understanding institutional work as "all human action that has institutional effects" (Lawrence *et al.,* 2009, p. 13) is more fruitful when aimed at studying emergence as it highlights the effects of actions in relation to creating, maintaining, or disrupting institutions – regardless of intent. After all, as "successful influence attempts by a delimited 'actor,' carrying a specific 'interest,' represent only one category of possible social change explanations, and successful change arguments need not be limited to it" (Jepperson, 1991, p. 158), downplaying the role of purposive action enables a more inclusive basis for comprehending the underpinning of institutional work, i.e. how actors and their actions also affect institutions. As such, institutional work does not only encompass deliberate actions of actors to create, maintain or disrupt institutions, but also "*the everyday getting by of individuals and groups* who reproduce their roles, rites, and rituals at the same time that they challenge, modify, and disrupt them" (Lawrence *et al.*, 2011, p. 57, emphasis added).

In contrast to the institutional logics concept, few studies have utilized institutional work in a healthcare setting. The most notable exception being Currie *et al.* (2012), who studied the institutional work, at the actor level of analysis, instigated as a result of managerial initiatives to implement new policy-driven roles for healthcare professionals. Currie *et al.* (2012) found that these policies were perceived as a threat to the power of the elite professionals (clinical geneticists in this case), who consequently indulged in various forms of institutional work aiming to maintain, or even strengthen, their positions. As such, the authors illustrated how institutional work may hinder radical change in healthcare and thus highlight the connection between institutional work and the rigidity of institutional arrangements in healthcare organizations. Moreover, in illustrating how a policy that was intended to alter practice resulted in the further reinforcement of institutional arrangements, Currie *et al.* (2012) highlight how managerially instigated QI may result in QIW with unintended consequences. Consequently, the study is essential in making explicit the viable utilization of institutional work focusing on healthcare professionals' perspectives, including their relative social position, when studying their involvement in QIW. There are other studies (e.g., Finn *et al*., 2010; Suddaby & Viale, 2011; Wright *et al*., 2015) which have, to some extent, studied institutional work in relation to aspects relevant for healthcare. However, empirical institutional work studies tend to focus on the macro-level of analysis, while rarely investigating the interaction of individual actors (Empson *et al.*, 2013).

In this study, utilizing the concept of institutional work enables the focus to be placed on how the actions and interactions of actors may affect the institutions that make institutional logics available in healthcare organizations. In relation to the concept of institutional logics, which is often better equipped to explain the rigid nature of institutional arrangements and the effects they have on actors in healthcare organizations, the most notable, and previously unexplored, prospect of institutional work is the way it facilitates understanding of how interactions, and the prerequisites for such interactions, between actors may loosen institutional constraints. As such, institutional work is utilized in this study in order to focus on actors' actions and interactions in QIW which transcend maintaining institutional work (i.e. actions and interactions that transcend the status quo), in order to complement the concept of institutional logics. The possibility of combining the concepts of institutional logics and institutional work, as well as their relation, is further outlined below.

Combining institutional logics and institutional work

There is a need to understand both the rigid and the dynamic aspects of the practices of healthcare professionals in order to understand QIW at the actor level of analysis. As previously mentioned, the institutional logics concept focuses upon how institutions make logics available which – at the actor level of analysis – provide guidelines for actors "on how to interpret and function in social situations" (Greenwood *et al.*, 2011, p. 318), providing a basis upon which people construct their individual day-to-day experiences (Thornton *et al.*, 2012). The concept is thus able to explain the major discrepancy and conflict between different healthcare professionals and managers in healthcare organizations, as they adhere to different institutional logics, with healthcare professionals adhering to different forms of medical professionalism and managers to the economic rationale of business-like healthcare (cf. Reay & Hinnings, 2005), entailing different mindsets and incorporating different understandings of what constitutes quality and how quality should be improved. These contradictions within healthcare organizations have previously been analysed utilizing the institutional logics concept, but relatively little effort has been aimed at addressing QIW specifically. The practices of QIW and the lack of involvement by healthcare professionals in QIW would consequently benefit from an elaboration utilizing the institutional logics concept.

Albeit the institutional logics concept has always underlined the fact that actors are able to exercise agency in relation to the guidelines which the logics provide (Thornton *et al.*, 2012), the main focus of the institutional logics concept is to understand how institutions might guide actors and actions rather than how actors and actions might also affect institutions, as is the focus in institutional work. While it is important to acknowledge the rigidity of institutional logics at the actor level of analysis in healthcare organizations, it is notable that social actors – albeit rarely – are able to bridge the 'worlds' that these logics constitute. In doing so, they are able to interact with each other in ways that require the deadlock, imposed by conflicting institutional logics, to be, at least momentarily, broken or at least mended. As such, this phenomenon requires a complementary analytical tool that might enable the understanding of the processes through which the interactions of actors might loosen institutional arrangements. The institutional work concept (Lawrence *et al.*, 2013) is such an analytical tool, as it enables a focus on the interactions of actors which not only maintain institutional arrangements but also interactions which, in the long run, might create or disrupt them. As such, in complementing the institutional logics concept, the most notable use for institutional work in this study lies in understanding how, and under what circumstances, actors are able to loosen the

constrains imposed by their adherence to an institutional logic, despite the perception of quality, and how quality is achieved, inherent in and prescribed by them. Studying institutional work facilitates progressing beyond recognizing the many obstacles and conflicts which adherence to diverse institutional logics may encompass, towards understanding how the different 'worlds' present within healthcare organizations – at the actor level of analysis – may be bridged.

This study maintains the analytical distinction between institutional logics and institutional work outlined above, as it is proposed to be generative in studying distinctive institutional dynamics when addressing various phenomena, facilitating a broader, richer, and more nuanced understanding of institutional arrangements (cf. Zilber, 2013). As such, it is argued that the combination of institutional logics and institutional work, understood as both being incorporated in the broader institutional logics perspective (Thornton *et al*., 2012), holds the potential to enable the emergence of a more accurate and complex understanding of the micro-level of institutional analysis (see Powell & Colyvas, 2008). While rare, the combination of institutional logics and institutional work is unobtrusive as "institutional work and practices are always shaped by available and accessible institutional logics" (Thornton *et al.*, 2012, p. 180). Institutional logics and institutional work are thus interconnected and dependent. However, in order to benefit from their ability to focalise varied institutional dynamics (see Zilber, 2013), their analytical delineation is kept distinct in this study.

The concept of institutional logics will be utilized when focusing on the actions and interactions of social actors, mainly relating to enacting and translating, and the practices that are intertwined with such acts, the institutional logics that are accessible and available, whereas the concept of institutional work is utilized in order to place the focus on the actions and interactions at the actor level of analysis that may enable institutions to be mended, bent, or even, in the long run, broken. As institutional logics are manifestations of institutions, actions and interactions that transcend what is prescribed by the order of the available and accessible institutional logics, are acts that may be labelled as institutional work that create and/or disrupt institutions and in turn may have institutional effects in the long run (cf. Battilana & D'Aunno, 2009). However, and most importantly, both concepts enable focus to be placed on the interest of practice and the lived experiences of actors in studying the involvement of healthcare professionals in QIW. In addition to the setting of the study, the next chapter outlines the methods utilized in order to study both institutional logics and institutional work at the actor level of analysis.

Methods and settings

Research approach and strategy

The research purpose of this dissertation is to describe and analyse the active involvement of healthcare professionals in quality improvement work (QIW) in healthcare organizations at the actor level of analysis. While it is argued that the agency and actions of healthcare professionals are pivotal in this inquiry, there is a lack of studies focusing on these components. The frequently noted lack of healthcare professionals' involvement in QIW has been attributed to the lack of acknowledgment of QI initiatives as interventions imposed upon already complex and diverse social 'worlds' (Powell *et al.* 2009), failing to acknowledge the distinct mindset that follows identification with and adherence to different institutional logics (Thornton *et al.*, 2012), and the subsequent impact of institutional complexity (Greenwood *et al*, 2011) in relation to healthcare professionals' involvement in QIW. When studying healthcare professionals' involvement in QIW, these aspects therefore call for a research strategy which is meaningfully able to capture, and account for, how the perspectives of healthcare professionals are intertwined and embedded in institutional complexity. As a result, a qualitative research strategy has been applied, as it is considered superior when addressing human perception and understanding (Stake, 2010) and underscores the interpretation of collected data and importance of context when understanding social behaviour (Bryman & Bell, 2007).

Furthermore, the research purpose entails studying an area where much research, addressing similar and adjacent areas, has been conducted. However, the theoretical framework, consisting of a combination of institutional logics and institutional work, is a novel approach to studying healthcare professionals' involvement in QIW. The study thus benefits from a pendulum movement between previous studies, the empirical data collected, and the theoretical framework, as it facilities the emergence of a more accurate and nuanced understanding of involvement in QIW. Such a pendulum is often defined as abduction and is described by Alvesson and Sköldberg (2009, p.4) as when the research process "alternates between (previous) theory and empirical facts whereby both are successively reinterpreted in the light of each other". Qualitative research enables such a process, which further advocates the qualitative research strategy as appropriate, hence enabling previous insights concerning healthcare professionals' involvement in QIW to be iteratively reinterpreted when applying the chosen theoretical framework.

Research design

While the overall research purpose of this study calls for a qualitative research strategy, the specific research questions require a research design which enables the study of context-bound practice, and more specifically facilitates understanding of the impact of institutional logics and institutional work at the actor level of analysis in relation to healthcare professionals' involvement in QIW. Institutional logics and institutional work are intrinsic and institutionalized elements in practice, requiring a research design that facilitates closeness, accuracy, and richness in the data collected. The case study design was therefore chosen as it allows for in-depth analysis through enabling an intimate connection with the empirical reality (Eisenhardt, 1989; Lee *et al*., 2007).

Additionally, to capture the complexity and multifaceted nature of social processes it was deemed vital that the design should allow for a combination of data collection methods such as document studies, interviews and observations. Such combinations of data collection methods are often used to advantage in the case study design (Eisenhardt, 1989) as they enable findings to become extensively anchored and extend the quality of qualitative descriptions (Bryman & Bell, 2007). Essentially, the case study allows the researcher to get close to the phenomenon of interest. This closeness was sought in order to capture the acknowledged complexity of healthcare professionals' involvement in QIW.

Moreover, case study research does not necessitate representativeness, research is often desirable with specific cases that are able to provide insights into certain phenomenon that other cases would not (Flyvbjerg, 2001; Siggelkow, 2007). While undertaking research that aims to scrutinize a specific occurrence, it is judicious to choose cases that exhibit distinct situations (Eisenhardt, 1989). Predictive theories and universal truths cannot be found in studies of human affairs; context-dependent knowledge is therefore preferable (Flyvbjerg, 2001). These insights were prominent in guiding the consideration of possible cases for this study; it was necessary that it entailed a managerially instigated QI intervention with the aim of affecting and incorporating the practices of a spectrum of healthcare professionals. Moreover, it was deemed advantageous if the QI intervention had been underway for some time as this would enable healthcare professionals to account for their narratives of 'what had been', while it was deemed appropriate if the QI intervention was still an intrinsic part of practice as this would enable it to be studied 'in action'. In order to find an appropriate case, a pre-study was conducted at an early stage of the dissertation work. This pre-study is presented below.

The pre-study: finding a case

The pre-study was initiated at an early stage of the dissertation work. The intent of the pre-study was threefold. First, it aimed to illustrate and disentangle a historical narrative and overview of recent developments and changes in and of the healthcare sector and its context. The pre-study thus facilitated additional knowledge of the field's context in addition to reviews of literature and research. As the dissertation's research purpose relates to a contemporary condition, the aim of the pre-study is to enable a longitudinal perspective of the healthcare sector. Hence, both historical and contemporary challenges facing the healthcare sector were the focus of the pre-study. The decision was taken to collect data through semi-structured interviews with people who held or had held various positions within the healthcare sector ranging from hospital director to organizational developer. Nine persons were selected to participate in the pre-study through a mixture of purposive and snowball sampling. The intent behind the interviews was to capture an "insider" perspective, and as such the interviews focused upon the experiences of those whose everyday work is related to the management, steering and leading of changes in the healthcare sector, to create narratives. The narrative in qualitative research is concerned with the collection of individual stories (Sandelowski, 1991) and with the construction of a narrative "reality" (Bruner, 1991). Most of the interviewees had experience spanning over multiple decades. They have collectively experienced the healthcare sector from various geographic locations within Sweden, as well as encountering its manifestation in different sizes and shapes. Some of the interviewees had experience from the private sector, thus contributing another perspective to the pre-study. A common denominator is that all of them possessed vast experience of the current state of the healthcare sector. During the pre-study it became apparent that things had changed over a relatively short period of time. This general consensus can be illustrated by the quotation below, articulated by a chief nurse who has been practicing since the late 1960s.

> We have never previously reflected on what things cost, or if we could afford them. Managers and physicians alike have had the attitude that the cost of healthcare is acceptable. Even that healthcare should cost, you can't put a price on saving lives. However, recently things have changed: healthcare mustn't cost as much.

In summary, the pre-study added an empirical element that helped to establish the notion, described in current research (e.g., Scott *et al.*, 2000), that the

managerial logic – incorporating an economic rationale – is now institutionalized in healthcare organizations.

In addition to adding a longitudinal element and establishing the changing milieu of contemporary healthcare organizations, the pre-study aimed to tentatively frame and probe the different institutional logics at multiple levels of analysis, manifested and expressed in the sector. Hence the second aim of the pre-study was to evaluate the validity of the institutional logics perspective as a suitable overall framework for understanding QIW in healthcare organizations. Such an aim was pursued by addressing discrepancies between the different social actors that populate healthcare organizations, concerning behaviour, actions and perceived rationale. It became apparent that there were multiple such discrepancies. For instance, physicians were more often addressed as troublesome in relation to managing and directing initiatives than other professions such as nurses. Power inequality, between different professional actors, professional autonomy, and beliefs that medicine above all else should guide the future direction of the hospital were also common topics that the interviewees discussed. However, despite the numerous different interests and rationales that were perceived to reside within the hospital, and a general notion that attempts to control, steer and structure were met with hesitation, many of the interviewees experienced such attitudes and approaches to be in decline. An acceptance of change was perceived to be growing, while not in any sense being universal, a complex reality where demands for change and preservation of traditions were similarly present in a delicate blend. The viability of utilizing institutional logics was thus further underscored as fitting in describing, analysing and understanding the different attitudes, standpoints and rationales of different social actors, whereas utilizing institutional work enables the focus to be placed on the dynamics instigating the perceived, at least partial, transition and bridging of actors' divergent perspectives.

The third and foremost aim of the pre-study was to find a case, or cases, that were deemed suitable to address the research purpose and the research questions. During the interviews, questions were asked and discussions were instigated to look for just such a case or cases. As stated previously, it was deemed advantageous that the QI interventions had been underway for some time – as this would enable healthcare professionals to account for their narratives of 'what had been' – while it was deemed appropriate if the QI interventions were still an intrinsic part of practice – as this would enable them to be studied 'in action'. Considering these criteria, the case chosen constituted the quality improvement work undertaken by a multi-professional team (MPT) in relation to the diabetes treatment and process for youth and adolescent

patients at a medium-sized Swedish hospital. The quality improvement work was instigated in 2010 by a managerially imposed QI initiative, which incorporated the flowchart as a mandatory tool for evaluating and improving the treatment process with the aim of addressing alarming QI data in relation to national levels in open comparisons with other hospitals. The QIW was still in progress when the case study was commenced in 2013. The case is presented in detail further down in this chapter. There now follows an outline of the methodological considerations of the study in addressing the topic and nature of the qualitative case study.

The qualitative case study

It has been argued that a qualitative research strategy and the case study design are necessary in order to address the research purpose and research questions of the study. The case chosen following an exploratory pre-study constituted the quality improvement work undertaken by a multi-professional team (MPT) in relation to the diabetes treatment and process for youth and adolescent patients at a medium-sized Swedish hospital. This case was deemed appropriate as the managerially instigated QI intervention challenges established practices. Institutional logics are embedded and institutionalized in practice (Lindberg, 2014) and hence difficult to study if practice remains relatively static. Struggles between institutional logics ultimately concern legitimacy (Cloutier & Langley, 2013), creating conflicts regarding which institutional logic should regulate certain activities and to which categories of person they apply (Friedland & Alford, 1991). Studying the agency and actions of social actors in utilizing institutional logics is thus facilitated by the dynamic imposed by the QI intervention on established practice – as the QI intervention instigates conflict in relation to legitimacy and consequently which institutional logics hold the mandate to influence the practice of healthcare professionals. However, as previously argued as a precondition of this study, social actors always exercise agency when manifesting institutional logics through translation and sensemaking, meaning that the content of a certain logic is not simply reflected by social actors. In this study, studying actions and interactions between social actors thus becomes a focal point when utilizing the institutional logics concept to analyse healthcare professionals' involvement in QIW. However, the dynamics instigated by the QI interventions also facilitate studying institutional work that creates and/or disrupts institutions, as such institutional work is argued to constitute, presumably rare due to the institutionalized character of practice, actions and interactions that transcend what is generally prescribed by the order of the available and accessible institutional logics. The dynamics instigated by the managerially initiated QI intervention studied therefore challenges

established practice, enabling the agency of actors in employing and translating accessible and available institutional logics in their actions and interactions to be studied, whereas the same dynamics create potential for actions and interactions that significantly deviates from acts aiming to retain the status quo (i.e. institutional work at the actor level of analysis that in the future might create and/or disrupt institutions). Utilizing the qualitative case study consequently enables the research purpose, and the interconnected research questions, to be tackled with the approach that is necessitated by utilizing the proposed theoretical framework incorporating the combination of institutional logics and institutional work. There is an outline below of the data collection methods applied in order to study healthcare professionals' involvement in QIW, utilizing the proposed theoretical framework at the actor level of analysis.

Data collection

As noted, the case study facilitates a combination of data collection methods (Eisenhardt, 1989), which enables findings to become comprehensively supported and enhances the quality of qualitative descriptions (Bryman & Bell, 2007). Considering the necessity for the collected data to capture the multiplicity of actors' actions and interactions, it was deemed vital that data was collected through multiple sources. Interviews and observations are the explicit data collection methods used in this study, yet documents (e.g., minutes from meetings, guidelines, flowcharts, and internal memoranda) constituted important components in contextualizing the interviews and observations conducted, as well as "knowing what to ask and what to look for".

Interviews

Semi-structured interviews were conducted with all members of the multi-professional team who were responsible for the treatment and care of the diabetes patients, as well as with their managers. In total, 18 team members: six nurses, five physicians, two counsellors, two dieticians, two play therapists, one psychologist and two managers - the director of the department and the head of the unit - were interviewed. In addition to the team members and their managers, two process developers (sometimes also referred to as improvement workers by the interviewees) were also interviewed. These process developers were dispatched on behalf of the management with the intention to act as experts in QI methods and tools while supporting their implementation in the healthcare professionals' QIW. Certain individuals were interviewed on multiple occasions in order to expand on topics and themes that it was deemed necessary to address further. The interviews ranged in length from 30 to 100 minutes – follow-up interviews were often shorter due to their limited scope – and were digitally

recorded with the consent of the interviewee and later transcribed verbatim. A total of 27 semi-structured interviews were conducted.

The semi-structured nature of the interviews allowed both interviewer and interviewee to elaborate and expand on topics of special interest or perceived relevance (Silverman, 2010). As such, no two interviews were the same. However, in all interviews topics related to the understanding of the interviewee's own role and responsibilities in relation to the quality improvement work. In addition, the opinions of other individual actors' roles and responsibilities were addressed. The interviews consequently contributed to the study by highlighting the interviewees' perception of themselves and their justification mechanisms for their own actions and behaviour. Furthermore, the semi-structured interviews enabled the interviewees to elaborate upon relations with other individual actors, as well as their perception of how other individual actors acted, and why, in relation to their involvement in the QIW. However, it is not sufficient to rely solely on actors' accounts as behaviour and actions described often differ from actual behaviour and actions, and furthermore do not enable the interactions of social actors to be studied – an aspect central to fulfilling this dissertation's research purpose and interconnected research questions. Observations were consequently undertaken in addition to the interviews.

Observations

As institutional logics are embedded and institutionalized in practice (Lindberg, 2014), and institutional work in this study is understood as the everyday getting by of individuals and groups (cf. Lawrence *et al.*, 2011) while accomplishing mundane, practical work (Smets & Jarzabkowski, 2013), it is unlikely that the actors studied would have been able to reflect meaningfully – and be reflexive – upon the impact of either institutional logics or institutional work. As such, it was deemed vital that the interviews were supplemented with another type of data collection method which enabled the practice of healthcare professionals to be studied at first hand. Observations are often utilized to achieve an understanding of organizational phenomena in their natural context, which is, as noted, something that is difficult to capture with interviews as the sole source of data in social sciences and particularly in case study research (Liu & Maitlis, 2010). Observations were thus undertaken in this study in order to study the action and interactions of actors while also facilitating analysis of how these actions and interactions corresponded to the attitudes and actions espoused by actors.

The observations consisted mainly of workplace team meetings where day-to-day practice as well as the QIW were addressed and discussed. As argued, these observations enabled the actions of actors, as well as their interactions, to be studied at first hand. Furthermore, as the QI intervention had challenged establish practice, observing the workplace team meetings enabled actors' manifestations and translations of logics to be studied in relation to the institutional logics that were perceived to be legitimate in guiding associated activities and consequently how the QIW should be undertaken. Moreover, in addition to workplace team meetings, meetings concerning specific, often acute, topics were also observed. The topics addressed at these meetings were perceived to be serious and troublesome and directly or indirectly related to the QIW. In relation to the workplace team meetings, which enabled fairly everyday activities of the QIW to be studied, the meetings concerning more acute topics further facilitated a study of how the individual actors handled institutional complexity and its concomitant diverse institutional demands as a result of the more intense and extraordinary nature of these meetings. These distinct types of observations enabled all forms of meetings to be studied that the multi-professional team had in relation to the ongoing QIW and everyday practice. Notes were taken throughout the observations to record interactions and conversations, with some conversations being annotated verbatim while other conversations and interactions were noted in summary. In total 10 observations (spanning more than 40 hours in total) were conducted. Altogether, the observations allowed for more in-depth interpretations to emerge (cf. Denzin, 1994), facilitating understanding of QIW through the perspectives of the healthcare professionals, as well as the impact of institutional logics and institutional work in its undertaking.

Data analysis

> Interpretation is the challenge at the heart of qualitative research. Without interpretation, we cannot make sense of our data (Willig, 2014, p. 136).

The data analysis in this dissertation is inspired by a constructivist approach (Silverman, 2001), encompassing constructivist ontology and interpretivist epistemology, with making sense of and interpreting data understood as the trade of the qualitative researcher (cf. Willig, 2014). As such, data analysis is not a linear procedure which is undertaken when all of the empirical data is collected. Instead, 'data analysis' is a constantly undergoing iterative process of interpretation. Alvesson and Sköldberg (2009) argue that interpretations of qualitative data are conducted on two different levels, incorporating a varied

degree of awareness of the interpretations which are made. Primary interpretations are the interpretations which occur before or during the interactions which are results of the data collection. The primary interpretations in this study thus occurred before and during the interviews and observations which were undertaken. The interpretive process is continuous and after a data collection event (i.e. after an interview or observation is conducted) interview transcripts and fields notes were read and re-read in order to pick up interesting themes. These readings were often combined with discussions with supervisors, with the aim of facilitating further reflections upon the data. Moreover, supervisors sometimes accompanied me on data collection events in order to obtain yet another perspective and set of interpretations on the empirical event, enabling more fruitful discussion. The basis for primary interpretations are constantly elaborated upon due to the increased volume of collected data, facilitating the understanding of what is interesting and meaningful in the specific case in combination with enhanced readings of previous studies and a more elaborate apprehension of theoretical constructs. In illustrating such a progression, it gradually became apparent in this study that logic identification and adherence among healthcare professionals constituted a vital component in understanding how they made sense of QIW, as well as their involvement in it. As a consequence, logic identification and adherence, along with adjacent themes, became a topic which was discussed frequently and previous studies concerning the topic become prominent in the process of reading. As a result, the basis for primary interpretations, both before and during data collection events, became more refined. In addition, as the primary interpretations identified certain themes and topics as especially relevant in understanding healthcare professionals' involvement in QIW, the focus of the data collection became progressively more precise.

Alvesson and Sköldberg (2009) argue that during secondary-level interpretations the researcher is more aware of the process of interpretation while undertaking a more in-depth exploration of the empirical material collected. The secondary-level interpretation of this study is inspired by thematic analysis (see Braun & Clarke, 2013), which entails identifying patterns in the data in a process of making the data meaningful, presentable and relevant in relation to the research purpose and the interconnected research questions. During the secondary-level interpretation, the pendulum movement, which is facilitated by the qualitative research strategy, enabled the empirical data and theory to influence each other and interact, iteratively seeking a plausible fit (see Ahrens and Chapman, 2006). This pendulum movement was interrelated with the posited theoretical framework of this study, incorporating both concepts of institutional logics and

institutional work in order to facilitate exploration and capture of the various institutional dynamics (cf. Zilber, 2013) in relation to the phenomena studied. Research question 1 of this dissertation places the focus on the effects of the professional and managerial logics on healthcare professionals' involvement in QIW. Consequently, the secondary-level interpretations undertaken in relation to paper 1 entailed focusing on the inherent tension between the professional and the managerial logic (cf. Freidson, 2001), as well as their inherent axioms concerning the legitimate basis for guiding practice, how this tension could be understood, seen, and manifest in the empirical material and subsequently how it could be related to and explain healthcare professionals' involvement in QIW. As such, the data analysis in paper 1 compares to what Reay and Jones (2016) denote as comparison with an 'ideal type' in qualitatively capturing institutional logics. Research question 2 continues to focus on institutional logics, however, it further addresses the distinct history and traditions of healthcare organizations in relation to physicians' and nurses' distinct ability to exercise control over professional work. Consequently, the analysis conducted in paper 2 focuses on making explicit how physicians and nurses relate to the inherent axiom of the professional logic, requiring that professional judgment and discretion is the legitimate basis for decisions, and in turn how this relationship affects, and makes distinct, their approaches and practices in QIW. The analysis in paper 2 thus modulates and contextualizes the effects of identification with and adherence to the professional logic in relation to healthcare professionals' involvement in QIW. Research question 3 further proceeds to delve into the effects of the professional logic in healthcare organizations, asking how organizing in multi-professional teams might affect practices despite them often lacking the utilization of multiple perspectives, as demanded by the managerial logic to achieve high quality care. The primary analysis conducted in paper 3 thus consisted of thematically outlining how organizing in multi-professional teams affected practice and why it affected practice in this way. The findings of the primary analysis were subsequently linked to the tension created by the multiplicity of professionals groups, their intra-professional discrepancies and power relations, participating in the team as well as the managerial demand imposed of utilizing multiple perspectives. The analyses conducted in papers 1-3 interconnect with the corresponding research questions 1-3. This enables the multifaceted utilization of the concept of institutional logics to study various aspects of the actions and interactions of social actors (the suitability of which in this regard has been extensively outlined and argued for in the theoretical framework), which mainly relate to enactment and translation, and the practices that are intertwined with such acts, the institutional logics accessible and available in describing and analysing healthcare professionals' involvement in

QIW. Research question 4, however, addresses how interactions between social actors facilitate bridging logics and in turn enable healthcare professionals' involvement in QIW. As such, the analysis of paper 4 is conducted utilizing the concept of institutional work, which enables a focus on the actions and interactions at the actor level of analysis, which might enable institutions to be mended, bent, or even broken in the long run. Consequently, interactions where individual actors were able to reciprocally exercise agency which transcended what was prescribed by the order and rigidity of the institutional logics available and accessible, as it has previously been argued that such interactions constitute creating and/or disrupting institutional work at the actor level of analysis (cf. Battilana & D'Aunno, 2009), were systemically identified and sorted. The analyses undertaken in papers 1-3 thus placed the focus on varied, and progressively intricate, aspects of institutional logic, whereas the analysis conducted in paper 4 focuses on the complementary aspects of creating and/or disrupting institutional work through analysing the interactions of actors which requires the rigidity of institutional arrangements to be, at least momentarily, broken or at least mended. Additional details concerning the data analyses undertaken are specified in the appended papers. The discussion concerning the generalizability and validity of this study will be further addressed and synthesized under this chapter's next subheading.

Generalizability and validity

> Sometimes we simply have to keep our eyes open and look carefully at individual cases – not in the hope of proving anything, but rather in the hope of learning something! – Hans Eysenck

Eisenhardt (1989), Eisenhardt and Graebner (2007), and Yin (2009) argue that the case study design is able to provide insights into new research areas in its preliminary states of investigation and that case studies are "generalizable to theoretical propositions and not to populations or universes" (Yin, 2009, p. 15). This means that cases study findings are not universally generalizable beyond the immediate case. However, case studies are not intended for such generalization. Instead case studies enable analytical generalization (Yin, 2009) in which the researcher strives to generalize the results from the case study to a broader theory. Flyvbjerg (2001) adds that the nature of the case study research method is often misunderstood as a consequence of the notion that natural science, and knowledge regarding objects, is what social science should aim to imitate and he argues that such a focus leads to a dead end as predictive theories and universal truths cannot be found in the study of human affairs. Context-dependent knowledge is therefore superior. Flyvbjerg states that the lack of

formal and statistical generalizability does not hinder the collective process of knowledge accumulation in a particular field or research area in social science; which is to be considered the ultimate goal of social science and its development of the knowledge of complex, context-dependent human affairs.

The findings of this study are consequently relevant for healthcare organizations in general, but also significant in a broader sense for organizations whose employees, to some degree, exhibit the characteristics of professionalized occupations. As such, in analysing the active involvement of healthcare professionals in QIW, the interpretations undertaken and the patterns identified are generalizable to the tendencies and phenomena exhibited in organizations inhabited by professionalized occupations and subsequently to the broader theory of professions and professionalism. Hence, the analyses undertaken in this study are parts of the collective process of context-dependent knowledge accumulation with regard to healthcare organizations specifically and institutionalized arrangements in organizations generally. The next subheading outlines the global and Swedish setting for this study, before presenting the empirical setting for the specific case in more detail.

The global and Swedish setting - healthcare systems' expansions and challenges

Healthcare systems[7] around the world are facing challenges; a main one being the financial strain they have inflicted as a result of the exponential increases in health expenditure (WHO, 2015a). The total spending[8] on healthcare systems in the world has increased rapidly, with total global expenditure amounting to US$ 7.35 dollars in 2013, which is more than double the amount spent in 2000 (WHO, 2015a). Mean expenditure in the OECD countries in 2013 was equivalent to 8.9% of gross domestic product (GDP), constituting 15% of total government expenditure (OECD, 2015). The figures were even higher for Sweden in 2013, with health expenditure equivalent to 11% of GNP and constituting 17% of total government expenditure (OECD, 2015).

This development in the OECD and Sweden has occurred fairly recently. In 1960 mean spending in the OECD countries was equivalent to 4.2% of GDP (SOU, 1993:38). In 1950 spending on health in Sweden was equivalent to approximately 3% of GDP (SKL, 2005a). During the 1950s and 1960s the

[7] A healthcare system is defined as "the sum total of all the organizations, institutions and resources whose primary purpose is to improve health" (WHO, 2016).

[8] Spending/expenditure "on health measures the final consumption of health goods and services (i.e. current health expenditure). This includes spending by both public and private sources on medical services and goods, public health and prevention programmes and administration, but excludes spending on capital formation (investments)" (OCED, 2015, p. 164).

healthcare system in Sweden was substantially expanded (SKL, 2005a). During the 1970s the healthcare sector became one of the largest public sectors in Sweden, both in terms of spending and the number of persons employed (SOU, 1993:38). The expansion continued, albeit at a slower pace, particularly during economic recessions, until the early 1980s (SKL, 2005a) when the cost in relation to GDP peaked at 9.5% (SOU, 1993:38), more than tripling in relation to GDP in 30 years. This percentage then dropped during the first half of the 1980s (SKL, 2005a), fluctuating fairly stably between 7.4% and 7.8% between 1985 and 2000 (OECD, 2016). In 2001 the number rose once again to 8%, remaining between 8.1% and 8.9% until 2010 when it hit 10.6% (OECD, 2016). Since then Sweden, and the OECD countries in general, have seen a continuing slight upwards trend in health spending, both in terms of per capita spending and as a percentage equivalent to GDP (OECD, 2015). Currently[9], Sweden's health expenditure in relation to GDP constitutes an all-time high.

The component to which most of the massive increase in health spending is attributed is the transformation of the sector, originating in the rapid technological development and changes characterizing the decades since the end of World War II and enabling a previously unprecedented range of improved diagnostic and therapeutic technologies to emerge (Gelijns & Rosenberg, 1995; IOM, 2001). It entailed new ways to practice medicine and incorporated groundbreaking ways to both detect and solve health problems (Gossink & Souquet, 2006; Socialstyrelsen, 2009a)**.** As a result, previously untreatable and undetectable conditions may now be treated successfully (SKL, 2005a). There are no indications of any decline in the rate of influence of science and technology on medical practice and its impact on the magnitude of treatable conditions is thus believed to represent an everlasting foundation in modern medicine and with it the cost associated with such developments (Gelijns & Rosenberg, 1995; IOM, 2001; SKL, 2005a; Gossink & Souquet, 2006; Socialstyrelsen, 2009a).

Furthermore, there is substantial causality between the improved quality of care which medical technological developments have allowed and an increased life expectancy (Socialstyrelsen, 2005), and it thus constitutes a major explanatory factor in the increased life expectancies seen across the globe (WHO, 2015a), the OCED countries and in Sweden (OECD, 2015). Average life expectancy in the OECD countries reached 80.5 in 2013, an increase of more than 10 years since 1970 (OECD, 2015). The prospect for Sweden's population is even greater; life expectancy in 2013 was 82 years (WHO, 2015b) and it is expected

[9] As of 2013 – the latest official statistics when writing this chapter.

to increase, reaching 88.2 years in 2060 (SCB, 2015). This major change in demographics entails an increased proportion of the older population relative to the younger population (SCB, 2014), with a concomitant decrease in the working-age population (WHO, 2015a). In addition, elderly populations often require more care (Socialstyrelsen, 2009b; OECD, 2015; WHO, 2015c) resulting in a double setback for health spending as the economically active population[10] is expected to decline while the non-active is expected to require more care. The increased quality of care characterizing the last seven decades is thus driving health expenditure due to its capacity to treat and cure as well as through its contribution to the aforementioned demographic shift.

The increased spending on healthcare systems is regarded as an increased concern, both in terms of the lack of consistent correlation between spending and achieving qualitative care, and its magnitude in correlation to GDP (OCED (2015). In Sweden, central, regional or local governments financed 84% of all health spending in 2013, making the Swedish healthcare system one of the most publicly funded in the world (OECD, 2015). It is a major concern that there are plainly no more financial resources to allocate and that it is pivotal for a more effective use of the healthcare system's resources (SKL, 2005a; 2005b). Most attention, both in Sweden and globally, has thus been aimed at changing and redesigning the healthcare systems in order to achieve the best use of resources rather than allocating more public funding or increasing the proportion of private out-of-pocket financing (IOM, 2001; SKL, 2005a; SKL, 2005b; WHO, 2014; OECD, 2015), prompting ever increasing measurements to achieve efficiency and promote the effectiveness of healthcare systems while still aiming to provide the care which the populations require (Gossink & Souquet, 2006). As a result, QI has become a cornerstone, not only in redesigning healthcare systems in the OECD and Sweden, but it is also perceived to be a fundamental component when developing healthcare systems in low- and middle-income countries (Balabanova *et al.*, 2013) where healthcare systems are currently undergoing a similar expansion as seen in the years after World War II in the industrialized western parts of the world (Mate *et al., 2013;* WHO; 2015a).

Case background and empirical setting

As previously specified, the case study pertained to the quality improvement work undertaken at a medium-sized Swedish hospital in relation to the care of youth and adolescents, ranging from 0 to 18 years of age, with diabetes mellitus.

[10] Defined as "all persons of either sex who provide, or are available to provide, the supply of labour for the production of economic goods and services" (UN, 2014, p. 43).

Diabetes mellitus is defined as a "group of metabolic[11] diseases characterised by chronic[12] hyperglycemia[13] resulting from defects in insulin[14] secretion, insulin action, or both" (Craig *et al*., 2009, p. 3). Put simply, diabetes mellitus means that the patients' insulin (the hormone that regulates the transport of energy in the form of sugar) production is insufficient, in some way, shape, or form in managing the transport of sugar from the patients' blood to the tissue that needs it. While diabetes mellitus is incurable, it is treatable, though medical treatment is necessary throughout the lifespan of the patient in order to prevent secondary diseases and major physical consequences such as eye, nerve, heart, and kidney damage. If untreated, a person with diabetes mellitus type-1 (by far the most common type of diabetes among children and adolescent) will die (IDF, 2015). Diabetes mellitus is widespread and more than half a million children worldwide (IDF, 2015) and seven thousand in Sweden (SWEDIABKIDS, 2015) are in need of insulin injections in order to survive (IDF, 2011). The dire potential consequences of unsuccessful medication mean that following up the treatment of patients suffering from diabetes mellitus is necessary and vital. Haemoglobin A1c (HbA1c), which refers to glycated haemoglobin, reflects a time averaged blood glucose (i.e. average blood sugar concentration present in the blood) during the previous 2-3 months and is consequently deemed a vital clinical measurement able to indicate successful medical treatment of diabetes mellitus (Hanas & John, 2014).

In 2001 the hospital where the study was conducted was connected to a national database, the Swedish Childhood Diabetes Registry, which enabled data concerning their patients to be compared with the patients of other hospitals. It was brought to the attention of the multi-professional diabetes care team that their patients had a high average HbA1c in relation to other hospitals nationally. As noted, a high level of HbA1c is undesirable as it entails an increased risk of the patient suffering further complications. As a consequence, the physician responsible at the time initiated an, as designated by the team, "improvement work project". This improvement work mainly encompassed activities related to implementation of a new set of routines regarding the period of time passing between patient visits. During this period, the management of the hospital had

[11] Meaning that they are somehow related to the metabolism, whereas metabolism is defined as "the chemical processes that occur within a living organism in order to maintain life" (Soanes & Stevenson, 2008).
[12] In relation to an illness, chronic is defined as "persisting for a long time or constantly recurring" (Soanes & Stevenson, 2008).
[13] Hyperglycemia is defined as " an excess of glucose in the bloodstream" (Soanes & Stevenson, 2008) whereas glucose is "a simple sugar which is an important energy source in living organisms and is a component of many carbohydrates" (Ibid).
[14] Insulin is " a polypeptide pancreatic hormone which lowers glucose levels in the blood, a lack of which causes diabetes" (Soanes & Stevenson, 2008).

decided that all chronic illnesses should be surveyed and treated as processes. This involved the use of flowcharts in order to visualize the different "steps" associated with the patients' "journey", from diagnosis of the condition to achieving greater autonomy in controlling and managing it, and the associated actives undertaken in relation to the treatment in order to streamline and standardize the treatment and care provided. QI tools and methods were thus imposed upon healthcare professionals' practice when performing activities aimed at improving the quality of care. Following the quality improvement work undertaken, the patients' average HbA1c started to decrease. After a few years, the diabetes care team had managed to substantially lower the worrying average HbA1c of their patients and the hospital's paediatric clinic had taken a new position among the foremost paediatric clinics in the country. In 2005 the diabetes care team's work was recognized and they received a national award for their efforts. However, the resignation of the physician who instigated the improvement initiatives led to the QIW of diabetes care team stagnating in 2006.

The years passed and in 2008 a new departmental director was appointed, the department having been managed by an externally contracted consultant for a period of time. Once settled in to the new position, the department manager felt the need to revive and revitalize the diabetes care team's QIW as the hospital's child and adolescence diabetes patients were once again demonstrating high average HbA1c in national comparisons. In addition to patients' high average HbA1c, the managerial focus of the QI initiative was to review the cost associated with patients' hospitalization on detection of the disease, and the cost associated with prescribing insulin and other medical devices. In the middle of 2010 the QI initiative was officially approved by the department manager, with the overall purpose, as stated in internal memorandum, to revise and optimize the processes concerning the treatment and care of child and adolescent patients with diabetes mellitus. It was further instructed that the standardized flowcharts used throughout the hospital should be applied to the QIW.

The QIW commenced shortly after the QI initiative was officially approved. The task of carrying out the QIW was mainly assigned to a newly formed working group consisting of one physician, who was responsible for the QIW, three nurses, specialized in diabetes, and one process developer. However, their task was also to communicate with the multi-professional diabetes care team as a whole in order to gather their queries, opinions and suggestions for improvement. As noted, the diabetes care team consisted of 18 members in total: six nurses, five physicians, two counsellors, two dieticians, two play therapists and one psychologist. While these numbers reflect the constellation of the diabetes team at the beginning of the study, minor staff adjustments were

implemented during the course of the study which did not substantially affect the constellation of the team or the ratio of different professions.

When the QIW commenced the first task of the working group's process developer was to guide the other members of the working group (i.e. the healthcare professionals) in how the flowcharts worked and how they were supposed to apply and utilize them in their QIW. As the QIW continued, the working group decided to primarily focus on problem areas identified during the initial hospitalization of newly diagnosed patients. Data collection for the case study began in January 2013. While the QIW was still in progress, the patients' average HbA1c had once again been reduced and the number of days that newly diagnosed diabetes patients spent hospitalized had also been decreased. As such, in terms of goal fulfilment, the QI initiative was deemed successful. However, while the healthcare professionals in the working group enjoyed a certain amount of autonomy in their QIW, the rationale imposed by the managerial logic created tension and conflict. This rationale mainly became apparent through the utilization of the QI methods and tools imposed, but also in relation to how the QIW was required to be evaluated and its results presented. It was compulsory to disclose and report the measurements and goals of the 'process' in terms of effectiveness, described in an internal memorandum as the ability to produce the "right" results, and efficiency, optimally in relation to available resources. Furthermore, multiple perspectives, relating to distinct aspects of quality of care (cf. Batalden & Stolz, 1993) such as how the QIW created value for the patient and how it contributed to the development of the workplace and its members, were required to be taken into consideration when the working group evaluated their QIW. The case thus truly embodies the notion of divergent and conflicting institutional logics at the actor level of analysis, validating its fit in relation to the overall research purpose and the interconnected research questions of this dissertation. The next chapter presents the findings of each individual paper in relation to its corresponding research question.

Presenting the papers: results

The research purpose of this dissertation is to describe and analyse the active involvement of healthcare professionals in quality improvement work (QIW) in healthcare organizations at the actor level of analysis. The research purpose is achieved through addressing the following research questions:

> *RQ1: How do the professional and managerial logics affect healthcare professionals' involvement in QIW?*
>
> *RQ2: How does physicians' and nurses' identification with and adherence to the professional logic constrain and enable diverse approaches and practices in QIW?*
>
> *RQ3: How may organizing in multi-professional teams affect practice and thereby be of relevance for explaining the conditions for QIW?*
>
> *RQ4: How might interactions between individual actors enable logics to be bridged and in turn facilitate healthcare professionals' involvement in QIW?*

Each research question is examined in one of the appended papers. The following sections present the results of the individual papers and their relation to the study's research questions.

Paper 1 - Healthcare quality improvement work: a professional employee perspective

Authors: Christian Gadolin and Thomas Andersson
Journal: *International Journal of Health Care Quality Assurance* (Accepted)

Research question 1: *How do the professional and managerial logics affect healthcare professionals' involvement in QIW?*

Previous research has established that there is often a lack of healthcare professionals' active involvement in QIW, and that they often exhibit resistance towards managers and managerially initiated QI interventions. The paper introduces and applies the proposed theoretical framework consisting of the combination of institutional logics and institutional work, though the concept of institutional logics is in focus. In utilizing the concept of institutional logics, the difficulties and challenges in attaining healthcare professionals' involvement in QIW are associated with their identification and adherence to professional logics, stipulating that professional discretion and judgments are legitimate in

directing work, a stipulation that is intrinsically at odds with the managerial logic as it mandates bureaucratic control over professional work. It is consequently argued that it is pivotal to acknowledge the effects of the conflict between the professional and managerial logics. The paper thus theoretically anchors the empirical findings regarding lack of involvement and resistance exhibited, with a concept that is able to address and handle the unique context of healthcare organizations, where healthcare professionals have had the ability to judge what denotes quality care and how it should be adequately improved. In complementing the institutional logics concept, the concept of institutional work is utilized in order to explain the mechanism that has a reverse impact on healthcare professionals' involvement in QIW, despite the impairing effects that the professional logic and managerial logics often introduce. This engenders the initial stage towards delineating what characterizes the interactions that facilitate healthcare professionals' involvement in QIW, despite the distinct mindsets and perspectives of different social actors.

In conclusion, the paper delineates the fact that the concept of institutional logics applies at the actor level of analysis in explaining how the concept relates to healthcare professionals' lack of involvement in QIW and their interconnected resistance towards managers and managerially instigated QI interventions. The paper underlines that the unique character of healthcare organizations, with autonomous professionals, has resulted in highly polarized institutional logics at the actor level of analysis, with a major effect on social actors' mindsets and perspectives. It thus expounds why there is often a lack of healthcare professionals' involvement in QIW and subsequently argues that institutional work might enable a bridging of institutional logics at the actor level of analysis in order to facilitate healthcare professionals' involvement in QIW.

Paper 2 - Professional employees' strategic employment of the managerial logic in healthcare

Authors: Christian Gadolin
Journal: *Qualitative Research in Organizations and Management: An International Journal* (Conditionally accepted)

Research question 2: *How does physicians' and nurses' identification with and adherence to the professional logic constrain and enable diverse approaches and practices in QIW?*

Previous studies have mainly addressed physicians in studying healthcare professionals' involvement in QIW. Overall, these studies have produced the

picture that it is difficult to involve physicians in QIW, since they are often sceptical towards managers and resistant to organizational change. While this portrayal is fairly established, there are studies indicating that the preconditions for nurses to involve themselves in QIW are distinct from those of physicians. Drivers of nurses' involvement in QIW have been shown to be dissimilar to those of physicians and nurses have been highlighted to easier reconcile with the managerial logic when assuming a managerial position. Furthermore, nurses have not enjoyed the same control over their own work nor have they had the ability to define what denotes quality of care and how it should be achieved. However, how these contextually contingent particularities affect physicians' and nurses' respective involvement in QIW has not been made explicit. The contextualized understanding of QIW in healthcare organizations consequently remains inadequate and the complexity that multiple professionals groups bring in relation to professionals' involvement in QIW remains unelaborated.

The paper highlights that the degree of identification with and adherence to the professional logic in general varies among physicians and nurses. This follows the unique tradition of physicians being able to control their own and other professionals' work, resulting in physicians' adherence to the professional logic in general being stronger than nurses' identification with and adherence to the professional logic. In consequence, the respective ability of physicians and nurses to utilize diverse approaches and practices in QIW are distinct, following their different relations with the axiom of the professional logic dictating professional judgments and discretion being superior in practice and work. Physicians' stronger identification with and adherence to the professional logic constrain them in undertaking approaches and practices that do not derive from the axiom inherent in the professional logic. Conversely, nurses are able to exercise a considerable degree of freedom in their approaches and practices in QIW as they are less constrained by their weaker adherence to the professional logic. This is illustrated in the paper through emphasizing nurses' ability to strategically employ the managerial logic explicitly when striving for desired outcomes.

The paper emphasizes the fact that the unique tradition of healthcare organizations, where physicians have enjoyed distinct control over work, entails the complexity of healthcare professionals' involvement in QIW increasing as physicians and nurses demonstrate divergent approaches and practices in QIW. Moreover, the paper underlines that physicians and nurses are able to manoeuvre the contemporary institutional complexity of healthcare organizations differently. Consequently, the dichotomy of professionals versus managers is not sufficient in understanding healthcare professionals' involvement in QIW.

The tradition and history of healthcare organizations requires that different professional groups are understood as partly unique due to their diverse identification with and adherence to the professional logic and the subsequent effects in relation to their approaches and practices in QIW. As such, nuances need to be incorporated in research which further addresses the study of professionals' involvement in QIW

Paper 3 - Organising healthcare with multi-professional teams: activity coordination as a logistical flow

Authors: Christian Gadolin and Ewa Wikström
Journal: *Scandinavian Journal of Public Administration*, 20(4), pp. 54-72.

> Research question 3: *How may organizing in multi-professional teams affect practice and thereby be of relevance for explaining the conditions for QIW?*

Previous research has established that despite the managerial logic being institutionalized and QI being an intrinsic part of contemporary healthcare, professional practice often remains stable and entrenched. The multi-professional team is a common principle for organizing care, sharing the principal starting point for many QI interventions, i.e. that the strategic utilization of multiple perspectives is essential in order for organizational performance and quality of care to be improved. While previous research has established that such utilization is often lacking in practice, there is a lack of studies exploring *how* the co-existence of professional and managerial logics plays out at the actor level of analysis in relation to the work undertaken in the MPT. The mechanisms which hinder the utilization of multiple perspectives and subsequently enable professional practice to remain stable and entrenched – despite QIW being undertaken – are therefore left unelaborated.

The paper concludes that the MPT does not function as the managerial logic intends, as it does not act as a forum where different professions share and integrate knowledge. The MPT fails to facilitate the strategic utilization of multiple perspectives to achieve improved performance. Instead, the paper highlights that the medical professions, with physicians at the fore, use the team in accordance with what they perceive to be of importance. In consequence, the activities of the MPT are dictated by the professional logic of the physicians. These findings highlight the fact that despite the intent to align the MPT with the managerial logic, its implementation and translation in practice is dictated by the most powerful professionals in healthcare organizations: the physicians.

However, it is important to note that despite the MPT not acting as a forum where different professions share and integrate knowledge, all members of the MPT gained positive effects in relation to their own individual work with the patient.

The paper highlights the fact that the effects of the MPT in practice are contingent on the context in which it is implemented. It illustrates that the physicians have the ability to steer the work of the MPT, and its associated members, towards focusing on areas which they believe to be of importance. As such, the paper underlines that the tradition of healthcare organizations, where physician have been able to control their own work and that of other professionals, remains important in understanding the contextual contingencies in which the QIW is undertaken. Although the paper specifically studies the organizing undertaken in MPTs, the paper highlights the mechanisms at the actor level of analysis, which allow professional practice to remain fairly stable despite the contemporary complexity of healthcare organizations. Albeit the institutional complexity of healthcare organizations consists of multiple nuances, or even variations, of professional and managerial logics, the paper illustrates that other professions are not able to affect practices to the same extent as physicians. Moreover, while being influential enough to incorporate mandatory QI interventions such as the MPT, the implication is that the managerial logic is unable to radically influence QIW undertaken in practice. Instead, it is clear that the position of physicians remains strong and that their ability to control their own and other professionals' work remains resilient – despite the diverse and contradictory demands imposed by the current institutional complexity of healthcare organizations. Consequently, the paper highlights the contextually dependent mechanisms at the actor level of analysis that enable the practice of healthcare professionals to remain fairly stable despite the unprecedented attempts to alter it, in illustrating how the QIW undertaken may actually preserve institutionalized arrangements instead of altering them.

Paper 4 - Institutional work through interaction in highly institutionalized settings: quality improvement work in healthcare

Authors: Thomas Andersson and Christian Gadolin
Journal: *Organization Studies* (In review)

Research question 4: *How might interactions between individual actors enable logics to be bridged and in turn facilitate healthcare professionals' involvement in QIW?*

Previous research argues that the institutionalized character of healthcare practices make them rigid and difficult to change. At the actor level of analysis this rigidity is reflected in individual actors' adherence to conflicting and often irreconcilable institutional logics, which inhibit different actors from influencing each other and hence uphold the rigidity of practice. Previous studies have suggested that constructive relationships, which enable actors' reciprocal influence and mutual understanding, are fundamental for achieving healthcare professionals' involvement in QIW. However, there is dearth a of studies addressing what characterizes interactions at the actor level of analysis that enable the often distinct mindset and perspectives of diverse actors to be bridged, facilitating the necessary new practices to emerge in order to realize healthcare professionals' involvement in QIW. As such, there is not yet any delineation of what separates interactions that enable the bridging of institutional logics, and their idiosyncratic attributes in relation to interactions that reproduce and hence establish institutional arrangements at the actor level of analysis.

In addressing this lack, the paper highlights the fact that most interactions taking place between the individual actors, in some way, shape, or form contribute towards upholding the institutionalized arrangements in healthcare, meaning that most interactions constitute institutional work which maintains institutions in the long term. However, interactions that facilitate the bridging of differing institutional logics at the actor level of analysis, i.e. that they enable the bridging of mindsets and perspectives of distinct social actors, are interactions that transcend what is prescribed by the institutional logics that are available and accessible. These interactions are denoted as institutional work which in the long run might enable the creation and/or disruption of institutions as they transcend the guidelines given by the manifestations of institutions at the actor level of analysis. Interactions which include the reciprocal acts of claiming and granting influence were prerequisites for healthcare professionals to involve themselves in QIW. The paper consequently highlights what types of interaction are necessary to break the deadlock imposed by logic identification and adherence. These interactions constituted institutional work at the actor level of analysis that in the long run might create and/or dispute institutions. Such institutional work facilities healthcare professionals' involvement in QIW. However, it is important to note that physicians' approaches in interactions are crucial, as they may have the ability to hinder interactions that enable the bridging of logics through their unwillingness to grant other individual actors influence.

In conclusion, the paper highlights the idiosyncratic interactions that enable the mindsets and perspectives of individual actors in healthcare organizations to be bridged, and in turn facilitate healthcare professionals' involvement in QIW.

However, following the unique historical and contemporary power position of physicians, it is clear that such interactions are primarily contingent on the approaches of physicians. The paper further accentuates the necessity of acknowledging the unique context of healthcare organizations, its relation to the facilitation of healthcare professionals' involvement in QIW and the conditions for actors' interactions which it implies.

Conclusions and contributions

This dissertation confirms that QI is often perceived as alien by healthcare professionals and that their active involvement in QIW is often absent (cf. Cabana *et al.*, 1999; Dijkstra *et al.*, 2000; Grol & Wensin, 2004; Audet *et al.*, 2005, Powell *et al.*, 2009; Tummers, 2012; Bååthe, 2015; Eriksson *et al.*, 2016). This dissertation argues that the primary reason for healthcare professionals' lack of involvement is the history and tradition of healthcare organizations, where professional judgements and discretion have been the cornerstone in dictating what denotes quality of care and how it should be achieved. In stark contrast, QIW represents the fairly new institutionalized presence of the managerial logic in healthcare organizations, which dictates that the schooled judgment of healthcare professionals is no longer omnipotent. This distinction is manifested in QIW through the broader span of aspects that are considered to constitute 'quality of care', as well as new approaches towards how quality of care should be achieved and improved in juxtaposition to the traditional principles of professional control (cf. Batalden & Stolz, 1993; Blumenthal, 1996).

At the actor level of analysis, this conflict was reflected in a general scepticism towards managers and process developers, as they were perceived to be representatives of the managerial logic, which in turn habitually made them out to be the general antagonists of the healthcare professionals. Subsequently, automatic resistance and/or hesitation towards managers and process developers was frequently an inherent feature of, and preconception by, healthcare professionals. Such preconceptions led to collaboration between social actors identifying with and adhering to different institutional logics often being undermined before they had even begun. Collaborative efforts between and among healthcare professionals and managers, collaboration being demanded by management, thus had contextually inherent difficulties in being constructive. The conflict of institutional logics at the actor level of analysis, both generally and specifically in relation to what denotes 'quality of care' as well as how it should be improved, affects the prerequisites for healthcare professionals' involvement in QIW. The dissertation argues that the lack of healthcare professionals' active involvement in QIW may principally be understood as the conflict between institutional logics at the actor level of analysis. These conflicts originate from what Friedland and Alford (1991, p. 256) describe as disagreements concerning "the appropriate relations between institutions, and by which institutional logic different activities should be regulated and to which categories of persons they apply" and thus ultimately which logic holds a

mandate to legitimately dictate practice (cf. Cloutier & Langley, 2013). Accordingly, this dissertation has established that the conflict of institutional logics at the actor level of analysis is a vital component in analysing healthcare professionals' involvement in QIW (cf. Currie *et al.*, 2012; Arman *et al.*, 2014). In utilizing the institutional logics perspective (Thornton *et al.*, 2012) in framing the empirical findings that healthcare professionals' active involvement in QIW is often lacking, the study makes explicit the connection between the institutions that govern social actors' actions and behaviour and the conflicts this may instigate in relation to QIW in healthcare organizations. The study thus places the focus on the actor level of analysis, with the aim of studying what actors do and understanding why, albeit making explicit the connection between the actor level of analysis and the collective nature of professionalized practices in utilizing the institutional logics concept in describing and analysing healthcare professionals' involvement in QIW. While the availability and accessibility of the professional logic and the managerial logic are not exclusive to the actor level of analysis in healthcare organizations, the salient institutionalized character of healthcare practices, following its long tradition of professional control of work, makes the dichotomy particularly relevant when studying the effects of managerially instigated QI in practice. Consequently, the underlying conflict between the professional logic and the managerial logic, originating from their distinctly prescribed legitimate bases for the control of work, is the quintessential starting point for understanding the difficulties of QI interventions in healthcare organizations as well as why it is difficult to facilitate healthcare professionals' active involvement in QIW. Future studies addressing QI interventions in healthcare organizations and/or QIW ought to take account of institutional complexity and the effects of conflicting institutional logics.

However, while it is necessary to acknowledge the influence of the conflict between the professional and managerial logics at the actor level of analysis, this dissertation makes explicit that social actors do not simply reflect the prescribed content of a certain institutional logic. The agency of social actors in relation to their employment of institutional logic at the actor level has previously been emphasized (e.g., McPherson & Sauder, 2013; Kristiansen *et al*., 2015; Bévort & Suddaby, 2016; Reay *et al.*, 2016), however, this study highlights the distinct preconditions for different professional groups in healthcare to exercise agency in relation to the institutional complexity of healthcare organizations and subsequently how it affects professionals' approaches and practices in QIW. In comparing the two largest groups of professionals in healthcare organizations, namely physicians and nurses, the study demonstrates the inter-professional discrepancies in relation to their degree of identification with and adherence to

the professional logic. In the unique contextual setting of healthcare organizations, physicians have had an unprecedented ability to control their own and other professionals' work, as reflected in their generally high degree of identification with and adherence to the professional logic. This entails them perceiving the axiom of the professional logic as legitimate, dictating that professional discretion is correct in directing work, and consequently that they perceive queries regarding what denotes quality of care and how it should be improved as contingent on schooled professional judgements. As previously noted, the right of exclusive control over work is "*the essential characteristic of ideal-type professionalism from which all else flows*" (Freidson, 2001, p. 32, emphasis in original). It is proposed that physicians are the professionals who come closest to the ideal-type profession (Freidson, 2001). This study suggests that this proximity remains in place. In this study, nurses' identification with and adherence to the professional logic is lower than that of physicians, which means that they are less constrained by the axiom of the professional logic and subsequently less constrained in their approaches and practices in relation to QIW than physicians. This is highlighted in the study through illustrating nurses' ability to strategically employ the managerial logic explicitly.

This study has elaborated upon the often acknowledged empirical phenomena that nurses are more disposed to successfully internalize a managerial identity (e.g., Llewellyn, 2001; Blomgren, 2003; Croft *et al.*, 2014, Andersson, 2015; Currie *et al.*, 2015) through emphasizing its interconnectedness with nurses' degree of identification with and adherence to the professional logic. Through highlighting the effects of logic identification and adherence on approaches and practices in QIW, the conclusion of the study is thus that professional logic identification and adherence is a vital component in understanding physicians' and nurses' diverse preconditions to involve themselves in QIW. While this dissertation solely juxtaposes two professionals groups, the methodological underpinnings of the study allow for theoretical generalizability, in other words, that the findings are of relevance for all professional groups working in healthcare organizations. In embracing the contextual particularities of healthcare organizations, this implies that the preconditions for various professional groups to involve themselves in QIW ought to be acknowledged in part as unique due to what is presumably their varied identification with and adherence to the professional logic and intertwined preconception of legitimate control of professional work. The study shows that it is not sufficient to address the broad consequences of professionalism, or even medical professionalism, in taking a professional employee perspective on healthcare professionals' involvement in QIW. Nuances specific to, and contingent on, the tradition and

history of healthcare organizations must be acknowledged when conceptualizing the difficulties derived from the professional status of healthcare occupations in relation to managerial interventions aiming to apply bureaucratic control over professional work.

Likewise, it is important to acknowledge the specific context of healthcare organizations in order to understand the outcomes of QIW. The study highlights the difficulties for multi-professional teams (MPT) to act as forums where different professions overtly share and integrate knowledge. Conversely, the physicians in the team are able to put their interests at the forefront of attention, enabling their perspective to be the principal guide in the efforts of MPTs. The utilization of multiple perspectives in the MPT is consequently impaired. It is argued that such utilization is pivotal for the success of the MPT in achieving improved performance (Daspit *et al.*, 2013), as well as a cornerstone in the broader category of QI tools and methods that emphasize collaborative QIW in order to realize better results in general (see Batalden & Stolz, 1993). The mechanism highlighted in the study, which allows the physicians to direct the practices and work of the MPT through the influence imbued by the physicians' professional logic, is not only of relevance in understanding the specific occurrence of how care is organized with MPTs, but is also relevant for the understanding of general challenges associated with managerially instigated QI initiatives, as their aim is often to initiate QIW where a broader organizational perspective is adopted. Adopting a broader organizational perspective demands circumventing the traditional preconception of physicians perceiving themselves as "lone agents of success or failure" (Berwick, 1989, p. 55) towards incorporating the perspectives of the multiplicity of social actors within healthcare organizations relevant for the quality of care provided and the interrelated outcomes of treatment. Consequently, the mechanism found in this study, explaining how the MTP functioned, are reasonably relevant for understanding all types of managerially enforced practices and QI interventions dictating the utilization of multiple professionals' perspective.

Combining the findings of this study, which highlight the fact that the impact even of institutionalized QI tools and methods is dependent on the hierarchization, enactment and translation of institutional logic at the actor level of analysis, with the findings of Currie *et al.* (2012), which highlight similar results in illustrating the institutional work undertaken by specialized physicians to maintain institutionalized arrangements when their professional dominance and control over work is under threat, enables different aspects concerning the broader viability of denoting practices in healthcare organizations as rigid to be addressed. The findings in this study illustrate how established routines and

practices may remain stable despite the forced application of tools and methods for organizing care that propagate a starting point which deviates from the tradition of healthcare organizations. The findings of Currie *et al.* (2012) complement the mechanisms illustrated in this study as they elucidate the institutional work undertaken by the most powerful professions in order to maintain institutions at the actor level of analysis when institutionalized arrangements are perceived to be a threat, when 'something new' is introduced. Jointly, the findings highlight the fact that the duality of institutional logics and institutional work, at the actor level of analysis, are of relevance for explaining the rigidity of healthcare organizations and how professional modes of working may remain entrenched despite unprecedented attempts to disrupt and change them over years of reforms (cf. Ackroyd *et al*., 2007) and despite their institutional complexity (Greenwood *et al.*, 2011). Overall, this dissertation illustrates the importance of recognizing the specific context and complexity of healthcare organizations in order to understand the results of managerially imposed QI structures. More specifically, it elucidates how the inherent tradition, most notably of physicians', professional autonomy, mean that the consequences of healthcare professionals' QIW are often divergent from managers' intended outcomes.

Above an account is provided of the research implications of the study in relation to the various challenges and difficulties originating from healthcare organizations' context and complexity, its effects on healthcare professionals' involvement in QIW, and the outcomes of such work. In addition to these implications, the study highlights the characteristics of the interactions among individual actors that may enable healthcare professionals' involvement in QIW. In other words, the characteristics of the interactions that transcended the reproduction of already established practices. As noted in the study, most interactions that took place among diverse individual actors in relation to the QIW undertaken embodied institutional work which maintained institutionalized arrangements and consequently maintained practice. These interactions did not enable reciprocal acts of claiming and granting influence, as the actors either kept their distance from each other or did not acknowledge an act of granting or claiming influence from their counterpart. In turn, these interactions hindered healthcare professionals' involvement in QIW through reinforcing the separation of their distinct perspectives and mindsets, which often entailed establishing the professional dominance of the physicians and subsequently denigrating the perspectives of other individual actors in having substantial influence in relation to the QIW. These interactions thus hindered QIW which took a broader system/organizational perspective.

In stark contrast to the lion's share of the interactions between individual actors taking place in relation to the QIW, some specific interactions were able to facilitate a loosening of institutional constraints and established practice. Characteristic of these interactions were individual actors' reciprocal acts of claiming and granting each other influence. As these interactions took place between actors who primarily adhered to different institutional logics, these interactions facilitated the bridging of institutional logics, and thus the manifestations of institutions at the actor level of analysis, enabling actions that modified or challenged established practices. These interactions enabled the individual actors to influence each other beyond what was prescribed by the perceived order of available and accessible institutional logics – enabling healthcare professionals' involvement in QIW to transcend what was customary. These interactions consequently constituted creative/disruptive institutional work at the actor level of analysis capable of inducing change despite the institutionalized character of healthcare organizations. However, the physicians' approaches in these interactions were pivotal. As a result of their strong identification with and adherence to their professional logic, and enabled by their often strong position in relation to other actors (cf. Topal, 2015), the physicians mainly undertook maintaining institutional work, preventing interactions that comprised creative/disruptive institutional work occurring through their persistence in preventing the influence of other actors. This study consequently strengthens the impression that physicians have strong professional positions within healthcare organizations with the ability to 'make things happen' (cf. Reay & Hinings, 2009; Croft *et al.*, 2014; Currie *et al.*, 2015; Currie & Spyridonidis, 2016), albeit often being reluctant to change due to their power position (cf. Battilana & D'Aunno, 2009; Currie *et al.*, 2012), while specifically highlighting how this actuality relates to the preconditions for facilitating healthcare professionals' involvement in QIW. In conclusion, these findings address the broader research agenda aiming to explain the preconditions for healthcare professionals' involvement in QIW. However, in recognizing the pivotal importance of acknowledging the unique context and complexity of healthcare organizations in such endeavours, this study takes account of the inability to find universal obstacles or barriers to healthcare professionals' involvement in QIW. Instead, the study illustrates the creative/disruptive institutional work required for actors to find new approaches to each other, facilitating the emergence of new routines and practices through interaction in everyday work. It is argued that institutional work is a relational phenomenon, contingent on the interactions of diverse actors who primarily identify with and adhere to different institutional logics. It has previously been argued that the relationships between individual actors in healthcare organizations are pivotal in

'bridging the worlds' and in enabling mutual appreciation and reciprocal influence (e.g., Bååthe, 2015; Andreasson *et al.*, 2016). This study shows *how* mutual appreciation and reciprocal influence is able to initiate creative/disruptive institutional work at the actor level of analysis, enabling actors to find new approaches to each other necessary to transcend the highly institutionalized character of healthcare organizations and as such enabling new routines and practices to emerge in relation to healthcare professionals' involvement in QIW.

Theoretical reflections and contributions

In addition to the implications of this study in relation to studying healthcare professionals' involvement in QIW outlined above, the dissertation necessitates additional theoretical reflections and reveals further theoretical implications. Overall, the theoretical contributions relate to the viability of understanding organizational practices as greatly influenced by the institutional logics available and accessible for social actors to elaborate (cf. Friedland & Alford, 1991) and perform into being (cf. Lindberg, 2014). In showing how the general contradiction between the professional logic and the managerial logic plays out at the actor level of analysis, the study confirms Friedland and Alford's (1991) proposal that some of the most important struggles in organizations and between groups are over which institutional logic should regulate which actives and to whom its prescriptions should apply. The dissertation concludes that actors within organizations may draw from various institutional logics when they rationalize actions and behaviour. In turn, the distinct basis that different institutional logics constitute in affecting actors' perspectives and mindsets may instigate seemingly irreconcilable conflicts at the actor level of analysis. The dissertation consequently suggests the appropriateness of utilizing the institutional logics concept in order to study and understand practice at the actor level of analysis (cf. Suddaby, 2010; Cloutier & Langley, 2013; Suddaby *et al*., 2013; Blomgren & Waks, 2015) as influenced by supraorganizational patterns of human activity (cf. Friedland & Alford, 1991). In doing so, the shortcoming often attributed to empirical studies, i.e. the lack of theoretical anchorage and failure to achieve cumulative knowledge (cf. Suddaby *et al.*, 2013; Seidl & Whittington, 2014), is adequately addressed in this study.

The study has further theoretical implications in relation to understanding the preconditions for diverse social actors to manoeuvre institutionally complex organizations where multiple and enduring institutional logics exert an influence (cf. Greenwood *et al.*, 2011; Besharov & Smith, 2014). The study found that a higher degree of identification with and adherence to the professional logic

diminished the prospect of professional actors strategically employing the managerial logic, as this would entail acknowledging its axiom of bureaucratic control of work as legitimate. These findings are aligned with the proposal of Pache and Santos (2013), who argue that individuals' responses to competing institutional logics within organizations are driven by the individuals' degree of adherence to each competing logic. Consequently, this study strengthens and elaborates upon the proposal that logic identification and adherence is a vital component in understanding the disposition of social actors to manoeuvre institutionally complex organizations. However, the agency of the professional actors, who were less restrained by professional logic identification and adherence, was also highlighted in the study through illustrating the nurses' ability to strategically employ the managerial logic, in that they were able to explicitly acknowledge bureaucratic control of work as legitimate. These findings strengthen the proposal that social actors may use institutional logics as "tools" to achieve desired outcomes (McPherson & Sauder, 2013), while simultaneously underscoring the necessity of understanding the contextual constraints imposed by institutional demands upon social actors' ability to do so. In summary, this dissertation establishes that social actors' logic identification and adherence is an important component in understanding the preconditions for them to manoeuvre institutionally complex organizations as well as the interconnected employment of the various accessible and available institutional logics. In a broader sense, the findings presented in this dissertation suggest that the dichotomy of professionals versus managers, or the professional logic versus the managerial logic, is ill-suited to capture complexity at the actor level of analysis. The reason for this is that contextual particularities may create nuances in relation to professional logics that it is not possible to adequately address using such crude antagonistic conceptualization of different groups of social actors (cf. Dunleavy & Hood, 1994). The notion of professional logic identification, adherence, or even content, should consequently not be applied bluntly to all types of professions.

It is, however, important to note that while this dissertation highlights the fact that the preconditions for social actors to manoeuvre institutionally complex organizations may be distinct, and consequently their ability to manoeuvre the multiple regulatory regimes they often face (see Kraatz & Block, 2008), outcomes in practice are dependent on elaborate interactions between social actors who hold varied, and often distinct, status and power *vis-à-vis* other groups of actors. As such, outcomes in practice of interactions among actors must be understood as interrelated in the hierarchization of institutional logics (cf. Arman *et al.*, 2014). The viability and necessity of understanding practice as

contingent on the hierarchization of institutional logics is further delineated in this dissertation, as it shows how physicians are able to steer the work of the MPT. Consequently, they also steer the work of the members that constitute the team in relation to primary efforts executed in the team structure due to the relative dominance of their professional logic in relation to the other professional groups. These findings broaden the concept of hierarchization of logics at the actor level of analysis in organizations to incorporate more elaborate and complex relations than merely the professional logic and the managerial logic (see Arman *et al.*, 2014), underlining the necessity of acknowledging the nuances of professional logics when studying their interconnectedness and relations in order to facilitate understanding of practice as contingent on their interactions. Moreover, the findings underline the fact that the physicians were able to steer the work of the MPT despite its structure being closely related to the managerial logic. As noted, it is argued that it is necessary for the MPT to utilize multiple perspectives in order to achieve improved performance and improved quality of care. Similarly, a fundamental underpinning of the managerial logic is to employ a broader systems/organizational perspective in order to facilitate consideration of multiple perspectives on quality of care, not just what is deemed to be quality by the physicians as has traditionally been the case (cf. Batalden & Stolz, 1993). Hence, the requirement to organize care with multi-professional teams may be understood as a manifestation of the institutionalization of the managerial logic in healthcare organizations (see Scott *et al.*, 2000; Audet *et al.*, 2005; Reay & Hinings, 2005). Consequently, this study highlights the necessity of acknowledging the impact of hierarchization of institutional logics at the actor level of analysis in order to explain outcomes of social actors' interactions. More specifically, the dissertation illustrates how the dominance of an institutional logic may enable organizational practice to remain fairly stable and entrenched, despite the multiple and conflicting demands exhibited within institutionally complex organizations.

In combining the findings of this dissertation with the findings of Currie *et al*. (2012), the ability of the diverse, yet interrelated, concepts of institutional logics and institutional work to put the focus on various institutional dynamics (cf. Zilber, 2013) at the actor level of analysis begins to crystallize. Whereas the findings of this study illustrate the applicability of the institutional logics concept in order to understand why organizational practices appear as they do, as well as explaining how institutionalized mechanisms uphold the rigidity of practices, the findings of Currie *et al.* (2012) highlight that the institutional work concept is exceptional in explaining how the actions of social actors are able to

maintain institutionalized arrangements even when they are seriously challenged. Moreover, Currie *et al.* (2012) indicate that institutional work which maintains institutions at the actor level of analysis are likely to be instigated by powerful/elite social actors as they aspire to preserve the hierarchization of logics and for their interconnected status/power to remain intact.

In explicitly utilizing the combination of the concepts of institutional logics and institutional work at the actor level of analysis, where both concepts are understood as included in the broader institutional logics perspective (Thornton *et al.*, 2012), this dissertation further strengthens the viability of the concepts to focus on distinct aspects of institutional dynamics as well as broadening the mechanism that the institutional work concept is able to capture. Whereas Currie *et al.* (2012) skilfully highlight the institutional work undertaken by elite professionals as a result of policies imposed that were perceived as an external threat to their dominance, thus illustrating that institutional work is able explain how the actions and interactions of social actors are able to uphold the institutional order when it is exposed to sudden and instant influences, this dissertation places the focus on how institutional work is similarly present and undertaken in more mundane day-to-day activities and work. This study emphasizes that most institutional work taking place at the actor level of analysis in everyday, mundane, practical work (cf. Smets & Jarzabkowski, 2013) maintains institutional arrangements due to mechanisms of decoupling, hierarchization, selective coupling and disparaging. All these mechanisms hinder social actors from influencing each other in ways transcending that which is stipulated by available and accessible institutional logics, which means that practices remain relatively stable and entrenched. However, the findings of this study further highlight the interactions of individual actors where the rigidity of institutional arrangements imposed by conflicting institutional logics are mended or at least momentarily broken. These interactions are characterized both by acts of claiming influence and acts of granting influence between actors adhering to different institutional logics. Consequently, these reciprocal acts of claiming and granting influence enable individual actors' interactions and actions to deviate from what is prescribed by prevailing institutionalized arrangements. In that they enable the rigidity of institutional arrangements to be at least momentarily broken or mended, these interactions constitute creative/disruptive institutional work at the actor level of analysis (cf. Battilana & D'Aunno, 2009), which might in the long run induce organizational and institutional change. The way in which institutional work is studied and understood at the actor level of analysis in this dissertation emphasizes the fact that that successful cognizant attempts by powerful actors to induce change is

solely one explanation of change (cf. Jepperson, 1991). Moreover, this dissertation emphasizes the interconnectedness of institutional logics and institutional work, acknowledging that "institutional work and practices are always shaped by available and accessible institutional logics" (Thornton *et al.*, 2012, p. 180). As such it is argued that institutional work at the actor level of analysis, when understood as "all human action that has institutional effects" (Lawrence *et al.,* 2009, p. 13) in order to place the focus on the emergence of institutions, may be operationalized as actors' actions and interactions that either maintain the order imposed by available and accessible institutional logics or as actors' actions and interactions that transcend this order. The latter are what characterize creative/disruptive institutional work, as only such actions and interactions may transcend the maintenance of institutional arrangements and in the long run have the potential to induce organizational and institutional change. Consequently, the proposals of this dissertation enable and encourage further studies of creative/disruptive institutional work at the actor level of analysis 'in the making', rather than retaining institutional work as a concept solely able to focus the macro-level of analysis in describing historical accounts of institutional changes over longer periods of time (cf. Empson *et al.*, 2013).

In conclusion, this dissertation illustrates how the concepts of institutional logics and institutional work are able to be beneficially utilized in combination in order to focus on distinct, yet interrelated and iterative, institutional dynamics at the actor level of analysis (cf. Zilber, 2013). As illustrated in this dissertation, the concept of institutional logics enables a focus on how institutions affect the actions and interactions of individual actors, which in turn enables an explanation of how supraorganizational patterns influence practice at the actor level of analysis (cf. Clegg, 2010; Suddaby, 2010). In contrast, as also illustrated in this dissertation, the concept of institutional work enables focus to be placed on how institutions are constantly and continuously dependent on the actions and interactions of social actors at the actor level of analysis. Moreover, both concepts place the focus on the importance of the agency of social actors within organizations, whether it relates to the ability of social actors to translate, enact, or employ the perceived content of an institutional logic or the ability of actors to instigate institutional work that either maintains or creates/disrupts institutional arrangements at the actor level of analysis. Consequently, it is argued that the theoretical framework utilized in this dissertation enables an eradication of the impressions of organizations as "uninhabited" (Bévort & Suddaby, 2016), satisfactorily addressing the lack of focus on actors within institutional theory and the interconnected lack of ability to explain organizational and institutional change (cf. Tolbert & Zucker, 1996; Dacin *et al.,*

2002, Clegg, 2010; Suddaby, 2010), while simultaneously upholding the necessity of acknowledging agency as embedded (cf. Battilana, 2006; Tornton & Occasion, 2008; Battilana & D'Aunno, 2009; Thornton *et al.*, 2012).

Practical implications

The purpose of this study is not to be normative in the sense that it aims to prescribe how QI interventions are supposed to be undertaken in order to achieve the involvement of healthcare professionals in QIW. However, as argued in the introduction, an increased understanding of QIW through the perspectives of healthcare professionals is important in such inquires. This study has underlined the importance for different social actors within healthcare organizations to be cognizant of the different mental images (i.e. logics) which guide their perceptions, and concomitant actions, in relation to what denotes 'quality of care', as well as how it ought to be improved. The lack of such awareness often hinders healthcare professionals from involving themselves in QIW. If healthcare professionals are not engaged, it is difficult for QI interventions to achieve an impact in practice.

Moreover, the findings of the study underline not only the importance of being aware of the different and diverse logics which permeate practice, but also what types of interactions are necessitated in order to facilitate healthcare professionals' involvement in QIW. These interactions are characterized by mutual and reciprocal influence, albeit often dependent on the attitudes of physicians in order for such interactions to take place. As such, the study implies that managers and process developers aiming to facilitate QIW should not focus upon the tools and methods of QI. Instead, they should approach physicians, while being cognizant their divergent perspective, with the aim of addressing aspects of the QI intervention that are aligned with their professional fulfilments. Pushing for specific QI associated methodologies or outcomes will most likely result in an inability to facilitate their involvement in QIW. However, it is not solely the responsibility of managers and process developers to recognize these distinct perspectives in order to facilitate healthcare professionals' involvement in QIW. Healthcare professionals, and particularly physicians due to their inherent status, must also be cognizant of the differences inherent in their distinct perspectives in relation to managers and process developers. It is the responsibility of healthcare professionals, managers, and process developers alike to facilitate mutual understanding and respect for each other's position and in turn enable constructive interchange and meetings between logics and actors to take place.

Future research

Further research addressing healthcare professionals' involvement in QIW would benefit from systemically studying the preconditions for the interactions among the individual actors in healthcare organizations to go beyond institutional work that maintains institutional arrangements as such interactions have been emphasized to enable social actors to find new approaches to each other in everyday work. As these interactions further facilitate healthcare professionals' involvement in QIW, it is arguably more constructive to study how such interactions may be encouraged in healthcare organizations rather than provocatively trying to identify the factors and/or barriers that hinder healthcare professionals' involvement in QIW. As extensively argued and illustrated in this dissertation, such undertakings are of questionable value due to elements of complexity and context.

As previously noted, this dissertation establishes the applicability of combining the concepts of institutional logics and institutional work in order to focus on various institutional dynamics at the actor level of analysis. Future research could further address the ability of social actors to strategically employ the institutional logics available to them. Whereas identification and adherence to logics has been argued to constitute a vital component in understanding the institutional constraints of the strategic utilization of other logics, it is important to study the circumstances under which this applies. The professional logic is intrinsically at odds with the managerial logic due to their inherent dichotomist ideological axioms concerning how work ought to be organized and controlled. Identification with and adherence to the professional logic, *ergo* means that strategic employment of the managerial logic is institutionally constrained. However, it is plausible that an individual actor who displays a high degree of identification with and adherence to a certain logic is less constrained to employ another available logic if they are less at odds with each other, as such strategic use would not affect the everyday identity work to as great an extent (cf. Lok, 2010). Consequently, the conditions that influence actors' ability to employ the institutional logics available to them need to be further studied and systemically outlined.

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