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

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5 ## Abstract

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

22 ## Keywords

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

Introduction

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

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

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

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

Institutional logics: coexistence and its consequences

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

logics are "the socially constructed, historical pattern 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" (Thornton & Ocasio 1998, p.804). In other words, institutional logics are the key means by which social reality is reproduced and changed. Distinctive domains of social practice—organizational fields—have their own sets of institutional logics, derived from societal-level logics, from the logics of neighbouring fields, and from the endogenous action of the individuals who populate them (Thornton et al. 2012).

Formative research within the institutional logics approach focused primarily on the dominance of given logics: how this was created, maintained and challenged (e.g. Scott et al. 2000). Increasingly, however, research has found that many fields are characterized by the co-existence of a plurality of logics—often with no single logic dominant in determining actors' disposition and behaviour. Rather than representing a temporary, transitional phase between epochs of dominance by a single logic, "some fields are better portrayed as leaning towards the 'relative incoherence' of enduring, competing logics" (Greenwood et al. 2011, p.323). Greenwood et al. (2011, p.332) note that research on institutional complexity has tended to assume that coexisting logics are "inherently incompatible," but more recent studies have challenged this assumption. Several have found that contradictory logics may coexist in an organizational field, often in a kind of 'creative tension' which means that their influences affect actors simultaneously (e.g. Reay & Hinings 2005; 2009; Lounsbury 2007; Greenwood et al. 2010; Goodrick & Reay 2011; Martin et al. 2015). The plurality of institutional prescriptions available means that a diversity of actor behaviours is often in evidence: for example, Lounsbury (2007) finds that different fund managers operate according to 'trustee' and 'performance' logics concurrently, depending on their geographical location.

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

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

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

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

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

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

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

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

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

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

interests?

Institutional logics in English healthcare, 2005-2011

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

In common with healthcare systems worldwide (e.g. Scott et al. 2000), the NHS is the site of long-term conflict among logics. Of particular note is the influence of the professional, corporate and market logics. The professional logic in healthcare can be characterized as the dominance of professionals over not just clinical but organizational decision-making, and deference among others (managers, patients and lower-status clinicians) to (medical) professional knowledge (Reay & Hinings 2009). The market and corporate logics are sometimes conflated (e.g. Currie & Spyridonidis 2016), but we follow Thornton (2002) in distinguishing between them as two potentially complementary, but conceptually separate, institutional logics. The corporate logic is realized through managerial techniques for controlling professionals' activity, for example performance-management regimes, standardization of clinical care, and development of capacity for surveillance and audit. The

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

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

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

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

275 2010) of the market and corporate logics.

276 Setting and methods

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

300 [TABLE 1 ABOUT HERE]

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

318 [TABLE 2 ABOUT HERE]

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

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

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

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

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

374 **Findings**

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

386 *Professionally led services and shifting institutional logics*

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

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

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

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

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

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

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

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

> "The mistake I've seen a lot of services make is that they try really, really hard to establish because they think there's a need to convince people, there's a need to get funded, and they start seeing stakeholders, but then it stops. […] Products don't survive in the market very long unless they inhabit the environment they're in, learn from it and modify based on their clients' continuously changing needs. And that's what differentiates successful products from not-successful products." (Director of Commissioning, Ashover, T_3)

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

The outcomes: domination; resistance; transformation

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

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

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

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

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

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

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

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

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

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

498 "To me it's actually really pretty streamlined, a very efficient service. […] What

they've done in terms of bringing things up into the twenty-first century is of value to the population, so I think they provide a valuable service." (Clinical director, Carsridge, T_3)

Between the contrasting experiences of Bolbourne, and Carsridge and Dovington, lay Ashover's. Here, funding was sustained throughout the period, but achieving this required fundamental changes to the ethos and delivery model of the service. At the behest of local decision-makers, the original holistic, public-health focus of the service gave way to something much narrower in remit, and better aligned with corporate and market expectations around efficiency and performance against specific measures. The focal actor was expected to agree to a "service specification" with "specific key performance indicators" developed with managers, "which I disagreed with but had to put them forward anyway" (T_4). The service was incorporated into a managed care pathway, with a much more tightly defined service-level agreement that focused on triaging patients at possible risk of inherited cancer. Alongside this, more forensic examination of the service's activities was introduced: "we have now a scoring of interventions, sort of whether it's a low intervention or a high intervention, […] and they're now reviewing that data collection as well, so there'll be a whole new system coming out" (Focal actor (nurse-manager), T_4). The positioning of the service within a managed pathway, along with this extra scrutiny and oversight for managers and commissioners, gave the service legitimacy with key decision-makers. It was now aligned with normative conceptualizations of how to deliver efficient and well managed healthcare, as part of a defined pathway that offered a cheaper alternative to hospital-based care:

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

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

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

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

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

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

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

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

551 *Making sense of the contrasting outcomes*

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

558 [TABLE 3 ABOUT HERE]

559 In all four cases, hard evidence about the efficiency or effectiveness of the services was
560 in short supply (see Martin et al. 2012). Evidence of this nature was difficult for focal actors to
561 generate—partly because they had never devised their services with such a crudely economic
562 calculus in mind, but also because generating such evidence was difficult in genetics with its
563 long-term, not short-term, outcomes: "it's difficult to demonstrate their value or the amount of
564 money they're saving," as a manager in Carsridge acknowledged (T_3). Explanations for the
565 divergent outcomes premised on a rationalistic understanding of organizational decision-
566 making can therefore be discounted.

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

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

574 of the focal actors in making the case for their services. Other micro-level studies have noted
575 the importance of actors who are "highly reflexive and somewhat creative in interpreting the
576 pressures for institutional change" (Bévort & Suddaby 2015; cf. Smets & Jarzabkowski 2013;
577 Currie & Spyridonidis 2016), and going against the 'institutional grain' clearly requires
578 capacity for lateral thinking and persuasive ability. There was some support for this notion in
579 our data. One decision-maker in Bolbourne intimated that the focal actor did not have "the right
580 personality to go out there and engage people and get people stirred up" (T_3). However, it was
581 clearly not the case that any of the focal actors was naïve about the changing environment they
582 were facing: over the course of our four interviews with each of them, they demonstrated an
583 astute, reflexive understanding the changing healthcare system and the risks this posed to their
584 services. And of course, unlike the seven other services sampled in our original evaluation,
585 these focal actors had at least obtained initial local funding beyond the pilot monies provided
586 by central government.

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

599 A more convincing and comprehensive explanation is possible if we focus on neither
600 actors' social position nor their creative capacity *per se*, but on the consequences for these of
601 the wider changes taking place in the field at the time. While the rise of the market logic over
602 the period of the study applied equally across the English healthcare field, its effects at an
603 organizational level were unequal. For the primary-care organizations that hosted the services
604 in Ashover and Bolbourne, the rise of the market was unprecedented, and brought significant
605 structural changes. As commissioning organizations (budget holders for the healthcare needs
606 of the local population), they were required to relinquish their responsibility for service
607 provision to enable competition for services that had been provided in-house. The services that
608 had been a part of these organizations, including Ashover's and Bolbourne's genetics services,
609 had to be reconstituted as financially independent standalone bodies, or incorporated into
610 existing provider organizations. Consequently, the focal actors in Ashover and Bolbourne
611 found themselves in the midst of a complicated process of organizational disengagement, and
612 were cut adrift from their organizational sponsors. The focal actor in Ashover found that her
613 new managers "didn't have as much insight into the service and were less committed to seeing
614 it expand" (T_3), while in Bolbourne, the service's manager had "less direct involvement" in the
615 service, "although because there was not really anyone else to do it I did carry on to an extent"
616 (T_3). Further, and more critically, the focal actors were exposed to a range of expectations
617 associated with the market logic that were foreign to them—and lacked the managerial support
618 necessary to coherently argue their case in response.
619 On the face of it, this challenge also applied to Carsridge and Dovington. However, here
620 the services were hosted by hospitals with long experience of participating in a competitive
621 market—and this equipped them much better to deal with the changing expectations of the new
622 regime. The primary-care organizations in which Ashover's and Bolbourne's focal actors
623 worked had only ever encountered the competitive market as budget holders, choosing between

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

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

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

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

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

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

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

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

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

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

663 In the absence of such support, Ashover and Bolbourne faced greater challenges. Bolbourne's
664 focal actor floundered, but in Ashover the focal actor was able to draw on her experience as a
665 manager—her dual embeddedness in the professional and corporate logics (Pache & Santos
666 2013)—to reframe her service. As we have seen, though, this came at the cost of transforming
667 the service model itself, so that it was premised not on a professional logic but on notions of
668 efficiency and throughput. For all four focal actors, however, the ability and opportunity to
669 invoke and make advantageous use of logics was heavily shaped—one might even say
670 structured—by influences beyond their capacity and social position as individual agents, but
671 below the level of the field as a whole. Organizational context and the nature of their
672 relationship with other agents—themselves affiliated with other logics—were crucial
673 mediators of the relationship between field-level configuration of logics and individual-level

674 autonomy.

675 Discussion

676 Our paper seeks to bridge macro-level and micro-level work on responses to institutional
677 complexity by using comparative, longitudinal analysis to examine the conditions under which
678 actors are able to defy changing institutional prescriptions. In particular, we show that a
679 common 'constellation' of institutional logics (Goodrick & Reay 2011; Waldorff et al. 2013)
680 could give rise to divergent outcomes at the level of practice. Constellations are thus not just
681 'celestial' features of the field-level 'sky': the relationship between logics was also realized
682 through the work of actors on the 'ground'. Most notably, whereas the corporate logic aligned,
683 as the literature predicts (Thornton 2002; Martin et al. 2015), with the market logic in some
684 cases, in others it proved a remarkably robust defence for the professional logic against the
685 market logic. But none of the actors had free rein to pick and choose from the plurality of logics
686 present in this complex field. Rather, influences above the level of the actor but below that of
687 the field were important mediators and shapers of autonomy.

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

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

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

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

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

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

746 within both the professional and the corporate logic proved a mixed blessing, enabling the
747 service to continue but only through transformation in its character. Boxenbaum and Battilana
748 (2005, p.359) echo Besharov and Smith's (2014) contention that staff with multiple
749 institutional affiliations can help to reduce incompatibility and increase autonomy: "the more
750 contexts individuals are embedded in, the more options they have available for transposing
751 practices." But while this helped Ashover's focal actor avoid the termination of the service that
752 occurred in Bolbourne, it offered her substantially less discretion than that enjoyed by the focal
753 actors in Carsridge and Dovington. Dual embeddedness may then improve actors' *access* to
754 different logics, but it does not necessarily give them freedom of choice in *enacting* them. The
755 configuration of organizations and the carriers of logics within them, not just their composition,
756 matters, and as such structurally differentiated hybrid arrangements have the potential, at least,
757 to reconcile conflicting logics as effectively as blended hybrids.
758 Understood this way, the findings of other micro-level studies that have emphasised the
759 ingenuity of individual actors might be seen in a slightly different light. For example, Murray
760 (2010, p.379) sees the response of scientists to unfamiliar commercial pressures arising from
761 the patenting of the genetic modification of 'OncoMouse' as the "sophisticated [production] of
762 new hybrids," in which the "expertise that allows [key actors] to transpose elements from each
763 logic" to protect the autonomy of science was crucial. Yet it is also evident from her study that
764 the privileged access to a wider, supportive, infrastructure—including "lawyers, TTO
765 professionals, university counsel, and corporate executives"—was also critical to this
766 endeavour: it was not expertise or status alone that enabled autonomy. McPherson and Sauder
767 (2013, p.186) show that actors in a drugs court draw relatively freely upon a "shared toolkit"
768 of logics in pursuit of their interests, but some actors are better placed than others to do so: the
769 relational position of probation officers means they occupy a position of 'brokerage' that allows
770 them privileged access to the 'home' logics of others, even though they lack the status of other

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

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

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

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

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

820 in the rules and norms of different logics were only as good as the organizational setting and
821 social relationships they enjoyed. Autonomy was constrained where these were lacking and
822 enabled when these were favourable. Over the period studied, institutional prescriptions were
823 consolidated, with greater *centralization* of logics and the ascendency of market and corporate
824 logics that seemed incompatible with the professional logic. Both of these changes should work
825 to constrain actors' autonomy. Nevertheless, meso-level features of organizations within the
826 field made a significant difference to the consequences for actors, maintaining latitude for some
827 while others faced constraint (cf. Besharov & Smith 2014). We contend that attending to these
828 features could go a long way towards explaining the disjuncture between macro- and micro-
829 level findings about the partial autonomy afforded to professionals at the coalface.

830 Our analysis offers several suggestions for future research. In particular, we suggest that
831 more attention to the meso-level mediators of agency, perhaps building on the typology we
832 outline above, would help to understand how the prescriptions and openings for discretion at
833 the field level do or do not translate into opportunities at the individual level. Further work that
834 combines a detailed, phenomenological understanding of micro-level activity with comparison
835 of similar or divergent contexts would be helpful. Relatedly, further conceptual development
836 of Thornton et al.'s (2012, p.7) notion of "avenues for partial autonomy" would be helpful in
837 reconciling macro- and micro-level work in the field of neo-institutionalism. As noted above,
838 while many macro-level studies claim to show how institutional complexity affords
839 opportunities for autonomy, they often remain steadfastly structuralist in the way they describe
840 these (e.g. Waldorff et al. 2013). Finally, we strongly endorse Greenwood et al.'s (2011) call
841 for research that embraces the impact of the coexistence of more than two logics, and Thornton
842 and Ocasio's (2008) point that what constitutes a logic needs to be carefully considered by
843 those seeking to study their effects. The market and corporate logics appear, on the face of it,
844 to present a concerted threat to the professional logic in rapidly changing fields such as

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

850 **Conclusion**

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

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1002

1003 **Table 1: Overview of the 11 pilots included in the original evaluation**

	Stream	Pilot lead	Profession of lead	Host organization(s)	Continued post-pilot?	Reasons for non-continuation
Ashover	Cancer genetics	Nurse by background; now manager	Nurse	Primary care organization	**Yes**	
Bolbourne	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**Yes**	
Carsridge	Cancer genetics	Clinical geneticist	Physician	Hospital organization	**Yes**	
Dovington	Service development	Specialist physician	Physician	Hospital organization	**Yes**	
E	Cancer genetics	Nurse	Nurse	Consortium of primary care organizations	**No**	Reconfiguration of primary care organizations and consequent failure to agree to continued funding
F	Cancer genetics	Clinical geneticist	Physician	Two hospital organizations	**No**	Failure to agree to continued funding (scaled down version maintained in one hospital)
G	Service development	Specialist physician	Physician	Three hospital organizations	**No**	Conflict over allocation of resources and professional roles among host organizations leads to agreement to discontinue
H	Service development	Specialist physician	Nurse	Hospital organization	**No**	Project ceased at end of funding; results included in guidelines for referrals to genetics service
I	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**No**	Always intended to be a time-limited educational intervention
J	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**No**	Geneticists refuse to support (see Martin et al. 2009)
K	General practitioner with a special interest	General practitioner	Physician	Primary care organization	**No**	Limited ongoing ‘associate’ role under geneticist super vision (see Martin et al. 2009)

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1005

1006 **Table 2: Summary of the four cases**

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

1007

1008 **Table 3: The differential translation of institutional change across cases**

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

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