Organization Science

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Much of the change that social movements try to accomplish requires changing practices inside organizations, yet reform implementation is difficult to achieve. This comparative case study of two hospitals demonstrates that implementing reform inside organizations may require internal reformers not only to mobilize with one another but also to stand up to internal defenders' countertactics in everyday encounters. Because reformer alliances across identity lines often require reformers with different statuses to collaborate with one another, defenders can divide reformer coalitions by linking reform practices to a status characteristic associated with lower-status reformers, denigrating higher-status reformers by associating them with these practices, and reintegrating higher-status reformers into the defender group. When status threat inside an organization is high to begin with, higher-status reformers are likely to be concerned about loss of privilege in the face of defenders' status-based countertactics and, in response, distance themselves from reform practices and align themselves with defenders to protect their identity and its rewards. This can undermine the multi-identity reformer coalition and cause change to fail. These findings regarding status-based countertactics contribute to our understanding of social movement implementation and microinstitutional change.

Key words: institutional theory; social movement theory; law and society theory; organization theory; social movements; institutional change; microinstitutional change; microfoundations; microprocesses; status; occupations; professions; power; politics; culture; gender; countermobilization; reform; ethnography; ethnographic; field study; comparative case study; medicine; health care
History: Published online in *Articles in Advance* December 2, 2011.

Introduction

Social movements often fight for new regulations intended to protect organizations' employees or customers (e.g., Davis et al. 2005, 2008; Edelman et al. 2010; Lounsbury et al. 2003; McAdam and Scott 2005; Rao et al. 2000; Soule and King 2006). But these new regulations do not automatically compel organizations to change practices (DiMaggio and Powell 1983, Edelman 1992, Meyer and Rowan 1977). Indeed, organizations often subvert the reforms that social movements have worked so hard to achieve (e.g., King and Pearce 2010, Zald et al. 2005).

Both social movement theory and neo-institutional theory have addressed the question of how and when macro-level changes fail to lead to change on the ground inside organizations. Social movement theory focuses on macro-level changes in frames and identities, mobilizing structures, and political opportunities that allow insiders to claim specific rights and demand the transformation of their organizations (Banaszak-Holl et al. 2010, Fligstein and McAdam 2011, Gamson 1992, Haveman and Rao 1997, McAdam 1982, McCarthy and Zald 1977, Snow and Benford 1988, Taylor and Zald 2010). It explains that changes fail to be implemented when external resources are weak, when top managers resist

reform, and when internal reformers fail to mobilize (e.g., Kellogg 2009, Lounsbury 2001, O'Mahony and Bechky 2008, Scully and Segal 2002, Weber et al. 2009b). Neo-institutional theory draws attention to new coercive, normative, or mimetic pressures that organizations must respond to in some way to preserve their legitimacy (e.g., DiMaggio and Powell 1983, Meyer and Rowan 1977, Oliver 1991, Scott 2007). It demonstrates that changes fail to be implemented when such pressures are weak or inconsistent, when there are high symbolic gains from program adoption but also high costs associated with implementation, and when organizational actors have professional identities or backgrounds that conflict with the proposed change (e.g., Barley 1986, Edelman and Petterson 1999, Edelman and Suchman 1997, Fligstein 1985, Heimer 1999, Heimer and Staffen 1998, Lounsbury 2007, Powell 1991, Sauder and Espeland 2009, Westphal and Zajac 1994).

The social movement and neo-institutional literatures have been critical to explaining how and when macro-level changes may be blocked inside organizations, but we must add to them to explain the outcomes I observed in my field study of two U.S. hospitals. Historically, surgical trainees ("residents") in U.S. hospitals worked 100–120 hours per week. A social movement composed

of patient safety and resident rights activists fought for and, in 2002, successfully pressured the American Council for Graduate Medical Education (ACGME) to introduce regulation to reduce the work week for residents to 80 hours.

Hospital administrators responded to the new regulation by developing programs to reduce resident work hours. Yet the implementation of these programs was contested inside hospitals across the country (e.g., Landrigan et al. 2006). The two teaching hospitals I studied responded differently to the new regulation: At Calhoun, reform was defeated after a lengthy struggle. At Advent, it was successfully implemented. (Both hospital names are pseudonyms.)

As I show below, the two hospitals were exposed to the same external resources and pressures. They were comparable in terms of industry sector, work organization, prior organizational performance, and other characteristics that have been shown to affect organizational response to external pressure for change. And in both, top managers created similar programs to help residents reduce their work hours and frontline reformers mobilized for change. How, then, can we explain the difference in social movement implementation and microinstitutional change in the two organizations?

In a prior article, I analyzed the successful implementation of reform at Advent and its failure at a comparable hospital (Bayshore). I demonstrated that reformer mobilization was responsible for successful reform at Advent and that, at the other hospital, reform was defeated because internal reformers did not mobilize with one another across ranks in the hierarchy to collectively act for change (Kellogg 2009). However, the lack of internal reformer mobilization cannot explain why reform faltered at Calhoun, and it is this failure that I explain here.

Here, I detail how at both Calhoun and Advent internal reformers mobilized to challenge defenders of the status quo. In fact, Calhoun actually had both a slightly greater number and greater percentage of these mobilized internal reformers than did Advent. Yet reform was not accomplished at Calhoun though it was at Advent.

I demonstrate that, to explain how and when macro-level changes fail to be implemented inside organizations, we must take into account not only the actions of external reformers, top managers, and frontline reformers but also the actions of internal defenders. In organizations where reform requires the collaboration of reformers with different identities and statuses, internal defenders can leverage status in their countertactics to persuade higher-status reformers to abandon their coalition with lower-status reformers and stop pressing for change. When status threat inside an organization is high to begin with, higher-status reformers are likely to be concerned about loss of privilege in the face of defenders' status-based countertactics and, in response, distance themselves from reform practices and align themselves with defenders to protect their identity and its rewards.

In what follows, I review the social movement and neo-institutional literature on failed reform implementation and microinstitutional change, and I describe the research setting and the details of the research design. I then explain the difference in outcomes at the two hospitals by recounting how reformers at both hospitals mobilized with one another across identities and statuses and how defenders at one of the hospitals undermined the reformers' cross-identity coalition. I end by discussing the implications of status-based countertactics for understanding social movement implementation and microinstitutional change.

Current Understanding of Failed Reform Implementation and Microinstitutional Change

Social movement theory and neo-institutional theory have each examined how and when macro-level changes fail to lead to changes on the ground inside organizations.

Social Movement Theory

Social movement theorists have emphasized that implementing reform inside organizations is difficult because it requires organization members to mobilize with one another and challenge the status quo (Davis et al. 2005, 2008; Lounsbury et al. 2003; McAdam and Scott 2005; Rao et al. 2000; Soule and King 2006; Zald et al. 2005). To do this, reformers must begin to see traditional practices as unfair and illegitimate (e.g., Creed et al. 2002, Kaplan 2008, Rao et al. 2003, Weber and Dacin 2011). They must ready themselves to take personal risks on behalf of the group as a whole (Moore 1996, O'Mahony and Bechky 2008, Scully et al. 1998). And they must develop a belief that collective action efforts against defenders can be successful (Binder 2002, Katzenstein 1998, Kellogg 2011b).

Three sets of actors are critical to accomplishing such mobilization—external reformers, top managers, and internal reformers. External reformers create frames that provide internal reformers with arguments for change, identities that provide them with new prescriptions for appropriate lines of action, mobilizing structures that provide them with the community and solidarity necessary to take the risks associated with protest, and political opportunities that provide them with leverage to make new claims (e.g., Fligstein 2001, Gamson 1990, Haveman et al. 2007, McAdam et al. 1996, Schneiberg and Lounsbury 2008, Snow et al. 1986, Taylor 1996, Weber et al. 2008). Top managers, when they are supportive of social movement reform, develop policies and commit resources to facilitate social movement implementation in their organizations (e.g., Briscoe

and Safford 2008, Scully and Segal 2002, Zald et al. 2005). Internal reformers use frames, identities, mobilizing structures, and political opportunities created by external reformers and available inside their organizations to organize with one another (e.g., Binder 2002, Gutierrez et al. 2010, Katzenstein 1998, Kellogg 2009, Moore 2008, Weber et al. 2009b).

Social movement theorists demonstrate that success in implementing social movement reform depends on the strength of these external and internal resources, on the internal reformers' connection with those who control them, and on the intraorganizational context (e.g., Lounsbury 2001, Morrill et al. 2003, Raeburn 2004). Reform is likely to fail when social movement frames or identities do not resonate with the beliefs of those within the organization, when mobilizing structures do not allow reformers to build solidarity with one another, when political opportunities or threats do not lower the costs of collective action, or when internal reformers do not have resources available to them.

Neo-Institutional Theory

Whereas social movement theorists demonstrate that macro-level changes provide new resources for internal reformers, neo-institutional theorists show that these changes also exert external pressures that organizations must respond to if they are to preserve their legitimacy in the eyes of important stakeholders (DiMaggio and Powell 1983, Greenwood et al. 2008, Scott 2007, Scott et al. 2000). Sometimes, however, institutional pressures are brought by outsiders who do not understand how to best require or measure change, who provide ambiguous criteria by which to identify compliance, who fail to address the organizational issues that members believe need attention, or who propose changes that run counter to the interests of powerful organization members (e.g., Edelman 1990, Gouldner 1954, Selznick 1949, Silbey 1981). In such instances, actors within organizations often thwart efforts to bring about macro-level changes (e.g., Meyer and Rowan 1977).

Three sets of actors are critical to thwarting institutional pressure for change—top managers, middle managers, and frontline workers. Top managers can buffer their organizations from change through strategic activities such as decoupling, compromising, defying, or controlling (e.g., DiMaggio and Powell 1983, Edelman 1992, Meyer and Rowan 1977, Oliver 1991, Silbey 1984). Middle managers can block change by dissuading their subordinates from using new programs provided by top managers in response to institutional pressures (e.g., Edelman et al. 1993, 2001; Harlan and Robert 1998; Heimer 1999; Heimer and Staffen 1998; Kelly and Kalev 2006). And, frontline workers can block change by purposely misinterpreting programs introduced by top managers in order to continue to work in traditional ways (e.g., Hallett and Ventresca 2006). Organizations are

most likely to subvert institutional pressures when external constituencies, legitimacy threats, or legal contexts are weak or inconsistent or when, despite the high symbolic gains associated with adoption, there are also high costs associated with implementation (e.g., D'Aunno et al. 1991, Lounsbury 2007, Powell 1991, Sauder and Espeland 2009, Westphal and Zajac 1994). Organizations are also likely to subvert institutional pressures when organizational actors have professional identities or backgrounds that conflict with the proposed change (e.g., Anteby 2010, Barley 1986, Fligstein 1985, Heimer 1999, Heimer and Staffen 1998).

The social movement and neo-institutional literatures have provided important explanations for how and when macro-level changes may be blocked inside organizations, but we must add to our understanding of the relationship between the macro-environment and intraorganizational dynamics to explain the outcomes I observed in my study. As I elaborate in further detail below, the two hospitals were exposed to the same social movement resources and institutional pressures and were matched on the characteristics that have been shown to affect organizational response to external pressure for change. In both hospitals, organizational elites created similar programs to help residents reduce their work hours, and frontline reformers mobilized for change. However, Calhoun ultimately rejected reform, whereas Advent embraced it. To explain this difference in outcomes, we need to bring an understanding of internal defenders, countertactics, and status into our explanations of reform implementation and microinstitutional change.

Bringing Internal Defenders, Countertactics, and Status into Our Understanding of Reform Implementation and Microinstitutional Change

Implementing social change inside organizations often requires internal reformers to build alliances with one another across lines—whether across lines of identity or position or privilege (e.g., Kellogg 2009, Zald and Berger 1978). Such coalitions of reformers have been shown to be fragile and difficult to sustain because different subgroups of reformers have different goals, different frames, or different practices (e.g., Foldy et al. 2009; Gamson 1990, 1961; McCammon and Campbell 2002; McCarthy and Zald 1977; Van Dyke and McCammon 2010). Yet even when reformer subgroups are similar across organizations, reformer coalitions may survive and successfully accomplish change in one organization and not in the other. Indeed, this is precisely what occurred at Calhoun and Advent.

To understand why, it is helpful to understand the dynamics associated with defenders, countertactics, and status. Movements of any visibility and impact create conditions for the mobilization of countermovements, which seek to preserve long-standing institutions by minimizing reforms (e.g., Meyer and Staggenborg 1996,

Zald and Useem 1987). In response to a movement's frames, mobilizing structures, and political opportunities, defenders may create opposing frames, mobilizing structures, and political opportunities to discredit, undermine, and resist those of the reformers (Ingram and Rao 2004, Ingram et al. 2010). Defenders may also try to break apart coalitions by emphasizing objective differences in interests among reformer subgroups (e.g., Brown 2000, Brueggemann and Boswell 1998).

As I elaborate below, I find that because some identities are linked to higher social positions than others, defenders can also break apart reformer coalitions by highlighting similarities between higher-status reformers and their lower-status counterparts. This threatens the social position of the higher-status reformers and the privileges they enjoy as occupants of that position. Scholars of status highlight two aspects of status that are important to the analysis presented in this paper: status characteristics and status threat.

An identity distinction among people is a status characteristic when widely held cultural beliefs associate greater worthiness and competence with one identity than with another (e.g., Berger et al. 1977). For example, gender is a status characteristic in this country because cultural expectations associate higher status and competence with men than with women (see Ridgeway 2011 for a review). Differentiated performance expectations operate in a self-fulfilling way—because high-status actors are expected to offer more competent performances, they are given more opportunities to participate, have more influence over others in a group, and have their performances evaluated more positively (e.g., Ridgeway and Correll 2004, Ridgeway and Smith-Lovin 1999, Wagner and Berger 1997). Actors with lower-status characteristics, on the other hand, end up receiving biased evaluations of competence and commitment; have stricter evaluation standards applied to their performances; and suffer bias in hiring, promotion, and salary decisions (e.g., Correll et al. 2007, Loyd et al. 2010, Ridgeway 2001).

Status threat comes into play because status is not fixed but is performed minute by minute in everyday actions and interactions (see Sauder 2005 for a review). Actors risk status loss when they deviate from accepted identity performances (e.g., Zuckerman 1999). Because high-status actors are secure in their group membership and have a great deal of control over their audiences, and because audiences assume that actions are of greater value when they are performed by high-status actors, high-status actors can often get away with deviating from expected performances (e.g., Gould 2002, Hollander 1958, Podolny 1993, Rao et al. 2005). But when an actor's status is not definite—when there is some chance that his status is under threat—he faces strong pressure to conform to expected behaviors (Phillips and Zuckerman 2001).

Theorists have noted that status threat comes in a variety of forms: (1) competitive threat, which arises from a lower status group newly competing for resources previously reserved for the higher status group; (2) distinctiveness threat, which occurs when distinctions between the lower status and higher status groups are blurred, casting doubt on the legitimacy of benefits based on these distinctions; (3) category threat, which arises when an individual is categorized against his will as a member of a lower status group than that to which he feels he belongs; and (4) acceptance threat, which challenges an individual's membership in a higher status group (e.g., Berdahl 2007, Blalock 1973, Branscombe et al. 1999, Duguid et al. 2012). Status threats can cause high-status actors to defend their position by discriminating against the lower-status group, emphasizing the veracity of differences between groups, dissociating themselves from lower-status partners, and refraining from low-status actions to prove themselves worthy of membership in the high-status group (Bendersky 2009, Bendersky and Hays 2012, Olzak et al. 1994, South et al. 1982, Willer 2005).

Status theory helps us to understand how status-based processes shape the behavior of actors in interaction. However, to explain the divergence in social movement outcomes I saw at Calhoun and Advent, it is necessary to add to this theory in two ways. First, because those studying status have not focused on countermobilization, we do not understand the ways defenders of the status quo can use status as a weapon to divide reformer coalitions pressing for change. Second, previous research on status has demonstrated that status characteristics have a strong effect on performance expectations when they are deemed relevant to the task at hand, but we do not understand how status characteristics can also affect performance expectations under conditions of status threat.

In this paper, I demonstrate that, because particular identities (such as male or female) are linked to particular status positions, reformer alliances across identity lines may require collaboration between reformers with different statuses. Defenders of the status quo can break apart such cross-identity reformer coalitions by linking reform practices to a status characteristic associated with lower-status reformers, denigrating higher-status reformers by associating them with these practices, and trying to reintegrate higher-status reformers into the defender group. When status threat inside an organization is high to begin with, higher-status reformers are particularly likely to experience concerns about loss of privilege, leading them to try to protect their position and its rewards by distancing themselves from the practices of lower-status reformers and visibly aligning themselves with higher-status defenders. This, in turn, can undermine the multi-identity reformer coalition and defeat reform implementation and microinstitutional change. In what follows, I review the methods used in the study and then describe how change unfolded in the two hospitals and why.

Methods

This paper draws on qualitative data collection and historical comparison to generate grounded theory. The two hospitals studied, Calhoun and Advent, were selected because they are located in the same region, did similar work, and responded to the same regulation. The sequence of the research was (1) new regulation was announced, (2) two similar hospitals were studied during the period just before and one year after the introduction of new programs designed to comply with the regulation, and (3) data were examined to determine the process by which reform was implemented at one hospital and not the other.

Study of Matched Cases

As noted earlier, Calhoun and Advent are remarkably similar in each of the organizational characteristics that have been shown to affect organizational change in response to external pressure. Both are elite teaching hospitals associated with major medical schools in the same urban geographic area. Both are public sector organizations, both share a positive performance history and image, and both employ residents with similar backgrounds. The hospitals are well matched in terms of top manager interests and surgical conditions treated on the services studied.

Authority relations in the two hospitals were also similar. Directors of the surgery department were surgeons who managed administrative issues associated with the activities of the other staff surgeons and the surgical residency program but who had little authority over the day-to-day practices of these staff surgeons. Staff surgeons brought revenue to the hospitals by bringing in surgical patients. Surgical residents assisted these staff surgeons who, in turn, provided them with hands-on training.

Teams of "chiefs" (fifth-year residents), "seniors" (second-, third-, and fourth-year residents), and "interns" (first-year residents) took care of 10–20 patients on any particular surgery service (e.g., vascular surgery). All residents "rotated" through areas such as general surgery, trauma, and other specialties, frequently changing work groups. Chief residents formulated daily plans for each patient on the service and assisted staff surgeons in difficult "cases" (operations) throughout the day. Interns implemented patient plans and assisted staff surgeons with simple cases. Senior residents were less involved than were chiefs and interns in the daily care of patients; they cared for the complex issues of general surgery patients and assisted staff surgeons with moderately difficult cases.

There were several differences among the hospitals, but none can explain why Calhoun did not implement reform whereas Advent did. The first is size. Calhoun is larger than Advent. Institutional theorists have suggested that larger organizations are associated with early adoption of compliance programs because they often have greater resources to invest in new programs and are more visible to governance bodies (Dobbin et al. 1988, Edelman 1992). This would lead us to expect that Calhoun would have implemented reform whereas Advent would not, yet the opposite was true.

Second, the hospitals experienced slightly different forms of regulatory pressure, yet these differences cannot explain why Advent reformed whereas Calhoun did not. In the spring of 2002, the ACGME announced that the new regulation would go into effect in July 2003. Advent experienced additional pressure because the ACGME had scheduled a site visit for that year. Advent introduced their compliance programs during the residency year of July 2002–June 2003 to signal their good intentions to the ACGME. Calhoun, not up for review from the ACGME until several years later, introduced their compliance program the following year, when the regulation actually went into effect. This difference in the form of regulatory pressure (ACGME site visit versus regulation officially in place) cannot explain the difference in change outcomes. Because Calhoun faced officially mandated work hour reduction (and risked the loss of accreditation if they did not meet the goal), one would expect that the environmental pressure would be greater in forcing change than it would at Advent. Because Advent effected change and Calhoun did not, differences in the form of regulatory pressure cannot explain the difference in outcomes.

Finally, Calhoun had a higher percentage of female residents than Advent (and a similar percentage of female staff surgeons). Because the current literature emphasizes the importance of internal reformers in effecting change, we might expect that the hospital with the higher percentage of female residents would embrace change, given that female residents were more avid internal reformers than were male residents. Yet just the opposite occurred (I will explain this counterintuitive result below).

Data Collection

This paper is part of a larger ethnographic study of medical reform in surgery that I conducted from 2002 to 2004 (Kellogg 2011a). I began my study of Calhoun and Advent by doing a "surface analysis" (Spradley 1979) of the culture and work practices before the initiation of the change effort. On the basis of these interviews, I made some delimiting choices about the particular area on which to focus my in-depth analysis (Spradley 1979). Because interns worked the longest hours and would be most affected by the changes, and because the actions of their managers, the chief residents, would be critical to interns' compliance with the new regulation, I focused on the practices that interns and chiefs would need to change to help the interns comply with the new regulation.

Table 1 General Surgery Chief Residents and Interns Interviewed at the Two Hospitals

Residents	Calhoun	Advent
Male chiefs	5	6
Female chiefs	3	1
Male interns	5	4
Female interns	3	3
Total chiefs and interns	16	14
Total interviews (pre and post)	32	27[a]

[a]One of these six male chiefs at Advent was only interviewed post change effort.

I conducted a total of 59 semistructured interviews with chief residents and interns, first before their new compliance program was introduced and then 12 months later, at the end of the residency year (see Table 1). The interviews, performed at the hospital and averaging between 30 minutes to 1 hour, were recorded and transcribed verbatim. I also spent time talking informally to groups of two or three residents in the surgical resident lounge and hospital cafeteria both before the resident year under study began and at its end.

To gauge support for the reform, in my prechange interviews I asked respondents how the impending changes would affect patient care, resident education, and their own quality of life outside the hospital. I also asked them to report their overall attitude toward the reform.

In my end-of-year interviews, I asked residents to describe what actions related to implementing the reform were undertaken by the residents. I did not ask any explicit questions about status, countertactics, or gender. Instead, these themes emerged unsolicited as respondents discussed the traditional surgical culture in prechange interviews and answered questions about how reform unfolded in their postchange interviews.

To measure how everyday practices actually changed in response to the new regulation, I purposely did not ask residents how many hours per week they were working before and after the proposed changes, as I was told by the residents that there might be pressure on interns to misreport their work hours so that the hospitals would not risk sanction from the ACGME. Instead, I asked residents to detail in prechange interviews which work practices would be required to enable interns to reduce their work hours to 80 per week and how often they currently engaged in these work practices. In my end-of-year interviews, I asked them how often they participated in each of these work practices required for compliance.

Analysis of Contradictory Outcomes
Once I had determined that changes in everyday practice had occurred at Advent and not at Calhoun, I contrasted the two cases to identify the processes associated with the different outcomes. My inductive analysis (Glaser and Strauss 1967) consisted of multiple readings of

interview transcripts as well as tracking patterned activities and issues related to change in ATLAS.ti, a qualitative data analysis program. In my coding of the interview transcripts, I associated virtually every passage with one or more codes that flagged highly specific but recurring topics related to change in the targeted practice. I provide more information about my analyses below.

Similar Initial Conditions at the Two Hospitals

Similar Historical and Planned New Practices at Calhoun and Advent
To understand the change process at Calhoun and Advent, it is necessary to understand both historical and planned resident practices. Historically, at both hospitals, chiefs and seniors had worked approximately 100 hours and interns approximately 120 hours per week.

At both hospitals, top managers introduced similar "night float" programs to allow residents to reduce their hours. These new programs added additional surgical residents to general surgery services, creating a "night float team" to work overnight each night; this team now could cover the two nights per week that chiefs, seniors, and interns had been obliged to be on call. To staff these teams, directors at both hospitals eliminated other surgical resident rotations so that their own surgical residents would be freed up to serve on night float teams covering the general surgery services. In addition, directors hired several physician assistants to help with administrative work during the day.

Under the new system, night float programs would allow residents at all levels to reduce their hours by 20 per week by virtually eliminating nights spent on call. This would put chiefs and seniors in compliance with the regulation. To further reduce intern hours to about 80 per week, interns would need to reduce the number of hours they worked on a regular workday from roughly 17 (4 A.M. to 9 P.M.) to roughly 13 (6 A.M. to 7 P.M.). Although reducing the number of nights spent on call was easy to do at both hospitals once top managers had secured additional resources for the night float programs, shortening intern workdays was more difficult to accomplish because it required changing long-standing surgical work practices.

Under the traditional system, chiefs had been responsible for overseeing all of the routine work associated with pre- and postoperative care, and interns had been the ones to carry out this work. Residents on a particular service had gathered together every evening between 5 P.M. and 7 P.M. for afternoon rounds, at which time chiefs reviewed the work the intern had done for each patient that day and gave the intern a list of tasks that needed to be completed after rounds ("post-round to-dos"). When chiefs and seniors were not working on call

overnight, they left the hospital immediately after afternoon rounds. But interns who were not working on call overnight did not attempt to hand off any routine work tasks, such as completing post-round to-dos, doing the paperwork required to admit a new patient ("admits"), or checking in with recovery room nurses about patients who had been operated on that day ("post-ops"), to the on-call resident. Interns took care of all of this "scutwork," even though doing so required them to stay in the hospital until about 9 P.M. and arrive the next morning at 4 A.M. Taking care of all of the scutwork also required interns to come in on Saturdays, even when they were not officially scheduled to do so.

Under the new system, night floats would cover all patient care work and scutwork from 6 P.M. to 6 A.M. Chiefs would be required to encourage interns to hand off any uncompleted work, including scutwork, to night floats, help interns finish their post-round to-dos, and instruct interns not to come in on Saturdays when not scheduled to do so. Interns would need to follow suit by handing off any post-ops (checks on patients after they came out of the operating room) and admits (new patient admissions to the hospital) not completed by 6 P.M., seeking help with post-round to-dos, and not coming in on unscheduled Saturdays. Chiefs and interns would work 13-hour days, 6 days per week, to allow for 1 hour of overlap on each end of the day. These work hour reductions would not entail a reduction in income for any of the residents; annual salaries were fixed.

Similar Internal Defenders at Calhoun and Advent
One might have expected that the plans for the new night float programs would have been greeted enthusiastically by the residents, who would be dramatically reducing their work hours with no corresponding reduction in pay. But many residents did not rejoice. In fact, they did the opposite.

The chiefs and seniors did *not* object to the fact that residents would be spending fewer hours overnight on call. What they objected to was the requirement that chiefs should encourage interns to hand off routine work to night floats, help interns finish their post-round to-dos, and instruct interns not to come in on Saturdays when not scheduled to do so.

The intensity of their negative reaction seemed to me quite disproportionate to what was, after all, a relatively insignificant change in surgical practice. One would think that their taking on an additional bit of routine work would be amply recompensed by the dramatic reduction of their own work hours. Furthermore, they themselves, relieved from having to work every third night on call, would now be well rested.

To understand why defenders of the status quo at both hospitals so strongly resisted these seemingly minor changes, it is necessary to understand how reform practices ran counter to the traditional identity and status

hierarchy in surgery. Historically, surgical residents were expected to be male, individualistic, and single-mindedly focused on work, characteristics they demonstrated by performing the role of "iron men," "trusting no one," and "living in the hospital." Even though most residents did not always act out all of these idealized characteristics, such behaviors were used to measure performance, and they were associated with the highest status in surgery.

Iron men (as they identified themselves when they described the long weekends on call that only surgical residents engaged in as "iron man weekends") at each hospital aspired to be seen as "go-to guys" with "hairy balls" and "nerves of steel" who were "unflappable" under pressure. A macho demeanor was de rigueur: hair was to be closely cropped, scrubs were to be worn low on the hips, surgical caps and masks were to be left dangling around their necks long after they had left the operating room (OR), they were to stride fast during morning rounds and swagger in the evening, they were to keep their bodies well toned. Much of their conversation with other residents involved fantasized or actual sexual exploits of team members. They used battle and war metaphors repeatedly, talking about "rescue missions" and "victories" in the OR.

As well as enacting a male persona, iron men were expected to act as individualistic heroes who could be counted on to single-handedly "make it happen," no matter what the circumstances. One of their favorite sayings was "Trust no one, expect nothing, suspect sabotage." This involved never handing off their work to anyone. In addition, they were expected to avoid the help of physician assistants and to discount the counsel of nurses and other physicians when making their decisions.

Additionally, iron men were expected to be intensely committed to their work. They accepted without question the schedules and vacations they were given and prided themselves on "living in the hospital." They asserted that their "fellow residents were their family" and rarely mentioned caring about others outside of the hospital. Instead, they constantly boasted about breaking commitments with disaffected wives and significant others.

This persona of the iron man had its roots in the early history of the profession. In a time when hygienic conditions were atrocious and when medical cures and techniques were primitive, lives often hinged on the heroic actions of such individualistic, hypercommitted male surgeons. Despite all the advances of modern medicine, because surgical residency has been designed to produce action-oriented male heroes who single-handedly perform death-defying feats and courageously act with certainty in all situations, this image of the ideal surgeon has not only survived into the present but continues to flourish (e.g., Cassell 1998).

Historically, residents who have acted as individualistic males with a single-minded focus on work have

occupied a high position not only in the status hierarchy of surgery but also in the medical profession and in society as a whole. One Calhoun iron man highlighted the way iron man practices distinguished him from workers in other professions:

> It's not like being an airline pilot…I can tell you personally, from having been up several days in a row, and having someone unwell come in. I know exactly what to do and what needs to be done. I'll guarantee you that, at the same post-graduate year of training, I could out-think or outperform any of our colleagues in other disciplines if a crisis came around. Because that's what we're trained for.

Yet at the time of my study, the power and prestige of surgery had already begun to erode (e.g., Cassell 1998). The 80-hour workweek was just one more change in a series of changes that threatened the iron man and his status. One Advent defender explained in a prechange interview:

> When I first started, surgery ruled the roost. It was testosterone city…. The chief resident was the boss of the hospital. When the chief spoke, that was it. I don't care if there were machine guns in the way, it got done. The chief was king and the residents were his army…. It was a battlefield mentality. Stuff hitting the fan, boom, boom, boom. It was like the Wild West. You just did everything. If someone got in your way, you let them know it. Now you would end up in [Director's] office with a letter in your file. One of my chiefs told the MICU [medical intensive care unit], "You a–holes are killing this patient." If you say that now, you are dead….

> Every surgery resident used to be at codes [emergency surgeries]. Now it is a special code team, and if it is a medical patient, the meddies are in charge. Now you have to watch them fiddle around. In the old days the chief would walk in and say, "I'm running this code."

> Now there are a lot more malpractice suits going on. And we have to be much more political with the other services. We used to run the ICU with an iron fist. Now we are neutered there.

The iron man identity (an identity equally pervasive at both hospitals) and the power and prestige that had historically been associated with it help explain why some residents resisted a change that seemed to be designed to benefit them. At each hospital, defenders of the status quo were composed primarily of chief and senior male residents who were able to accomplish most of the actions required to live up to the iron man ideal. Because they were single or had wives or girlfriends who were willing to cook for them, do shopping and housecleaning, provide childcare, and put up with frequent last-minute cancellations of social plans, these residents were able to differentiate themselves from others by demonstrating the key behaviors that counted for high performance in surgical residency: maleness, individualism, and intense commitment to work.

Whereas, historically, demonstrating high performance had required residents to individualistically accomplish work and be the first ones there and the last ones to leave, under reform, demonstrating high performance required residents to accomplish work as a team and leave the hospital at the end of the day. The reform thus challenged the socially constructed measures of performance that had allowed these chief and senior iron men to distinguish themselves from others. Because status, in large part, was based on attributions of performance, the reforms threatened to take away their hard-won status and the privileges associated with it.

Similar Internal Reformers at Calhoun and Advent

Not all residents at the two hospitals were comfortable with the iron man expectations, however, and those who were not became advocates of reform. To better understand who these reformers were, I coded my prechange interview data and classified people as reformers or defenders based on their beliefs upon entering the new system.[1] Reformers fell into three subgroups: (1) female chiefs (2) some male chiefs, and (3) interns (see Table 2).

Female chiefs at the two hospitals advocated reform primarily because they occupied inferior positions on the surgical wards and wanted to improve the valuing of women in surgery. Even though they were able to act like iron men to some extent, they could never completely live up to the idealized expectations

Table 2   Defenders and Reformers

Residents	Reasons for stance on change in sign-out practice	No. at Calhoun	No. at Advent
Defenders		3	4
Male chiefs	Feel change violates traditional iron man expectations and the professional power and privilege associated with these	3	4
Reformers		13	10
Male chiefs	Interested in creating more time for personal life responsibilities, in valuing alternative male identities, and in valuing team-centered patient care work outside of the operating room	2	2
Female chiefs	Interested in improving the position of women in surgery	3	1
Male and female interns	Interested in working 80 hours rather than 120 hours; not yet socialized into traditional iron man expectations	8	7
Total		16	14

that required demonstrating maleness, individualism, and intense commitment to work. They were not allowed to enter certain spaces, use particular language, express particular emotions, or engage in particular deeds that were part and parcel of the performance of maleness and individualism. Moreover, the surgical expectation that surgery be a resident's only priority was incompatible with the macro-cultural belief that the world of home and hearth is a woman's primary focus. Also, to the degree that they tried to enact the traditional surgical identity, female chiefs had trouble fulfilling cultural expectations in the eyes of significant others outside the hospital. Thus, female chiefs were interested in challenging the iron man identity and valuing a different set of practices that, as women, they could more easily accomplish.

Some of the male chiefs also supported change because they too felt that the iron man role hampered fulfilling their expectations for other social roles they valued: the roles of father (rather than hypercommitted worker), of egalitarian male (rather than superordinate male), or of "patient-centered" resident (rather than individualistic hero).

The third subgroup of reformers, the in-coming male and female interns, were unlike the female and male chief residents who had been trained under the iron man system. As new members of the profession, they were ignorant of traditional practices, the accounts that justified these practices, and the roles that imparted moral value to them. Although they did not yet understand the surgical social world, they were quite familiar with the arguments that had been made by the patients' rights and residents' rights reformers and thought they made sense. To them, working 80 hours a week rather than 120 sounded like a good idea. Thus, interns supported reform practices initially because this is what they were taught before they started the program.

Similar Defender and Reformer Tactics at Calhoun and Advent

Similar Defender Socialization Tactics at Calhoun and Advent

During intern orientation week, the directors at Advent and Calhoun announced the details of the new programs in "grand rounds" meetings that were attended by staff surgeons and residents. With the introduction of the new programs, interns at both hospitals tried for a very brief period to comply with the new practices by handing off post-ops and admits to night floats, enlisting help from their chiefs with post-round to-dos, and not coming in on Saturdays when not scheduled to do so. Defender chiefs, who played an important role in the socialization of interns because they were responsible for their professional development, almost immediately began to dissuade interns from putting the new practices into effect.

These chiefs led interns to break with their old identities by losing their tempers; insulting the interns; and threatening them whenever they tried to hand off routine work, accept help from others, or avoid coming in on Saturdays. They taught interns new role expectations by telling stories and engaging in gossip. And they gave interns explicit and implicit feedback about the gap that existed between interns' displayed persona and the traditional surgical identity.

Their socialization tactics initially led interns to refrain from attempting handoffs, from asking for help with post-round to-dos, and from avoiding coming in on Saturdays. Given this early blocking of change, the differences in outcomes at Calhoun and Advent might be explained as resulting from a difference in socialization tactics or in intern response to them at the two hospitals. But if this were the case, I would have expected to hear about either different socialization tactics used at the two hospitals or different intern responses to these tactics. I heard about neither.

Instead, socialization was ineffective in ultimately blocking change at both hospitals, because at the same time interns were being taught traditional expectations by defender chiefs, they were being taught new expectations by reformer chiefs. Because they received mixed messages from defenders and reformers, most interns did not internalize traditional expectations. The reason most stopped attempting handoffs and seeking help with post-round to-dos early in the year was not because they thought these practices harmed patient care or their own education but because they feared retribution from their defender chiefs, who influenced access to their training and career placement.

Similar Internal Reformer Mobilization at Calhoun and Advent

Whereas defenders' socialization tactics initially led interns to stop individually engaging in reform practices, subsequent reformer mobilization allowed them to collectively engage in these activities later. At both Calhoun and Advent, reformers responded to resistance by mobilizing with one another in hospital spaces that existed apart from defenders (for a detailed account of this relational mobilization at Advent, see Kellogg 2009). Historically, residents on a particular service had gathered together every evening between 5 P.M. and 7 P.M. for "afternoon rounds" to review the patient care work that they had performed for each patient that day. Afternoon rounds meetings on services (e.g., the vascular service) staffed with only reformers allowed for isolation from defenders, interaction among reformers, and inclusion of residents in all work positions involved in the practice targeted for change.

In these spaces, reformers built a sense of efficacy—a feeling of hope that collective action efforts against defenders could be successful and an assurance that

reformers from different subgroups, acting together for change, would each complete the diverse tasks required to successfully accomplish new handing-off and helping practices. Here, too, reformers developed a collective "we" across subgroups. Reformers referred to themselves as "progressive residents," "team players," "complete doctors," and "surgeons with a life." Additionally, in these spaces reformers at both hospitals created cross-group frames by discussing the unfairness of maintaining traditional practice and by talking about the legitimacy of new versus old practices. Reformers' frames—that both men and women could be good surgeons, that it was possible to achieve continuity of care in the team, that it was important to learn by reading and working in the clinic in addition to learning by operating, and that residents learned better when they were well rested—ran counter to defenders' frames. Reformers' sense of efficacy, identity, and frames were inclusive of the key concerns of each of the reformer subgroups— female chiefs, male chiefs, and interns—so they allowed reformers to see themselves as a unified group with a common adversary, the "old school" residents.

As they built up feelings of opposition against defenders, reformer chiefs began actively supporting handoffs and helping, and interns on teams led by defender chiefs began attempting handoffs and requesting help with post-round to-dos. Earlier in the year, ignorant of the traditional iron man expectations, interns had attempted handoffs and sought help, and defender chiefs had responded to what they considered their lack of capability with socialization tactics that were designed to teach the interns iron man expectations. But now, interns knew better. They had demonstrated their knowledge of traditional expectations by refraining from handoff and helping behavior after their early attempts had been rebuffed by defenders. Interns' engagement in handoff and helping behaviors at this stage represented a "loyalty norm" violation (Phillips et al. 2011) that sent a signal that their commitment to the defenders was impure. By organizing with one another to attempt handoffs in the face of resistance, reformers struck at the very heart of the iron man's world. Handoffs and helping challenged not only the traditional practices the defenders were skilled in using but also the socially constructed measures of performance (maleness, individualism, and hypercommitment to work) that afforded them high status in the profession and in society at large.

Similar Status-Based Countertactics at Calhoun and Advent

In response to interns' and reformer chiefs' collective engagement in handoff and helping behaviors, defenders at both hospitals turned to new retaliation strategies. They tried to divide the reformer coalition by using status-based countertactics against the higher-status male reformers. Defenders linked reform practices to a status characteristic (gender) associated with the lower-status female reformers, denigrated the male reformers by associating them with these practices, and tried to reintegrate male reformers into the defender group.

Defenders at Calhoun and Advent labeled the reform as feminine by using gendered language to describe reform practices and reformers. For example, they suggested that the work hour reform had made surgical residents "soft" and "weak." An Advent defender said,

> When you think of surgeons, they are rough around the edges. They are hard core spitting and swearing and burping. Lots of flexing of muscles. Now the interns are a bunch of softies.

They used gendered intonation that emphasized the stereotypical female characteristic of emotionality, helpfulness, and sensitivity to the needs of others. In talking about reform at the end of the year, one Calhoun chief asserted, "All of this stuff about [and here he imitated a high female voice] 'Ooooh, I'll do this for you. Ooooh, let me help you get out of here.' It's bulls–t. The interns need to learn to do it themselves."

In addition, defenders denigrated the status of male reformers by associating them with these so-called "feminine" practices. Sometimes, they directly told male reformers that they were acting feminine when they tried to use the practices. For example, one Calhoun female reformer recounted, "If the interns said, 'I'm going to head out,' the old school chiefs would ridicule them and say, 'You're so weak. Don't be a wuss.' They do it to the guys, not the women."

At other times, defenders denigrated male reformers indirectly by gossiping about their femininity behind their backs. They called them "weak," "softies," "part-timers," "wusses," "namby-pamby," and "girls" for using reform practices. One defender suggested that an intern was not tough enough to handle hypercommitment to work: "One weekend on call, [defender chief] commented to me that he had hinted to the intern on Saturday morning that maybe he would like to round with him on Sunday. But the intern said, 'No ... not tomorrow; that's my day off.' Wow. That would have been unheard of .... He [the intern] should have been able to handle it ...."

Defenders also implied that male reformers were more attracted to the female realm of home and hearth than to the male world of the operating room. One Calhoun defender mocked an intern who had left at the end of a work shift to go to a picnic: "I had one intern who (at the end of his shift) was like, 'Gotta go. I have to leave, I have a picnic.' I kid you not, that's what he said, 'I have a picnic to go to. I'm going to stay for a little and then I have to go.'" Going to a picnic rather than the operating room, the defender implied, was something no real man would do.

Finally, they tried to "reintegrate" (Heimer and Staffen 1995) male reformers by visibly rewarding them with male camaraderie and games if they backed off their reformist stance and by excluding those who persisted in reform. For example, at Advent, defenders stopped inviting persistent male reformers to work out at the gym, to "make rounds" (check out newly hired nurses), or to "go to the office" (go to the front lobby to rate the attractiveness of women coming in and out). This was clearly meant to sanction reformers' involvement in reform because defenders had included them in these activities before reformers had begun attempting handoffs in the face of resistance. Defenders also denied persistent reformers the special teaching reserved for members of the Boys' Club. An Advent defender explained how he had rewarded a male intern who had ignored the new rules: "Who do I want to hook up? People want to operate. When I throw the juniors a bone, it is because they have worked hard for me. Like [male intern]. I let him do a splenectomy.... That was a total bone. It is a third- or fourth-year case."

Why did defenders target male reformers? Historically, performing well had required a resident to work as an individual and to be the first one at the hospital and the last to leave. Under reform, performing well required residents to accomplish work as a team and to leave the hospital at the end of the day. Because long-standing cultural beliefs code (1) men as individualistic and women as communal (e.g., Eagly et al. 2000, Fiske et al. 2002) and (2) men as working long hours and women as leaving early to take care of responsibilities at home (e.g., Bailyn 2006, Perlow 1998), the reform threatened to overturn the gender hierarchy by allowing women to demonstrate greater competence than men. By joining with women to fight for reform practices, male reformers were displaying disloyalty by supporting a group that the defenders viewed as a direct threat to their male group. As males, these reformers were good targets for conversion to defenders because their own status was supported, in part, by the traditional gender hierarchy.

Why did defenders invoke gender in their countertactics? Labeling male reformers as female was an effective way to threaten their status because females have traditionally had lower status in surgery than males. Moreover, it was an easy "frame extension" (Snow et al. 1986) to label reform practices as feminine because cultural beliefs link reform practices—communal work and fewer hours spent in the workplace—to females.

Were defenders' tactics organized? Although defenders did not formally plan out what responses to use and not to use, through their male bonding activities, they did form a collective (e.g., Martin and Collinson 1999). They strategized and coordinated their resistance efforts during casual dinners in the cafeteria, discussions in the surgical lounge, hallway conversations, and other occasions on which they gathered. When I asked in an end-of-year interview if they got together to discuss the change, one defender chief at Calhoun responded, "We'll sort of congregate down in the cafeteria. You sit down and talk, and people tell stories and stuff like that. Basically, we just blow off steam. So when the interns started trying get out of here at 5:59, of course we talked about it.... We needed to beat it into these guys that it wasn't acceptable."

Subsequent Divergence at Calhoun and Advent

Different Outcomes at Calhoun and Advent

Although early processes were similar at Calhoun and Advent, through an interplay of tactics and countertactics over the course of the year, reformers' long-term actions in the two hospitals diverged. Calhoun reformers abandoned their coalition and failed to accomplish social movement implementation and microinstitutional change. Advent reformers maintained their coalition in the face of these countertactics and successfully implemented the changes needed for reform.

To determine success or failure, I gauged changes in everyday practice that, in my prechange interviews, residents at Calhoun and Advent indicated would have to occur to ensure compliance with the new regulation. As noted earlier, interns would need to hand off any incomplete post-ops and admits by 6 P.M., to accept help with post-round to-dos, and to avoid coming in on unscheduled Saturdays. In turn, chiefs would need to refrain from punishing them for handing off work uncompleted by 6 P.M., to help interns with post-round to-dos, and to tell them not to come in on Saturdays unless they were scheduled to do so.

To measure end-of-year intern actions, I gathered both intern self-reports and chief reports about the interns; to measure end-of-year chief actions, I gathered chief self-reports and intern reports about the chiefs. Self-reports and other-reports were consistent with one another.

Calhoun residents did not implement these everyday practices and, indeed, falsified the time sheets they submitted to the ACGME in order to cover up their actual work practices. As one intern at Calhoun confessed, "The only way the outside knows if we do is by what residents report. And I would be a fool to report Calhoun and ruin my own training." So, at Calhoun, despite their initial support for change, most residents reversed their early practices by the end of the year and resisted implementation of change.

In contrast, at Advent, interns engaged in reform practices at the end of the year. In addition, chiefs who had been defenders at the beginning of the year by the end of the year had begun to use these reform practices too (see Table 3).

Table 3 Divergence in End-of-Year Outcomes at Calhoun and Advent

Residents	Calhoun beginning-of-year % consistently using reform practices	Calhoun end-of-year % consistently using reform practices	Advent beginning-of-year % consistently using reform practices	End-of-year % consistently using reform practices
Male chiefs	40	0	33	100
Female chiefs	100	100	100	100
Male interns	100	0	100	100
Female interns	100	0 (tailored)[a]	100	100
% Consistently using reform practices	81	19	71	100

Notes. Calhoun: $N = 16$ (five male chiefs, three female chiefs, five male interns, and three female interns). Advent: $N = 14$ (six male chiefs, one female chief, four male interns, and three female interns).

[a]Tailored indicates that Calhoun female interns tailored their practices to the chiefs with whom they were working at the time.

Thus, we have two organizations with similar external pressures and resources, similar organizational characteristics, similar internal reformer mobilization, and similar defender countertactics. Yet in one case reform was not implemented, and in the other case it was. How do we account for this difference in outcomes? To do so, we need to understand the difference in initial degree of status threat posed to the male resident group overall by female residents at the two hospitals even before the new night float programs were introduced.

Different Initial Status Threat at Calhoun and Advent

Historically, for residents in surgery, there had been an unequal distribution of resources (such as teaching by staff surgeons and recommendations for further training) between male and female residents. As a group, males dominated females, and this historic fact was important to the men who later became male reformers when the night float program was introduced. Such dominance enabled all male residents, iron men or not, to maintain their privilege (e.g., Glick and Fiske 1999, Ridgeway 2011).

Female residents posed two potential threats to the status of the male group—a competitive threat and a distinctiveness threat—and the degree to which they posed these threats was different at the two hospitals: at Calhoun the competitive and distinctiveness threats posed by female residents were strong, whereas at Advent they were weak.

Competition for resources is threatening to a higher status group because resources that were previously reserved for its members become available to others as well; as growing numbers in a lower status group seek

access to new rewards, advantaged groups seek to maintain their former privilege (e.g., Blalock 1973, South et al. 1982). In surgery, male residents traditionally have occupied the highest positions of the surgical hierarchy. As in hospitals across the country, at both Calhoun and Advent, most years there were much fewer female than male chief residents. Female residents comprised about a third of all residents at each hospital, but they tended to be clustered at the bottom of the surgical hierarchy, with only about 10%–15% comprising the chief resident classes.

But during the year reforms were implemented at both hospitals, by chance Calhoun had an unusually high percentage of female chiefs—three out of eight total chiefs (38% female chiefs)—much higher than at Advent, where out of a total of seven chiefs, there was only one female (14% female chiefs). Because the male group had historically been dominant, increasing numbers of women in leadership positions at Calhoun posed a competitive threat to the male resident group that did not exist at Advent. In addition, one of the female chiefs at Calhoun posed an additional competitive threat to the male group that year by applying for a postresidency position in trauma surgery,[2] a specialty traditionally reserved for males. Male residents at Calhoun experienced this anomalous spike in the number of females in leadership positions as a threat. In my prechange interviews at Calhoun, several male residents mentioned that the number of female residents who would be serving in the chief position that year was unusually high. One male chief at Calhoun noted, "This year is a strange year; the women are taking over." Female chiefs at Calhoun also commented on the competitive threat they posed to the male group. One said, "This is one of the few times when you can go straight from being the slave to being the competitor."

Female residents posed not only a competitive threat to the male group at Calhoun, but they also posed a threat to the distinctiveness of the male group. When women act in "masculine" ways, they challenge the distinctiveness between men and women. Blurring distinctions that are usually made between categories (e.g., men versus women) is threatening to the higher-status group because it suggests that these distinctions and the benefits associated with them are illusory and illegitimate (e.g., Berdahl 2007).

In some respects, female residents at both Advent and Calhoun blurred the distinction between men and women by acting the way high-status males acted: they told the same kinds of stories about idiotic medical residents, unflappable staff surgeons, and annoying nurses; they strode rather than walked; they paged jokes back and forth to other residents; and they lobbied their chief residents for more difficult cases.

What was striking, though, was that the female residents at Calhoun used a wider range of high-status

"male" actions than the female residents at Advent did. At Calhoun, they dressed and behaved like the high-status male residents, whereas at Advent, they looked and acted more like low-status actors. In the the operating room—one of the most important spaces in the hospital where status is performed—Calhoun female residents wore the same surgical caps the male residents wore; at Advent, they wore the "shower caps" worn by the lower-status nurses. Calhoun female residents wore no jewelry or makeup; at Advent, they wore both. Calhoun female chiefs gave their interns nicknames; at Advent, only the male chiefs exercised this prerogative. Calhoun female residents told stories of their going out drinking; Advent female residents said they rarely did so. Calhoun female chiefs reported "throwing bones" (assigning cases that were officially above the required resident year, a typical practice among male residents) to their interns. Advent female chiefs did not. Calhoun female residents recounted episodes where they had aggressively "told a staff surgeon to move over" in the operating room so that they could take charge. Advent female residents reported avoiding even being suspected of doing this.

By acting masculine in so many ways, Calhoun female residents laid claim to the higher-status male position. By doing so, they made it difficult for the male residents to distinguish themselves from the female residents and, consequently, threatened the status of the Calhoun male resident group.

To explore why and how the coalition broke apart at Calhoun and not at Advent, I coded pre- and postinterview data by resident for each of the 30 residents. As I explain below, I found that, in the context of high initial competitive and distinctiveness threats, male reformers at Calhoun experienced a greater level of concern about loss of male privilege in the face of defenders' countertactics than did those at Advent (see Table 4). As a consequence of being concerned about the loss of male privilege, male reformers at Calhoun distanced themselves from reform practices and aligned with male defenders, leading to the failure of widespread reform at Calhoun.

Before detailing the process by which a difference in the level of status threat at the two hospitals led to the different implementation outcomes, it is helpful to address two alternative explanations for this difference in outcomes. First, is it possible that the greater difference in how male versus female residents behaved at Advent allowed reformers to be more confident in standing up to defenders because they had already seen different approaches? But if this was what led reformers to stand up to defenders at Advent, I would have expected to have heard about the initial diversity in practices critical to intern floorwork, such as helping and handoffs, rather than diversity in practices related to dress and demeanor; I did not.

A second possible explanation is that female residents at Calhoun engaged in more male practices because Calhoun was a more hostile environment to women, and so there was greater pressure on women to act like men. If this were true, one could attribute the difference in outcomes to a difference in female reformer effort at the two hospitals, with Calhoun female residents not attempting change as aggressively as Advent female residents because they felt more threatened. My data do not support this explanation. First, my context is different from other studies that have observed the phenomenon of women acting like men to fit in. For example, in Turco's (2010) study of the leveraged buyout industry, women comprised less than 10% of professional staff and were working in the absence of new frames, mobilizing structures, and political opportunities that would have given them new resources for change. So they acted as individuals and fearfully conformed to male practices to fit in. In contrast, in my case, women comprised about a third of the residency program in each hospital and were working during a time when a social movement was providing resources to reformers inside hospitals to challenge the status quo. Second, my data do not support the claim that the female residents at Calhoun felt threatened. Turco's women reported that they felt like they had to watch *SportsCenter* in order to survive. In contrast, the women at Calhoun reported engaging in masculine acts with glee. They said that they enjoyed the "edgy" surgery culture, said that "it's part of why I went into surgery," and felt that "women can do anything these guys can do, and probably do it better or we wouldn't have gotten this far." Although females acting masculine may be an act of submission in some cases, I find that it may also be an act of defiance, and the latter was the case at Calhoun.

Capitulating to Status-Based Countertactics at Calhoun

Calhoun High-Status Reformers Experience Concerns About Loss of High Status. Although I did not ask specific questions about status, when I did ask about barriers to change, male reformers at Calhoun expressed two concerns related to the loss of high status. Their first concern was that they would be categorized in a lower status group against their will: they worried that they would be seen as female. One Calhoun male intern said,

> You hear all the time that "you don't work as hard as me. You don't operate as much. You're weak." You know the whole "back in the day" argument, and the thing is, you do get concerned about "are you tough enough?"

Another Calhoun male intern related:

> I think you end up feeling inadequate because of the level of expectations from the old school chiefs. Because, historically, the intern always showed up at 4 A.M. and basically pre-rounded. Now, it's supposed to be working rounds, so no pre-rounding, and we are all supposed to

Table 4 Effects of Initial Status Threat on Response to Status-Based Countertactics

Response to status-based countertactics	Associated practices	Calhoun strong status threat	Advent weak status threat
Male reformers		*N* = 7	*N* = 6
Experience concerns about loss of high status	Express concerns about being seen as feminine	7	0
	Express concerns about being left out of Boys' Club	6	0
Distance themselves from lower-status practices and reformers	Distance themselves from feminine labels	6	0
	Align with male defenders	6	0
	Consistently refrain from reform practices	7	0
Female reformers		*N* = 6	*N* = 4
Experience concerns about loss of high status	Express concerns about being seen as feminine	0	0
	Express concerns about being left out of Boys' Club	0	0
Distance themselves from lower-status practices and reformers	Distance themselves from feminine labels	0	0
	Align with male defenders	0	0
	Consistently refrain from reform practices	0	0

get the numbers together. But, with the old school guys, the few times I haven't come in early, it hasn't been acceptable.... They are obviously pissed off, you know, rolling their eyes and calling you weak. It would also happen in the evenings, if you signed something out.... They make you feel like you're a wuss with an easy life. That you're not man enough to be a surgeon. You know, like, "When I was a kid I had to walk to school in five feet of snow without my shoes on!"

Concerns about being seen as feminine were shared by male reformer chiefs. One Calhoun male reformer chief noted,

I just wish these guys would stop making comments about the 80-hour work week.... I think that it is very undermining to...all of us, to make us feel like we're any less of a surgeon because of the new rules.... They just like to say how tough they were when they did it.

The second concern Calhoun male reformers had was that they would not be accepted within the higher-status group because they were not seen as prototypical members of that group—they worried that they would be excluded from the high-status Iron Man Boys' Club. One Calhoun male intern said,

You want to be respected by these guys. There's a lot of joking around in surgery, and when you're accepted by them, it's great.... And, if you're not, they can make your life miserable.

Similarly, a Calhoun male reformer chief said,

There is a lot of machismo in surgery. It is a pissing contest. Who is the slickest? It's like the Army. Very hierarchical, don't be weak. You fell asleep in your 60th hour? You're so weak! The culture and that kind of thinking is barbarous. But I would never say that in front of a staff surgeon or another resident. I'm telling you because this is anonymous.... Everyone wants to be the last to leave. [Otherwise] it would be like, "See, he left at 6:30." That kind of thing isn't forgiven by these guys.

Calhoun High-Status Reformers Distance Themselves from Lower-Status Practices and Reformers. Both male and female residents reported that they noticed that male reformers became noticeably concerned about maintaining their male identity. One Calhoun female chief suggested that the male chiefs who had initially supported the work hour changes had been pressured into resisting the changes "to show that they were macho."

In an attempt to protect their male identity (and the high status it conferred), male reformers at Calhoun distanced themselves from feminine labels by insisting that they were not really weak, even though they were often called so. One male intern told me how interns now did not really have it much easier than those who had come before:

There are a lot of little jokes about, you know, well, with the 80-hour work week, you guys have it easy. I think there have been some cases of where maybe we feel a little less, I don't know if "respected" is the right word, because of an easier lifestyle–quality of life as an intern.

Similarly, a Calhoun male reformer chief pointed out that it was ridiculous to suggest that people working so many hours a week were weak:

The big thing is "you're so weak." But surgical residents work a lot. We get worked unbelievably, for many, many hours.... We used to work iron man weekends from Saturday at 6 AM to Monday night. That is more than many people work in a month.... For all other people, even 80 hours is twice as long as their regular workweek.... And 80 is really 90 or 100, and 100 is a lot. It is not like all of a sudden I'm playing tennis and sitting in Starbucks in the middle of the day. I'm now able to do the basic activities of daily living and bodily fluids.

The second way prior male reformers at Calhoun attempted to protect their male identity was to align themselves with male defenders, who, they implied,

taught them the correct way to behave. One Calhoun male intern described how, after he had worked initially with reformer chiefs, he was assigned to a team with a defender chief who, he joked, "made a man out of me":

> Then, I worked with [defender chief] who is old school, hard core. He has a reputation for breaking down the interns and toughening them up...I'd come in at 4:30 [A.M.] and we'd round at 5:30 [A.M.]. We decided we wouldn't follow the rules and we worked on Saturdays. He was never trying to get me out [at the end of the day]. He told me that a certain amount of stuff is expected. Since then, I never leave at 6 P.M., ever.

Calhoun male reformer chiefs also aligned themselves with male defenders by publicly declaring their allegiance to them. For example, as the end of the resident year approached, two male staff surgeons were in the running for a teaching award. The three female chiefs and the male chief who had initially been the most vocal male reformer all voted for the surgeon who had a reputation for taking the most time with the residents. The other four male chiefs voted for the other "very macho" staff surgeon. Then, the male chief who initially had voted for the first surgeon sent an e-mail to all of the chiefs saying that he had changed his vote so that, as he said, "the women wouldn't win." The female chiefs were outraged.

One female chief described the incident to me in detail: "So the one guy who was on our side said verbatim, over e-mail, 'Well I don't like him either, but I'd rather see the girls suffer. Women shouldn't be in surgery anyway.' So he changed his vote." She went on to say that "that e-mail was followed by the other guys saying, 'Ha-ha, we won.'... The final e-mail was from one of the guys who wrote and said, 'You women, you lost, and let's face it—surgery is a man's sport.'... And not a single one of the guys, in my class or any other class, because, of course, everybody heard about it, said that it was unacceptable." Another female chief related, "In the end, these guys have got to be part of the guys."

Calhoun Reformers Fail to Implement Widespread Reform. In the face of male chief reformer reversals, female chiefs at Calhoun remained committed to their activism. They did so because they questioned the old school values of machismo, individualism, and hierarchy. In addition, they were on their way out of Calhoun and felt they had little to lose by continuing to support change.[3]

But the desertion of the male chiefs from the reformer coalition struck a fatal blow to widespread reform implementation at Calhoun. In response to it, male interns began to refrain from using reform practices across the board. They no longer engaged in handoffs nor did they accept help with post-round to-dos. They came in on Saturday even when female chiefs instructed them not to. The status of the male interns had already

been under attack because of the defenders' status-based countertactics. Once male chiefs deserted the coalition, male interns faced even greater risks of being seen as feminine (because now the only chiefs who used reform practices were women) and being left out of the Boys' Club (because it was the male chiefs, as the highest-status males, who determined membership in this club). In this context, it is not surprising that they abandoned reform practices across the board to prove themselves as men and stem further status loss. Several of them told me that when they stayed late in the hospital, they rarely did work the night float could not handle. Instead, they said, they were in the hospital doing paperwork to maintain their reputations as "strong" residents who did not hand off work.

Perhaps more interesting is the response the female interns, which lends support to the argument that it was status-based countertactics (using the status characteristic of gender), not another form of countertactics, that led to the failure of reform at Calhoun. In contrast to the male interns who avoided reform practices when working with both male and female chiefs, female interns tailored their practices to the chief with whom they were working; when they worked with female chiefs, they used reform practices, and when they worked with male chiefs, they refrained from using reform practices. Female interns continued to use reform practices when working on teams led by female chiefs because they were not concerned that using these practices would lead others to see them as feminine (because they were already seen that way) or to leave them out of the Boys' Club (because they were already left out of it). Thus, they had no need to abandon reform practices across the board to protect their status. One female chief explained, "Women don't care about being macho.... Women feel like, if there's no reason to do something, we won't." But female interns did stop attempting handoffs when working on teams led by male chiefs because they no longer believed that their challenges would lead to widespread change in practice.

Not Capitulating to Status-Based Countertactics at Advent

Advent High-Status Reformers Do Not Experience Concerns About Loss of High Status. As they had at Calhoun, defenders at Advent attempted to divide the reformer coalition by labeling reform practices as feminine, denigrating the masculinity of particular male reformers, and trying to reintegrate male reformers into the defender group. But male reformers at Advent did not capitulate to these countertactics. Because the status threat at Advent was low, male reformers there did not experience concerns about loss of male privilege.

Table 4 shows that male reformers at Advent were less concerned about being seen as feminine or being left out of the Boys' Club than were male reformers at

Calhoun. "The old school guys like to say that handoffs are weak, that we are all becoming soft," one Advent male reformer chief said. "I don't buy it. Unless we do things differently, surgery is never going to change."

Advent High-Status Reformers Do Not Distance Themselves from Lower-Status Practices and Reformers. Because male reformers at Advent were not concerned about loss of male privilege, they did not engage in compensatory acts such as distancing themselves from feminine labels or aligning themselves with defender males. An Advent male intern recounted this incident:

> One time at afternoon rounds, I hadn't checked the film, and the (defender) chief went off on me. It was totally inappropriate. It was in front of everyone on the team. He was like, "You look like you're gonna cry. Are you gonna cry?" He did it because earlier they had been making [derogatory] comments about female residents, and I didn't join in...I refused to participate in that kind of crap just so I could be accepted by them.

Advent Reformers Implement Widespread Reform. The continued participation of the male chiefs in the reformer coalition was critical to widespread reform implementation at Advent. First, it meant that a greater percentage of chiefs handled "minor snafus" that resulted from the reform practices and did not denigrate the interns who were involved in them. Second, because male chiefs were part of the coalition, male interns' concerns about loss of male privilege were minimized; reform practices were not exclusively used by women, and there was an alternative Boys' Club (led by male reformer chiefs) that they could be part of. Finally, both male and female interns believed that their challenges could lead to widespread change in practice, so they continued to take the risks associated with change.

Because male reformers at Advent maintained their coalition with female reformers, they continued to put pressure on defenders to change. The continual lack of cooperation between defenders and reformers led to breakdowns in everyday working procedures—handoffs were fumbled, orders were ignored, instructions were stonewalled—and defender chiefs found themselves trying to manage a system that seemed to be falling apart. Staff surgeons were dismayed about the growing disarray, but reformer chiefs pointedly argued that breakdowns were not a necessary outcome of the new system. Work had been handled easily without lapses in patient care, they said, whenever chiefs had been willing to work in a less hierarchical manner by helping with post-round to-dos and encouraging night floats to accept handoffs.

The continuing breakdowns put defender chiefs in a bind. By resisting handoffs and helping, defender chiefs were fulfilling traditional iron man expectations, but they were not getting routine work accomplished. They felt they could not encourage interns to hand off and seek help with work, for then they would not be acting as true "commanders" of would-be iron men. But they also felt it was their obligation to be "go-to guys" for the staff surgeons by ensuring that all work on patients was done.

In the end, iron man chiefs decided that their obligation to the staff surgeons was stronger than their obligation to teach interns in traditional ways. One defender chief explained, "If something doesn't get done, as the chief resident, you are responsible. You are it. The staff surgeons expect you to take care of everything.... You are expected to know everything and do everything, or you get a beating for it."

Presented with both a crisis and new practices that were successful, defender chiefs who had previously argued that the reforms undermined patient care now began to acknowledge that these reform practices were not harmful. They now began to suggest that although the interns might learn more slowly, they would learn all they needed to know by the end of residency. The new support of the prior defender chiefs at Advent made it easier for interns to attempt handoffs and ask for help, and these practices became the new steady-state practice at Advent.

How did these changes affect patient care at Advent? Because there are so many care providers involved in surgical patient care, there were too many confounding factors to be able to objectively measure the effect. To do that, one would need to conduct a controlled study of medical errors that closely tracked all these inputs in addition to resident work hours and errors. However, I do have subjective data on the consequences of change. In my end-of year interviews, prior defender chiefs expressed surprise that the changes had had no negative impact on patient care. They noted that some minor things such as the ordering of noncritical tests were delayed, but even they did not think that these missteps negatively affected patient care.

Discussion

At both Advent and Calhoun, reformers from different identity groups mobilized with one another for change, and internal defenders tried to divide their coalition using status-based countertactics. At both hospitals, defenders targeted male reformers using the status characteristic of gender. And at both hospitals, defenders' labeling of male reformers as feminine was threatening because females have traditionally had lower status in surgery and in society than males, and because the reform practices themselves—communal work and fewer hours spent in the workplace—were easily typed as "female."

At Calhoun, where status threat for male reformers was high to begin with because the male group was under competitive and distinctiveness threat from female residents, the higher-status male reformers were anxious

about the loss of male privilege in the face of defenders' status-based countertactics; they tried to protect their status by distancing themselves from the practices of lower-status reformers and aligning themselves with higher-status defenders. In contrast, at Advent, where the initial status threat was low, the higher-status male reformers did not experience concerns about loss of male privilege in response to defender countertactics, and they maintained their coalition.

I use these findings to introduce the concept of *status-based countertactics* (see Figure 1). When a reform threatens the socially constructed measures of performance that have historically allowed high-status members to distinguish themselves from others, many of them are likely to resist it. In contrast, members, high-status or otherwise, who have had difficulty complying with these historical measures of performance are likely to become internal reformers. Different groups of these reformers may have different identities and build alliances across identity lines that require reformers with different statuses to collaborate with one another.

Defenders may try to divide such cross-identity reformer coalitions by using status-based countertactics against higher-status reformers whose own status is supported by the traditional hierarchy that the reform threatens and who are, therefore, displaying disloyalty to their high-status group by siding with the lower-status reformers. Defenders may link reform practices to a status characteristic associated with lower-status reformers, denigrate the higher-status reformers by associating them with these practices, and recruit higher-status reformers to the defender group. Defenders will likely use a status characteristic whose value hierarchy is under fire from the reform and which can be easily linked to reform practices because of cultural beliefs that associate reform practices with the lower-value status characteristic. In the case presented here, gender fit well.

Status-based countertactics will be most successful in dividing the reformer coalition when the targeted high-status reformers are already under a high degree of status threat (e.g., competitive threat or distinctiveness threat). Under these conditions, higher-status reformers are particularly likely to experience concerns about being categorized in the lower-status group against their will and not being accepted by the higher-status group because they are not seen as exemplary members of this group. These concerns may lead them to distance themselves from the practices of lower-status reformers and visibly align themselves with higher-status defenders to prove themselves as members of the high-status group and to protect the privileges associated with this group. This, in turn, can undermine the multi-identity reformer coalition and cause reform implementation and microinstitutional change to fail.

Contributions to Our Understanding of Social Movements

This paper makes several contributions to our understanding social movements. First, theorists who have examined social movement implementation have demonstrated that internal reformers are key players in implementation because they participate in everyday organizational practices in ways that external reformers cannot (e.g., Binder 2002, Katzenstein 1998, Kellogg 2009, Lounsbury 2001, Meyerson 2001, Meyerson and Scully 1995, Moore 2008, O'Mahony and Bechky 2008, Raeburn 2004, Rao et al. 2003, Scully and Segal 2002, Zald et al. 2005). However, these theorists have not explored the dynamics associated with mobilization across diverse identities inside organizations. This is unfortunate because, as organizations are composed of actors with different identities who operate within a variety of institutional and organizational rules (e.g., Morrill 1995, Morrill and Rudes 2010, Morrill et al. 2003, Zald et al. 2005), internal reformers often must create coalitions across multiple identities to accomplish change. For example, during the implementation of environmental reform inside universities, a multi-identity coalition was required for successful challenge: student reformers needed to ally with faculty and administrator reformers to accomplish change in recycling practices (Lounsbury 2001). According to the argument presented here, higher-status faculty and administrator reformers may have needed to stand up to defenders on campus who threatened the status of faculty and administrator reformers by drawing on culturally available meanings about students to paint all reformers as immature or strident activists. But such countertactics and responses to them have not been previously examined. I demonstrate that coalitions composed of reformers with diverse social identities are particularly vulnerable to attack because different identities are often associated with different statuses. Internal defenders can demobilize higher-status reformers by linking reform practices to a status characteristic associated with lower-status reformers, denigrating higher-status reformers by associating them with these practices, and trying to reintegrate higher-status reformers into the defender group.

Second, prior research has shown that success in implementing social movement reform depends on the strength of external and internal resources; on the internal reformers' connection with those who control these resources; and on intraorganizational contextual factors such as spaces, networks, and logics that facilitate reformer mobilization (e.g., Creed et al. 2002, Kellogg 2011b, Raeburn 2004, Weber et al. 2009b). This study highlights an additional intraorganizational contextual factor that can shape reform implementation—degree of

Figure 1   Using Status-Based Countertactics to Block Social Movement Implementation and Microinstitutional Change
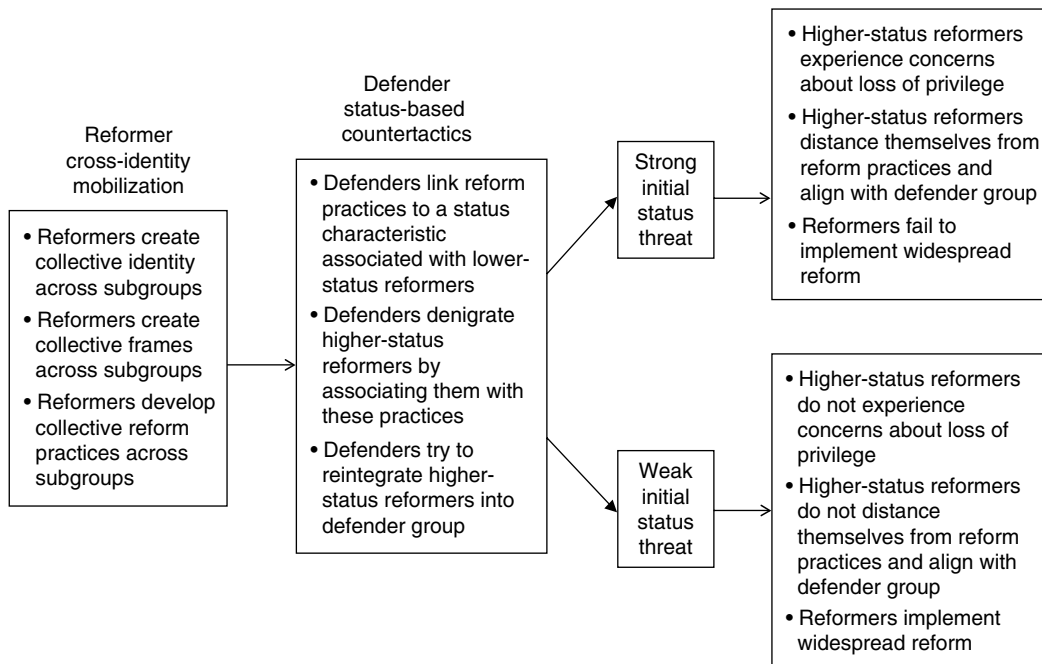
initial status threat to high-status reformers. When status threat is initially high, high-status reformers are more likely to feel concerned about loss of privilege in the face of status-based countertactics and to distance themselves from lower-status reformers to protect their identity and its rewards.

Finally, theorists of social movements and organizations have suggested that status affects reform implementation in two ways. First, high-status actors may be at the vanguard of reform implementation because they have more latitude to defy conventions because they are secure in their group membership and likely to be imitated because they are visible role models (Rao et al. 2005). Second, actors inside organizations may refrain from mobilizing to protect their status if external countermovements portray reform as immoral or unsafe (Weber et al. 2009b). The findings presented in this paper suggest that high-status actors may not be at the vanguard of reform implementation but rather of reform resistance in cases where reform threatens the socially constructed measures of performance that have historically allowed them to distinguish themselves from others. In addition, threats to the status of internal reformers can be posed not only by external countermovements but also by internal defenders, defenders can threaten the status of internal reformers not only by portraying reform as immoral or unsafe but also by linking reform practices to a status characteristic associated with lower-status reformers in the coalition, and threats to status can not only prevent mobilization from happening but also help reverse it once it has occurred.

Contributions to Our Understanding of Institutional Change

This paper also makes several contributions to our understanding of institutional change. First, where early neo-institutional theory suffered from an actorless bias (e.g., Barley and Tolbert 1997, DiMaggio 1988, Hirsch and Lounsbury 1997, Powell and DiMaggio 1991), recent studies have explored the agency by which members accomplish institutional change. Actors now abound, doing all kinds of things (e.g., Barley 2008, Battilana 2011, Colyvas and Powell 2006, Lawrence et al. 2009, Powell and Colyvas 2008, Reay et al. 2006, Tolbert et al. 2011, Zilber 2007). And yet, with all of this emphasis on agency, no studies have sufficiently explained why these newly empowered actors have not brought about big changes. Why all of this agency and not much big change? I demonstrate that it is not because actors do not matter but that, when they encounter obstacles, they can sometimes circumvent or overcome them (as at Advent), and sometimes they cannot (as at Calhoun). Sometimes obstacles impede actors or require more finessed moves born from an understanding of how status and interests can sway collective action. Adding defenders to the story of institutional change helps us see that, although we should not ignore actors, we should not overly simplistically assume that they will be efficacious as long as they have access to the right cultural and political resources. Theorists examining institutional change at the macro level have shown us that actors exist in a complex and dynamic system comprising mobilization and countermobilization (e.g., Ingram and Rao 2004, Ingram et al. 2010, Levy

and Scully 2007). To date, countermoves inside organizations have been undertheorized, and institutional stability has often been assumed to be a result of inertia or of dominant cultural beliefs or norms that actors strain against (e.g., Dacin et al. 2010). Adding an understanding of countertactics inside organizations helps us to address the puzzle of why we see such constrained change despite such dynamic agency.

Second, previous research suggests that organizations are most likely to subvert institutional pressures when such pressures are weak or inconsistent, when there are high symbolic gains from program adoption but also high costs associated with implementation, and when organizational actors have professional identities or backgrounds that conflict with the proposed reform (e.g., Anteby 2010, Barley 1986, Edelman and Petterson 1999, Edelman and Suchman 1997, Fligstein 1985, Heimer 1999, Heimer and Staffen 1998, Lounsbury 2007, Powell 1991, Sauder and Espeland 2009, Westphal and Zajac 1994). The findings presented here demonstrate that initial degree of status threat is also important to the blocking of microinstitutional change. When high-status actors are under a high degree of status threat to begin with, they are particularly likely to experience concerns about loss of privilege in the face of defenders' status-based countertactics and to abandon the reformer coalition to prove themselves as members of the high-status group and to protect the privileges associated with this group.

Third, these findings contribute to our understanding of the relationship between status and institutional change. Theorists studying this relationship have demonstrated that status affects whether actors are likely to try to change institutions. Low-status actors often feel free to defy accepted practices because they are less constrained by traditional ways of doing and thinking (Haveman and Rao 1997, Leblebici et al. 1991, Powell 1991), because they are excluded regardless of their actions (Phillips and Zuckerman 2001), or because they are interested in the status mobility that institutional change facilitates (Lounsbury 2002, Rao 1994). High-status actors often feel free to defy accepted practices because they are confident in their social acceptance, because they judge that others in their field will try to emulate their actions, and because they provide channels for ongoing diffusion of practical knowledge to these emulators (Greenwood and Suddaby 2006, Sutton and Dobbin 1996, Weber et al. 2009a). The findings presented here show that status is important to institutional change not only because an actor's social position shapes likely change behavior but also because status can be used as a weapon by defenders of the status quo to divide reformer coalitions pressing for change.

Finally, the paper contributes to our understanding of gender and institutional change. Most research on gender and institutional change tends to analyze changes

that affect equal opportunity for women, such as changes in inequitable hiring and evaluation or promotion processes that block women's access and advancement (e.g., Briscoe and Kellogg 2011, Castilla 2008, Dobbin 2009, Dobbin and Kelly 2007, Fernandez-Mateo, 2009, Fernandez and Sosa 2005, Kelly et al. 2011). Some theorists have begun to explore how institutional change itself is a gendered process. Because workplace policies, practices, rewards, and career paths are based on long-standing norms and beliefs that suggest that those who work long hours and continuously are the most able, most committed, most "ideal workers" (Acker 1990, Bailyn 2006, Williams 2000), institutional change requires challenging gendered understandings and role expectations (e.g., Bailyn 2006; Ely et al. 2003, Fletcher 1999; Kelly et al. 2011; Perlow 1997, 1998; Rapoport et al. 2002). In addition, gendered meanings are available as cultural resources that actors can draw on to further their own ends (e.g., Einwohner et al. 2000, Taylor and Whittier 1998). My findings add to our understanding of gender and institutional change by demonstrating that defenders can draw on the status characteristic of gender to attempt to divide and conquer male–female coalitions.

Future Research
This analysis raises several questions for future research. First, to what extent is the concept of status-based countertactics generalizable to other settings? I would expect to see status-based tactics in settings where (1) reform indirectly challenges socially constructed measures of performance that have historically allowed members of the high-status group to distinguish themselves from others and (2) cultural beliefs link reform practices to a status characteristic associated with lower-status reformers.

For example, in the case presented here, the reformer coalition was composed of men and women, chiefs and interns, and whites and blacks. Defenders did not use status-based countertactics against whites collaborating with blacks even though whites were higher status than blacks in surgery, because engaging in reform practices did not challenge the racial hierarchy. In addition, the status characteristic of race was not easily linked to reform practices because no cultural beliefs associated reform practices with the lower-status black reformers.

In contrast, defenders used status-based countertactics against men collaborating with women because reform practices, although not directly related to the gender hierarchy, indirectly challenged this hierarchy. By joining with women to fight for reform practices, men were demonstrating disloyalty to the high-status male group. In addition, the status characteristic of gender was easily linked to reform practices because of cultural beliefs that associated reform practices with the lower-status female reformers.

To generalize this argument to another situation, hospitals are under pressure to implement "evidence-based medicine" (i.e., improve patient care by using treatment plans based on the best available scientific evidence). This reform indirectly challenges socially constructed measures of performance that have historically allowed doctors to distinguish themselves from other, lower-status members of the hospital staff such as "business types." According to long-standing cultural beliefs, (1) doctors apply clinical judgment, business types apply actuarial methods; (2) doctors are clinic-centered, business types office-centered; and (3) doctors are concerned with patient care, business types are concerned with process improvement. Given these beliefs, a reform that requires applying actuarial methods, doing office-centered work, and engaging in process improvement threatens to overturn the occupational hierarchy by allowing business types to improve their performance relative to doctors.

In their countertactics, defender physicians are likely to use the status characteristic of their occupation because labeling doctors as business types will be particularly effective as business types have traditionally had lower status in hospitals than doctors. Too, it would be an easy frame extension because cultural beliefs link reform practices—applying actuarial methods, doing office-centered work, and engaging in process improvement—to the lower-status business identity.

Status-based countertactics are more likely to be more successful in dividing the reformer group when doctors are already under a higher degree of status threat (e.g., competitive and distinctiveness threats) from business types. For example, these countertactics are more likely to be successful at a hospital where administrators have just hired a number of business types who are behaving like the high-status doctors by using medical jargon or entering spaces such as medical clinics that have historically been used only by doctors. Here, in the face of status-based countertactics, reformer doctors may be more likely to distance themselves from the practices of lower-status business types and visibly align themselves with defender doctors to prove themselves as members of the high-status group and to protect the privileges associated with this group. Future research can help determine whether and how status-based countertactics apply to other status characteristics, settings, and reforms.

Second, this paper argues that the reason for the difference in outcomes between the two hospitals was that a higher level of initial status threat at Calhoun led the male reformers there to capitulate in the face of further status threats posed by the defenders' countertactics. It is possible that this difference in initial status threat also led Calhoun defenders to more aggressively use status-based countertactics. (This would be consistent with research showing that high-status actors sanction lower-status actors who try to engage in high-status behaviors; see, e.g., Eagly et al. 2000, Glick and Fiske 1999, Heilman et al. 2004.) If this were the case, then the difference in outcomes at the two hospitals would be the result of both the difference in initial status threat and the difference in degree of use of status-based countertactics. My data demonstrate no differences in the degree to which these countertactics were talked about in interviews with residents at the two hospitals; however, interview data are not the best way to measure actual frequency of countertactics used. Future research could investigate this alternative explanation further.

Third, both theorists and activists are often concerned about whether change actually happens and whether it actually serves those whom it was meant to protect (e.g., Castilla and Benard 2010, Kalev et al. 2006). Because this study was conducted in only two organizations and used qualitative methods, it is not well suited for answering such questions. Recent evidence suggests that hospitals across the country are still struggling to implement reform. The regulations took effect in 2003, yet in the intervening years, the ACGME has had to take action against some hospitals that have continued to violate them; even more disturbing, there is enough evidence of inaccuracies in residents' reports to suggest that many of the hospitals that are thought to be complying with the regulations in fact are not (Institute of Medicine 2008). In 2007, pressured by reformers who argued that the initial work hour regulation introduced by the ACGME had not been effective in solving patient care and resident safety problems, Congress directed the Institute of Medicine to study the issue. Their report presented detailed evidence linking fatigue to cognitive and behavioral errors outside of clinical settings (Institute of Medicine 2008). In addition, a study in the 2004 *New England Journal of Medicine* conducted within a clinical setting found that reducing medical residents' work hours during rotations in the intensive care unit resulted in a significant reduction in medical errors (Landrigan et al. 2004). Yet further research is needed to determine to what extent the reform has been implemented across the country and to what extent it has improved patient safety in places where it has been implemented.

Finally, the practical implications of these findings are complicated. On the one hand, the findings suggest that lower-status reformers would do well to respect traditional status hierarchies and behaviors to minimize the threats to higher-status reformers and so limit defenders' ability to divide a multi-identity reformer coalition. On the other hand, such status hierarchies and behaviors are often precisely the problem that lower status reformers are interested in remedying. It is possible that in some cases, lower-status reformers may be able to improve their own organizational position more easily by collaborating with higher-status reformers to accomplish a reform such as resident work hour reduction (which serves both low-status and high-status reformer interests)

than by working solely with other low-status reformers to accomplish a reform such as women's rights (which serves primarily low-status reformer interests). Future research could investigate whether there are particular kinds of settings or reforms in which it makes sense for lower-status reformers to purposely minimize competitiveness and distinctiveness threats to more easily collaborate with higher-status reformers.

In sum, this study demonstrates that implementing reform inside organizations may require reformers not only to mobilize with one another across diverse identities but also to stand up to defenders' countertactics in everyday organizational encounters. When a reformer coalition is composed of reformers with different statuses, defenders can leverage status to divide the coalition by linking reform practices to a status characteristic associated with lower-status reformers, denigrating higher-status reformers by associating them with these practices, and trying to reintegrate higher-status reformers into the defender group. When status threat inside an organization is already high, higher-status reformers are particularly likely to experience concerns about loss of privilege. These concerns may lead them to try to protect their position and its rewards by distancing themselves from the practices of lower-status reformers and visibly aligning themselves with higher-status defenders. This, in turn, can undermine the multi-identity reformer coalition and cause reform implementation and microinstitutional change to fail. An understanding of status-based countertactics is critical to explaining how and when internal reformers can accomplish the institutional change that social movements try so hard to win.

Acknowledgments

Endnotes
[1] I also coded my end-of-year interview data to identify who had initially used reform practices and who had opposed them. I found that residents' prechange beliefs were consistent with their beginning-of-year use of reform practices as reported in end-of-year interviews. I did not have access to performance ratings to determine whether performance ratings correlated with behavior.

[2] To protect the confidentiality of my informants and the hospitals in which they worked, this specific subspecialty name has been changed to another that reflects similar characteristics.

[3] All chiefs at both hospitals were leaving at the end of the year, so the difference in outcomes at the two hospitals did not stem from the fact that the Calhoun female chiefs had little credibility because they were leaving.

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