Changing Professionals

Professionals' Role in the Institutional Dynamics of German Health Care

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List of Abbreviations

AHP	-	Allied Health Professions
AWMF	-	Association of the Scientific Medical Societies in Germany
BÄK	-	German Medical Association
BMG	-	Federal Ministry of Health
CAM	-	Complementary and Alternative Medicine
CDA	-	Critical Discourse Analysis
CDC	-	Center for Disease Control and Prevention
CG	-	Cancer Genetics
CT	-	Computer Tomography
DKG	-	German Hospital Federation
DPR	-	German Nursing Council
DRG	-	Diagnosis-Related Group
EHS	-	Environmental Health and Safety Office
EFQM	-	European Foundation for Quality Management
EU	-	European Union
fsQCA	-	fuzzy-set Qualitative Comparative Analysis
G-BA	-	Federal Joint Committee
GKV-SV	-	National Association of Statutory Health Insurance Funds
GPSI	-	General Practitioner With Special Interest
HPC	-	Health Professions Council
HR	-	Human Resources
ICAEW	-	Institute of Chartered Accountants in England and Wales
IT	-	Information Technology
IQWIG	-	Institute for Quality and Efficiency in Health Care
KBV	-	National Association of Statutory Health Insurance Physicians
KTQ	-	Cooperation for Transparency and Quality in Health Care
NFC	-	National Forensic Council
NHS	-	National Health Service
OSH	-	Occupational Safety and Health
SD	-	(Non-Cancer) Service Development
SGB	-	German Social Code
SHI	-	Statutory Health Insurance
SVR	-	Advisory Council on the Assessment of Developments in the Health Care System
UK	-	United Kingdom

1 Introduction

German health care, like most health care systems in the Western world, has undergone profound changes over the last four decades (Giaimo & Manow, 1999). Starting with financial reforms in the late 1970s, German policymakers have introduced increasingly radical changes in health care legislation over the last years (Lungen & Lapsley, 2003). Among the primary goals of these reforms were the containment of costs in the face of an aging society (Altenstetter & Busse, 2005: 132f.) and the securing of high medical quality through increased market competition between health care providers (Neubauer & Pfister, 2008: 157).

While Germany's health care sector seems to be in a constant state of flux, change in this field does not come easily. Especially when politically or economically motivated changes collide with health care professionals' ideas on desirable goals and appropriate modes of restructuration, change becomes a challenging endeavor (Ackroyd, Kirkpatrick, & Walker, 2007; Degeling, Maxwell, Kennedy, & Coyle, 2003). The complexity of change in health care can be attributed to the unique role that professionals obtain in this sector. Like few other (service) sectors, health care is dominated by the normative control of professionals (Elston, 1991; Freeman & Moran, 2000; Scott, Ruef, Mendel, & Caronna, 2000). Professionals are members of autonomous occupations with exclusive authority over advanced knowledge (MacDonald, 1995: 1) who experience public recognition as they execute services of high societal value (Burkart, 2006; Parsons, 1937). As such, they have substantial political leverage and significantly shape the process and outcome of changes in socially important sectors like health care (Elston, 1991; Kurunmäki, 1999). Examples of how professionals influenced changes in German health care include lobbying activities of the German Medical Association against new modes of hospital funding (Bundesärztekammer, 2014) and petitions against the commercial provision of physician-assisted suicide (Bundesärztekammer, 2012).

While these examples show how medical professionals attempted to secure the status-quo, professionals do not only serve as a conservative force in health care (Kuhlmann, 2006: 25f.). They also initiate change in both their own standards of practice (e.g. Dent, 2002; Kitchener & Mertz, 2012) and the boundary conditions of their work (Leicht & Fennell, 1997; Suddaby & Viale, 2011). By promoting or resisting changes in the diverse contexts of their practice, professionals influence the functionality of essential societal sectors like health care and law (Castel & Friedberg, 2010; Kilpatrick, Lavoie-Tremblay, Ritchie, Lamothe, & Doran, 2012; Salhani & Coulter, 2009; Waring & Bishop, 2010). Hence, it is crucial to understand when, why, and how professionals engage in the change of their institutional

environment, that is, the entirety of regulatory, normative and cultural-cognitive contexts in which they are embedded (cf. Scott et al., 2000: 48ff.).

As one of the most influential theories in organization research (Greenwood, Oliver, Sahlin, & Suddaby, 2008: 30f.), neo-institutional theory[1] has already started to examine how professionals alter the rules, norms, or interpretive schemes of their institutional environment (Battilana, 2011; Kitchener & Mertz, 2012; Muzio, Brock, & Suddaby, 2013; Scott, 2008b; Suddaby & Greenwood, 2005; Suddaby & Viale, 2011). Mostly under the labels of 'institutional change' (Muzio et al., 2013; Scott et al., 2000) and 'institutional work' (Currie, Lockett, Finn, Martin, & Waring, 2012; Goodrick & Reay, 2011; Singh & Jayanti, 2013; Suddaby & Viale, 2011), research has provided valuable insights on professionals' role in the dynamics of their institutional environment. Scholars have shown, for example, how professional associations draw on discursive means to change dominant conceptions of appropriate organizational structure (Greenwood, Suddaby, & Hinings, 2002), how professionalization efforts of former occupations inform public legislation (Kitchener & Mertz, 2012), and how professionals maintain their status by resisting new modes of service provision (Currie et al., 2012). While institutional change has been one of the central themes in institutional research for over two decades now (Scott, 2010a) and professionals are commonly identified as central element in institutional dynamics (cf. Scott et al., 2000; Singh & Jayanti, 2013; Suddaby & Greenwood, 2005), scholars have only recently begun to explicitly theorize the relationship between professionals and institutional change (Muzio et al., 2013; Suddaby & Viale, 2011). Given the various contexts in which professionals operate and the multiplicity of roles they obtain, ranging from political actors with considerable societal leverage to salaried employees in large corporations, our understanding of when, why and how professionals affect institutional change is still far from clear.

To address this research gap, this dissertation aims to expand our understanding of the relationship between professionals and institutional dynamics in health care. In the following sections, I will further elaborate on health care as empirical setting of this thesis and will identify the theoretical gaps in research on professionals' role in institutional change and stability. Further, I will give an overview of the specific goals as well as the structure of this thesis.

[1] Here and in the following, the terms „institutional" and „institutionalism" will be used in reference to neo-institutional theory in organization research (Greenwood, Oliver, Sahlin, & Suddaby, 2008), unless indicated otherwise.

1.1 Institutional Change in Health Care and the Role of Professionals

Nothing appears to be as constant as change in the health care systems of the developed world (Kuhlmann & Annandale, 2012). This phenomenon is often attributed to current demographic developments taking place in most Western societies (Nicholas & Smith, 2006: 480). Highly industrialized countries like Germany face an aging population and a corresponding increase in age-related illnesses against the background of a rapid expansion of innovative treatment options (Pammolli, Riccaboni, & Magazzini, 2012). With the goal to provide high-quality health care while keeping costs at bay, policymakers and managers are united in their efforts to achieve effective and efficient change in the structures of health care (Perleth, Jakubowski, & Busse, 2001). However, change in health care is far from being a linear process, but instead follows complex dynamics (Grol, Baker, & Moss, 2002: 7; Hinings et al., 2003; Parkin, 2009). The complexity of change in health care mainly stems from the normative aspects inherent to the provision of medical services which may literally boil down to life-or-death decisions (Martin & Singer, 2003). Even though increasing shortage of financial resources forces economic perspectives upon health care, scholars point out that "health care systems are primarily driven by values not by economic forces" (Light, 1997: 110; see also Kuhlmann, 2006: 40). Hence, to understand the dynamics of change in health care, we must direct our focus to those who provide the moral values to this field, that is, professionals (cf. Hafferty & Light, 1995; Kuhlmann, 2006, 2008; Wolinsky, 1988). A prime example of how professionals infuse a field with values is the long-standing dominance of the professional ethics of medicine in health care (cf. Currie et al., 2012). Primarily based on the Hippocratic Oath as the first formalized professional code of conduct (Miles, 2005), medical ethics represent the normative basis of health care as a societal and economic sector (cf. Freidson, 1985). While scholars and practitioners observe that the medical profession has lost part of its normative power due to the rise of managerialism in health care (Relman, 2007; Scott et al., 2000), the provision of health care is still virtually inseparable from the work of highly trained health care professionals (e.g. Noordegraaf & Van der Meulen, 2008; Sanders & Harrison, 2008; Watkins, 2005). This work extends to the provision of services on the practice level but also to the design of the organizational and the wider institutional environments in which professionals' services are embedded (Muzio et al., 2013; Scott, 2008b; Suddaby & Viale, 2011). Any change in health care is thus also a change in and/or through the health care professions (cf. Ferlie, Fitzgerald, Wood, & Hawkins, 2005). Accordingly, it is impossible to grasp the origins and processes of change and stability in health care without drawing specific attention to the role of professionals in these dynamics.

The notion of professionals as forces of change and stability in different areas of organizational life has found its way into organization research with the development of neo-institutional theory. In line with the explanatory focus of early neo-institutional research, professionals have initially been depicted as source of normative pressures causing stability and structural homogeneity within organizational fields (DiMaggio & Powell, 1983), defined as a "community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside of the field" (Scott, 2008a: 86). Despite the notion that professionals are "primary types of actors *shaping* institutional environments" (Scott, 1987: 493, emphasis added by author), professionalization has long been theorized as mechanism of convergent organizational change in line with the status-quo of the institutional environment (D'Aunno, Sutton, & Price, 1991; Dacin, 1997).

Yet, institutional theory has changed and so has the conceptualization of professionals. Within the last two decades, the focus of institutional theory has shifted from explaining the convergence of structures and the reproduction of practices in different organizational settings (Boxenbaum & Jonsson, 2008; Guler, Guillén, & Macpherson, 2002; Kennedy & Fiss, 2009) towards the dynamics of institutions themselves (Hargrave & van de Ven, 2006; Holm, 1995; Leblebici, Salancik, Copay, & King, 1991; Sherer & Lee, 2002). With this rising interest in the origins and processes of institutional change (Battilana, 2006; Battilana, Leca, & Boxenbaum, 2009; Beckert, 1999; Maguire & Hardy, 2009), institutional research has also renewed and broadened its interest in the study of professions and professionals (Muzio et al., 2013). Specifically, the link between professionals' institutional work, i.e. the creation, maintenance and disruption of institutional arrangements and practices (Lawrence, Suddaby, & Leca, 2011; Lawrence, Leca, & Zilber, 2013; Lawrence, Suddaby, & Leca, 2009a), and institutional change has been the object of extensive scientific scrutiny (e.g., Currie et al., 2012; Micelotta & Washington, 2013; Reay, Golden-Biddle, & Germann, 2006). Conceptually, professionals have developed from the enforcers of normative beliefs on appropriate organizational structure and conduct (DiMaggio & Powell, 1983) to what Scott (2008b) terms the "lords of the dance". According to him, professionals are "the most influential, contemporary crafters of institutions" (Scott, 2008b: 223). This appraisal of professionals as most powerful actors in organizational fields is supported by a substantial amount of empirical research that, both implicitly and explicitly, identifies professionals as institutional agents who, more or less successfully, initiate (Goodrick & Reay, 2010), direct (Greenwood et al., 2002), or hamper (Dunn & Jones, 2010; Micelotta & Washington, 2013) field-level change.

However, the notion of professionals as "lords of the dance" (Scott, 2008b) and the focus of research on their proactive and purposeful exertion of agency in processes

of institutional change (Kitchener & Mertz, 2012) appears to fall short of the realities of many professionals. While undoubtedly central actors in many organizational fields and of crucial importance to broader society, members of the traditional professions (e.g. health care professionals) have to witness how their formerly high status is withering away (Noordegraaf, 2007; Noordegraaf & Van der Meulen, 2008). In most western countries, societal and technological changes start to undermine professionals' authority and autonomy (Elston, 1991; Kurunmäki, 1999), and market logics gradually begin to erode the logic of professionalism (Kitchener, 2002; Scott et al., 2000). Leicht and Fennell (2008: 431) summarize these developments as follows:

"[T]he classic autonomous, peer-oriented professional practice is under pressure from institutional constituents interested in lower costs, more accountability, and ethical transparency at the same historical moment that technological changes put pressure on traditional, institutionalized methods for delivering professional services. The combination of new places, new people, new technologies and new clients has pushed professionals in new and uncharted directions."

In addition to an increasing number of social expectations that challenge the exertion of ideal-type professionalism, these expectations may also vary over different contexts, thereby enabling and constraining professionals' agency in idiosyncratic ways. For example, medical managers in large hospitals are expected to also promote efficient processes in their organization (Doolin, 2001; Iedema, Degeling, Braithwaite, & White, 2004; Kuhlmann et al., 2013) while legal professionals in multinational law firms may have to integrate several diverging ideas on appropriate legal practice in their routines (Smets & Jarzabkowski, 2013). Hence, it is important to study professionals' involvement in institutional dynamics against the background of the different contexts of their work.

While research on institutional change still tends to focus on drastic changes brought forth by public struggles between different constituents of a field (Suddaby & Greenwood, 2005; Zietsma & Lawrence, 2010; Zilber, 2007), we have to acknowledge that professionalization and the enactment of professionalism is not only a political process at the field-level – it is far from that (Kellogg, 2009; Kellogg, Breen, Ferzoco, Zinner, & Ashley, 2006; Kitchener, 2000). Today, many professionals work as employees of large organizations that are under managerial rather than professional control (Leicht & Fennell, 1997). Within organizations, professionals frequently experience tension between the autonomous organization of their work, a core characteristic of professionalism (Freidson, 1984), and the bureaucratic standards associated with the hierarchical organization of work (Engel, 1970; Marcus, 1985). This tension may increase professionals' reflexivity and may motivate them to exert agency (cf. Battilana et al., 2009). Accordingly, much of

professionals' involvement in institutional change is taking place within the boundaries of organizations as they seek to defend their professional autonomy (Dent, 2003) and struggle to balance different logics encapsulated in their roles as managers, employees, and members of a profession (Doolin, 2001). These processes of institutional change are usually less dramatic than the political quarrels on the level of organizational fields (Kellogg, 2009; Singh & Jayanti, 2013), and commonly the product of what scholars describe as everyday institutional work that is "nearly invisible and often mundane" (Lawrence, Suddaby, & Leca, 2009b: 1). Despite the fact that many studies restrict their research focus to macro-level processes of institutional change, initiated by political actors such as professional associations and legislative bodies (Galvin, 2002; Greenwood et al., 2002; Lounsbury, 2002; Suddaby & Greenwood, 2005), field-level change often originates from incremental, sometimes even unintentional, institutional work on the routine-level (Jarzabkowski, Matthiesen, & Van de Ven, 2009; Lounsbury, 2008). Smets, Morris, and Greenwood (2012: 893) describe this kind of institutional work as "situated improvising" rather than strategic action (see also: Jarzabkowski et al., 2009; Lounsbury, 2008).

Against the background of the diverse setting in which professionals operate, the increasing constraints on professional work, and recent findings on practice-driven processes of institutional work, we find two major shortcomings in extant literature on professionals' role in institutional change:

First, much of extant literature focuses to the highly visible instances of institutional change on the field-level, initiated by elite actors and implemented through often dramatic processes of political action (Greenwood et al., 2002; Kitchener & Mertz, 2012). While the need to direct more attention to the microfoundations of institutional change has been frequently emphasized (Lawrence et al., 2013; Powell & Colyvas, 2008), institutional research has been slow in adopting a micro-perspective on institutional change as constant, incremental, and ubiquitous phenomenon. In particular, institutional research has only begun to theorize and empirically explore the less visible instances of professionals' institutional work efforts within the boundaries of their organizations and their daily routines (Reay et al., 2013; Waldorff, Reay, & Goodrick, 2013). Further, the different levels on which institutional change may occur have so far mostly been studied in isolation (for exceptions see: Purdy & Gray, 2009; Seo & Creed, 2002; Smets et al., 2012). Hence, we still know little about how professionals enable institutional change and stability on the micro-level and how multilevel institutional dynamics interrelate through professionals' involvement.

Second, while comprehensive case studies have provided us with valuable insights on how and why professionals shape institutional change, most research empha-

sized professionals' central status within a field and conceptualizes them as powerful agents who successfully initiate and direct the implementation of new institutional arrangements and practices (Battilana, 2006; Scott, 2008b, 2010b). In doing so, research on professionals' role in institutional change is facing similar pitfalls as the concept of 'institutional entrepreneurship' (Battilana et al., 2009). Initially developed to explain how "new institutions arise when organized actors with sufficient resources see in them an opportunity to realize interests that they value highly" (DiMaggio, 1988: 14), the conceptualization of the 'institutional entrepreneur' has been criticized for depicting actors as "hypermuscular supermen, single handed in their efforts to resist institutional pressure, transform organizational fields and alter institutional logics" (Suddaby, 2010: 15). While professionals do hold exclusive authority over specific fields of expertise and still enjoy higher status than most members of other white-collar-occupations (Leicht & Fennell, 1997; Reed, 1996), theories of increasing de-professionalization and proletarization of the professions (Barnett, Barnett, & Kearns, 1998; Wolinsky, 1988) shed a critical light on professionals as guiding and mostly unrestricted forces in institutional change. Accordingly, research needs to take into account that while the professions constitute a source of institutional pressure (DiMaggio & Powell, 1983), professionals' reflexivity, power, and agency are also limited through their embeddedness in diverse political, social and work contexts (Leicht & Fennell, 2001: 96ff.).

Overall, it seems fair to state that institutional research is only at the beginning of understanding how professionals and institutional dynamics are intertwined, that is, when and why professionals engage in institutional change, how they exert institutional work and how their institutional work efforts are enabled and constrained by the multiple contexts in which they operate. Given the relative lack of studies that provide a balanced view on the diverse antecedents and processes of professionals' institutional work against the background of professionals' embeddedness in political systems, organizational hierarchies and everyday routines, it is not surprising that scholars still find that "the precise role of professionals and professional services firms in processes of institutional change remains under-theorized and under-examined" (Muzio et al., 2013: 700). It is the goal of this thesis to add to the resolution of this theoretical puzzle by integrating and extending theoretical and empirical findings on professionals' institutional work.

1.2 Goal and Structure of Thesis

With an empirical focus on the health care sector, this dissertation addresses the questions on when, how and why professionals influence institutional change and stability. Specifically, this dissertation focuses on the institutional work efforts of different groups of health care professionals, namely physicians and nurses, within

German health care. Given the significant regulatory dynamics that German health care experienced during the last decades, this setting provides a particularly favorable background for the study on when, why, and how professionals seek to create, maintain and disrupt institutions.

Elaborating on how professionals interact with the different contexts in which they are embedded, this thesis aims to provide a holistic picture of professionals' engagement in institutional dynamics. In particular, this thesis contributes to the growing literature on the micro-processes of professionals' institutional work within the diverse contexts in which these actors operate.

This dissertation is divided into seven main parts. It starts with an introductory overview of the empirical setting of this thesis that will illustrate its practical relevance. In **chapter two,** I will first explain the structure of German health care with a special focus on the institutions and actors that constitute this field (Chapter 2.1). Second, I will trace the most important regulatory changes between 1977, the year of the first comprehensive financial reform in modern German health care, and today. I will then briefly outline to which extent these changes in the regulatory environment of this sector entailed processes of institutional change in the normative and cognitive foundations of health care (Chapter 2.2).

Following this brief synopsis on institutional change in German health care, I will lay the conceptual foundations of this thesis. **Chapter three** contains four main sections, which, in sum, will provide a general understanding of how professionals and institutional dynamics are intertwined. Starting with a basic definition of professions and professionals, I will first elaborate on how the conceptualization of professionals moved from a trait-based approach (Greenwood, 1957) to an interactionist explanation on what constitutes a profession (Freidson, 1988a) (Chapter 3.1). While I will draw on the sociology of the professions as the probably most influential theoretical perspective on the nature of professionalism (Elliott, 1972; MacDonald, 1995), the focus of this chapter lies on an institutional perspective on the professions as socially constructed entities (Torres, 1991) as well as on professionals as agents in the institutionalization of the professions (Larson, 1979). The following section is dedicated to an overview of the different levels on which professionals operate (Chapter 3.2). I will illustrate how professionals act as political force on the field-level, how they fulfil managerial and employee roles within the hierarchical structures of organizations, and how they execute their craft as participants in routines. I will proceed with a brief discussion on why professionals need to be studied as carriers of multiple logics (i.e. distinct patterns "of material practices, assumptions, values, beliefs, and rules" (Thornton & Ocasio, 1999: 804)) and how professionals can be viewed as institutional workers who shape their profession as well as adjacent institutions (Chapter 3.3). I will end chapter three by devel-

oping an integrated model on how professionals exert institutional work on and across the different levels of their practice (Chapter 3.4). Specifically, I will elaborate on how professionals' institutional work can generally be conceptualized as 'boundary work', implying that professionals' change and maintain institutional arrangements by selectively in- and excluding specific institutional logics into their profession, their organizational roles, and their daily routines.

Chapters four, five, and six comprise the main parts of this thesis, including three self-contained empirical studies. Each chapter discusses in more detail selected aspects of professionals' institutional work in German health care on the field-, the organization-, or the routine-level. Specifically, I will provide new insights on how professionals exert institutional work as political actors on the field-level (Chapter 4.3), as recipients of planned changes within their organizations (Chapter 5.3), and as participants in organizational routines (Chapter 6.3). While each study represents a distinct research effort, they are united in their goal to provide a more fine-grained understanding of the 'whens', 'whys', and 'hows' of professionals' institutional work.

In **chapter four**, I will address institutional change on the field-level (i.e. the level on which collective actors interact and recognize each other as part of a distinct social community (Scott, 2008a: 86)). The chapter begins with a descriptive analysis on how selected field-level changes in German health care within the last decade have influenced and were influenced by professionals (Chapter 4.1). This section will provide the empirical context for the qualitative study in the further course of this chapter. The focus of chapter 4.1 will be on the dynamics between external shocks (e.g. an aging population), regulatory changes, and the professional projects (Larson, 1979) of different health care professions. The next section of chapter four contains the theoretical perspective on the interaction between professionals and field-level changes (Chapter 4.2). Drawing on a comprehensive literature review, I will provide an in-depth discussion of the antecedents and processes of professionals' involvement in changes within organizational fields. During the course of this review of extant conceptual and empirical research, I will identify gaps in the literature on professionals' role in field-level-change. The last section of chapter four contains a qualitative study on how federal, physician and nursing representatives make use of vocabulary structures to promote or inhibit institutional change (Chapter 4.3)[2]. It contributes to extant research by providing a more-fine-grained view on the use of discursive means as tools in disruptive and maintaining institutional work. Specifically, this study identifies three distinct patterns of vocabulary construction as means of institutional work and shows how existing power relations

[2] Earlier versions of this study have been presented at the EGOS Colloquium 2013 in Montreal, Canada and the 1st First Austrian Young Scholars Workshop in Management 2013 in Linz, Austria.

within a field are reinforced when high-status actors gain interpretive control of a debate's key phrases.

Chapter five will deal with institutional change on the organization-level. I will first provide a descriptive overview on major changes within the structures and processes of German health care organizations (Chapter 5.1). The main focus of this section will be on changes in hospitals as these organizations host several professional groups and regularly become an arena of professional politics (Iedema et al., 2004; Mesler, 1991; Mueller, Sillince, Harvey, & Howorth, 2004; Oborn, 2008; Porter, 1991). I will elaborate on how regulatory changes informed the provision of health care in hospitals. Specifically, I will discuss in more detail how hospitals increased their use of industrial management concepts and how the division of labor between different health care professionals changed. In the second section of this chapter, I will provide the theoretical background for the empirical study that follows. I will discuss findings on professionals' institutional work within the boundaries of their organizations and identify shortcomings within this literature (Chapter 5.2). In the last section of chapter five, I will present an empirical study based on the configurative method of fuzzy-set qualitative comparative analysis (fsQCA)[3]. The study addresses the question of when and why nursing professionals are open to changes in institutionalized practices. One contribution of this study lies in the analysis of 'reactive institutional work' within organizations in the sense of professionals' openness to change. Overall, I find three configurations of boundary conditions that foster nursing professionals to be open to changes in their working practices. The results suggest that configurations of boundary conditions only foster nursing professionals' openness towards changes in institutional practices when they provide professionals with both pragmatic and normative legitimization accounts. This study furthers our understanding of professionals' reaction to planned institutional change by elaborating on how characteristics of change projects must interact with organizational boundary conditions to foster perceptions of usefulness and appropriateness at the same time.

Chapter six addresses the routine-level of institutional change and stability in German health care. In the first section of this chapter, I will describe how recent developments in German health care affected the treatment routines within hospitals (Chapter 6.1). A key focus of this section will be on the growing standardization tendencies within health care routines. While these developments promise both large efficiency gains and improved quality of care, they also restrict professionals' autonomy (Timmermans & Berg, 2003). As autonomous conduct is a key aspect of professionalism, these routine-level developments do not only challenge profes-

[3] Earlier versions of this study have been presented at the EGOS Colloquium 2014 in Rotterdam, Netherlands and the Annual Meeting of the Academy of Management 2014 in Philadelphia, PA.

sionals' working structure but also their role identities (Doolin, 2002; Marcus, 1985). In the second section of chapter six, I will discuss insights from extant research on professionals' institutional work within this micro-sphere of organizational life (Chapter 6.2). Due to a relative negligence of organizational routines as level of analysis in research on institutional agency, this section will draw on institutional *and* routine research to provide theoretical insights on how professionals exert agency within routines as "effortful accomplishments" (Pentland & Rueter, 1994: 488). In analogy to the previous chapters 4.2 and 5.2, I will elaborate on how current literature needs to be extended to gain a fuller understanding of professionals' institutional work on the routine-level. The final section of chapter six contains another fsQCA study[4] (Chapter 6.3). This study explores when and why written organizational rules are persistently enacted by professionals within medical treatment routines. In doing so, this study sheds light on the dynamics of mundane institutional work that occurs alongside professionals' daily work (cf. Lawrence et al., 2013) while accounting for the embeddedness of routines in organizational and wider institutional environments. Overall, the study reveals three multilevel configurations of institutional, organizational, and task conditions fostering persistent rule enactment. This study contributes to extant literature by emphasizing how contextual embeddednesss affects professionals' routines – an aspect which is oftentimes missed by practice-minded routine researchers (Parmigiani & Howard-Grenville, 2011). This study suggests that theories of organizational routines need to be broadened to include the interplay of multilevel dynamics to explain persistence of written rules in organizational routines. Hence, it proposes a "routines-in-situations perspective" to explain routine dynamics and rule persistence in professional settings.

I will end this dissertation with **chapter seven** which includes an in-depth discussion on how the findings of this work connect to extant research on the role of professionals in institutional dynamics, and how they add to our current knowledge in this field. Figure 1 gives a brief overview on the structure and the main contents of this thesis.

[4] This study was jointly conducted with Hendrik Wilhelm. Earlier versions have been presented at the EGOS Colloquium 2012 in Helsinki, Finland and the Annual Meeting of the Academy of Management 2013 in Orlando, FL.

Figure 1.1: Structure of the Thesis

Chapter 1: Introduction
Setting the Scene
- Empirical background: institutional change in German health care (Ch.1.1)
- Research gaps: (1) professionals are multiply embedded actors who (2) do not possess unlimited agency. Their role in institutional change should be studied accordingly. (Ch. 1.1)
- Goal of thesis: a holistic picture of when, why, and how professionals engage in institutional work, accounting for the different contexts on which they operate (Ch. 1.2)

Key research question:
When, how, and why do professionals influence institutional dynamics?

Chapter 2: Setting: Changing German Healthcare

Empirical Foundations
- The structure of German health care (Ch. 2.1)
- Institutional change in German health care: how constant reforming changed the guiding logics of health care in Germany (Ch. 2.2)

Chapter 3: Theory: Professionals' Role in Institutional Dynamics
Conceptual Foundations
- The characteristics of professionals (Ch. 3.1)
- Professionals' working environments: field, organization, and routine (Ch. 3.2)
- How professionals drive institutional dynamics: institutional logics and institutional work (Ch. 3.3)
- Conceptual model: how professionals change institutions on and across different levels (Ch. 3.4)

Chapter 4: Professionals and Field-Level Change
Professionals' Role in Field-Level Change within German Health Care
- Current field-level changes: the interaction between economic necessities and professional projects in German health care (Ch. 4.1)
- Theoretical background: antecedents and processes of professionals' involvement in institutional dynamics → specific gaps in field-level research (Ch. 4.2).
- Empirical study 1: Vocabularies as enablers and constraints in institutional work - Establishing new modes of task division in German health care (Ch. 4.3)

Chapter 5: Professionals and Organization-Level Change
Professionals' Role in Organization-Level Change within German Hospitals
- Current organization-level changes: hospitals under managerial control, using industrial management concepts, and re-defining professional boundaries (Ch. 5.1)
- Theoretical background: antecedents and processes of professionals' involvement in institutional dynamics → specific gaps in organization-level research (Ch. 5.2).
- Empirical study 2: Openness to institutional change - altered task responsibilities in German university hospitals (Ch. 5.3)

Chapter 6: Professionals and Routine-Level-Change
Professionals' Role in Routine-Level Change within German Hospital Routines
- Current routine-level changes: routines between standardization and autonomous professional practice (Ch. 6.1)
- Theoretical background: antecedents and processes of professionals' involvement in institutional dynamics → specific gaps in routine-level research (Ch. 6.2).
- Empirical study 3: When do rules persist in routines? A fuzzy-set analysis of care pathway enactment in clinical treatment routines (Ch. 6.3)

Chapter 7: Discussion and Conclusion

2 Setting: Changing German Health Care

According to the World Health Organization (2000), German health care is among the most-efficient health care systems in the world.[5] However, more recent rankings shed a more critical light on Germany's health care system. In the 2010 health care system ranking of the Commonwealth Fund, Germany only ranks 4th on overall health care system performance among seven Western countries (Mahon & Fox, 2010).[6] While the German health care sector performs well regarding timeliness of care, it lacks effectiveness and coordination of care, ranking only 6th and 7th place respectively (idb.).

Put under cost pressures due to demographic challenges like an aging and increasingly morbid society (Arnold, Litsch, & Schellschmidt, 2001; Nicholas & Smith, 2006), it has not gone unnoticed by policymakers that the performance of Germany's health care sector leaves room for improvement. In attempts to secure the efficient provision of health care, policymakers have introduced several financial and structural reforms during the last four decades (Kamke, 1998). Yet, not all of these reforms generated the desired outcomes (Döhler, 1995) and several attempts of restructuring health care evoked fierce struggles between legislators, statutory health insurance funds, and service providers, including hospitals and, not least, health care professionals (Höppner & Kuhlmey, 2009; Kuhlmann, 2006; Kuhlmann & Allsop, 2008).

The reason for the contested nature of changes in this sector can be found in the unique history of German health care that brought forth a corporatist governance structure (von Winter, 2014; Wendt, Rothgang, & Helmert, 2005). This corporatist structure leaves considerable discretion over the operational design of health care to decentralized governance bodies such as the Federal Joint Committee (Gemeinsamer Bundesausschuss: G-BA). While self-regulation within a profession is not uncommon in Western health care systems (Lameire, Joffe, & Wiedemann, 1999), the governance structures of German health care are exceptionally deeply intertwined with professional interests (Kuhlmann & Allsop, 2008). For example, the National Associations of Statutory Health Insurance Physicians and Dentists are two of the four member associations in the G-BA, a central federal body in German

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[5] Germany obtains the 25th rank among 191 member states of the United Nations. The efficiency ranking is based on a weighted index comprised of the following indicators: health, health inequality, level of responsiveness, distribution of responsiveness, and fairness in financing (Tandon, Murray, Lauer, & Evans, 2001).

[6] Performance evaluation is based on patient and physician surveys and includes the following areas: Quality (including Effective Care, Safe Care, Coordinated Care, and Patient-Centered Care), Access to Care (including Cost-Related Problems of Access and Timeliness of Care), Efficiency, Equity and Ability to Lead Long, Healthy, and Productive Lives. The countries included in this ranking are (listed according to their ranking position): The Netherlands, the U.K, Australia, Germany, Canada, and the United States.

health care, responsible for translating abstract legal frameworks into specific resolutions and directives to regulate the provision of health care (G-BA, 2014e). Besides the multiple interdependencies between professional governance and the administration of the health care system as a whole, Germany is further characterized by an extensive social security system that has long separated health care from the logics of the free market. Accordingly, policymakers faced the challenge of enforcing reforms against the interest of powerful stakeholders and a historically grown detachment from market logics.

The goal of this chapter is to provide an overview of the origins and the structures of German health care and to give insights into the latest structural changes of this highly important sector. This empirical background provides an important foundation to the studies in chapters 4.3, 5.3, and 6.3 as any changes in such highly institutionalized fields as health care need to be assessed against the background of their contextual embeddedness. In the first section, I will elaborate on the historical origins of German health care and illustrate how its current corporatist structure came into existence. Further, I will give a short overview on the most important stakeholders in the political processes that shape German health care. In the second section, I will explain the most important health care reforms that have been introduced since the end of 1970s and have induced a paradigm change from a state-protected social sector to a (partly) liberalized health care market. I will further illustrate how these changes altered the structures of the field and how they affected the relative position of different stakeholders such as insurances and health care professionals.

2.1 German Health Care: Institutional Foundations and Present State

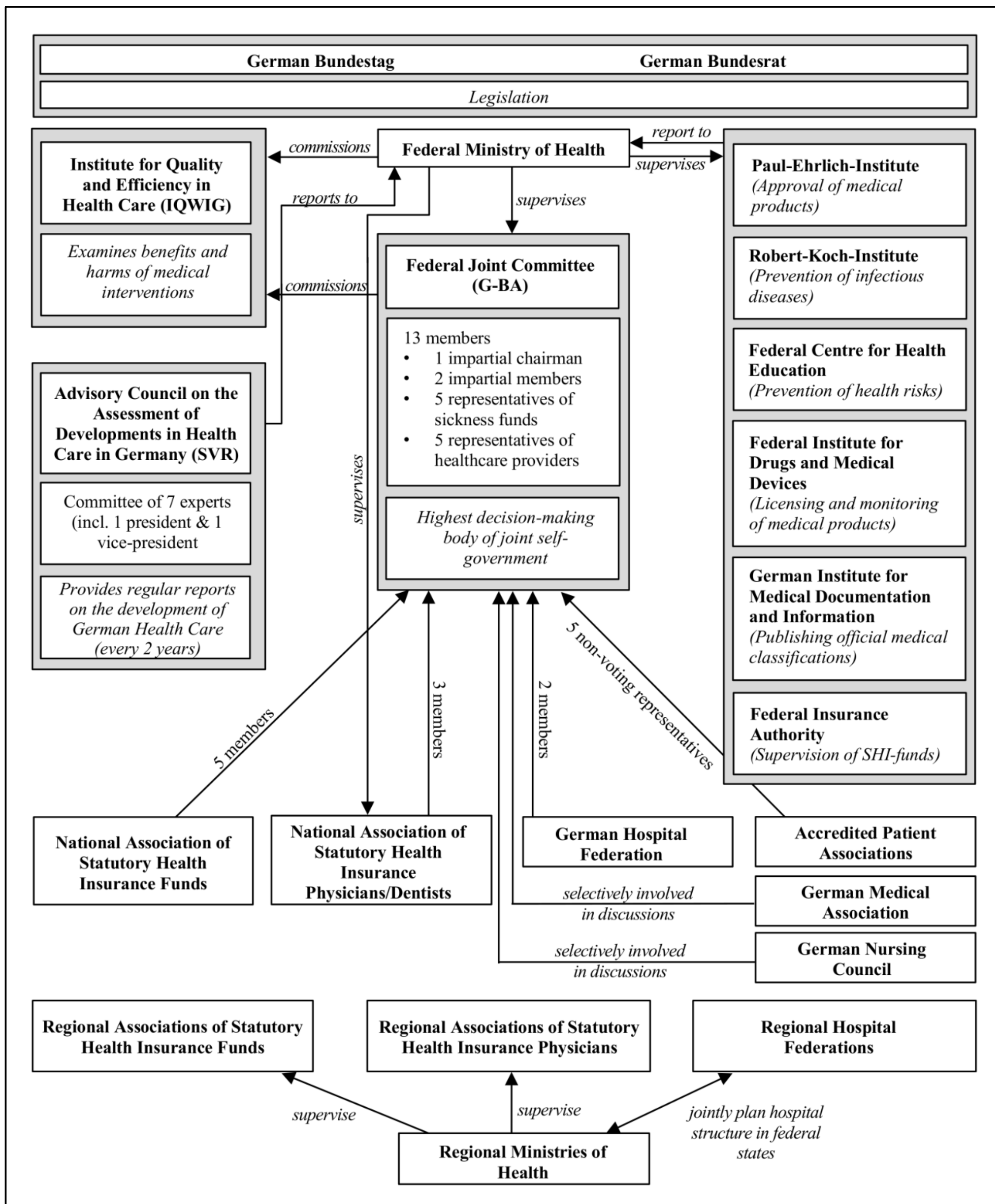
Germany's current health system dates back to Otto von Bismarck, Germany's first chancellor, who established mandatory health care insurance in 1883 (Kamke, 1998). With statutory health care, one of the most central characteristics of German health care evolved: statutory health insurance funds (SHI-funds). In opposite to purely market-based health care systems, German health care is based on the principle of solidarity. The SHI funds had initially been developed to provide lower-class workers with access to adequate health care but were successively opened for all citizens (Bärnighausen & Sauerborn, 2002). The idea behind this system was to secure health care for all individuals in the German state, regardless of their health risk.

In the early years after their inception, SHI-funds made individual contracts with selected physicians, effectively excluding a considerable number of physicians from providing medical services to SHI-fund-members who represented about 18

percent of the German population by 1911 (Simon, 2013: 34). Yet, the treatment of insured patients was an attractive option for physicians to secure and expand their income as most people without insurance were not able to afford health care, which generated a considerable income uncertainty for physicians (Simon, 2013: 36). Especially after SHI-funds had been opened for larger parts of society, including more wealthy classes of employees like clerical workers, the number of doctors with own offices increased rapidly, roughly doubling between 1885 and 1919.Yet, SHI-funds still had the privilege of including and excluding physicians from providing medical care covered by the insurance. In a reaction to the licensing monopoly of the SHI-funds, physicians founded the 'Hartmannbund' in 1900 with the goal to substitute individual contracts between SHI funds and physicians for collective agreements. The ensuing struggles between the Hartmannbund and the SHI-funds culminated in 1905 with the "Leipzig doctors' strike" (Kunstmann, Butzlaff, & Böcken, 2002). By 1913 and under the protectorate of the German government, the SHI-funds and the Hartmannbund reached agreement in the form of the "Berlin Convention" that created the structural basis for Germany's current health care system which strongly relies on self-administration. The Berlin convention granted the Hartmannbund co-decision rights in the selection and appointment of SHI-approved doctors. Further, the closure of individual contracts required the consent of the contract committee that represented physicians and SHI-administrators equally (Simon, 2013: 36). However, the peace between the SHI-funds and the Hartmannbund was only temporal. After the end of the Berlin convention in 1923, doctors and SHI-funds were unable to come to a new agreement. Eventually, the government of the Weimar Republic intervened by integrating the main contents of the Berlin convention into federal law and further expanding the system of joint self-government (Simon, 2013: 37). Between 1923 and 1932, several changes in the structure of German health care were introduced which have – in their basic structure – survived until today. First, the government founded the 'Committee for Physicians and Health Insurance Funds of the German Empire' (Reichsausschuss für Ärzte und Krankenkassen), a joint body of physicians and statutory health insurance funds which was entrusted with the development of guidelines for the admission of physicians (Simon, 2013: 38). Further, arbitration courts with equal representation were established to settle potential disputes between physicians and insurances. By 1932, individual contracts between the SHI funds and physicians had been replaced with collective contracts between the SHI funds and the Association of Statutory Health Insurance Physicians which took the position of the Hartmannbund. Apart from an interruption during the Third Reich, German health care remained mostly self-governed through a collaboration of service providers (i.e. physicians) and SHI funds.

Today, the structure of German health care still clearly reflects its origins: While governmental bodies on the macro-level provide the general jurisdictional frame, German health care is still characterized by a strong self-administration on the meso-level that translates abstract laws into concrete resolutions and guidelines. The following overview over the main decision-making bodies (BMG, 2014b) will give a more detailed picture on how politics, professionals, and health care funds are intertwined within German health care (see Figure 2.1).

Figure 2.1: The German Health Care System



On the macro-level, the federal ministry of health (Bundesministerium für Gesundheit: BMG) represents the central authority of German health care[7]. It drafts bills, ordinances and administrative regulations that directly or indirectly support its core task "of safeguarding and further developing the effectiveness of the statutory health insurance" (BMG, 2014a). A key responsibility of the federal ministry of health is the supervision of subordinate federal agencies like the Robert-Koch-Institute (which is responsible for the identification, prevention and control of infectious diseases) or the Federal Institute for Drugs and Medical Devices (which authorizes, registers, and controls the risk of drugs and other medical products). Every two years, the BMG commissions the Advisory Council on the Assessment of Developments in the Health Care System (SVR) to issue a report on current developments in health care, including themes such as structural and demographic challenges (SVR, 1994) or the development of the health care professions (SVR, 2007). These reports are mostly used to develop and refine legislative initiatives that are introduced to the Bundestag which – under cooperation of the Bundesrat – decides whether the proposed bills will be passed.

Yet, despite its central position within the German health care system, the BMG only provides the general regulative environment, the 'legislative boundaries' for the federal bodies on the meso-level which more directly regulate and supervise the provision of health care. Even the BMG (2014b) itself points out that a great part of health care regulation is being delegated to the meso-level, summarizing its function as follows: "The state provides the framework. The partners of the self-government design the provision of health care".

Since 2004, the Federal Joint Committee (G-BA) has become the most important federal body to translate and implement government regulation. It is the highest board of the joint self-government of service providers and SHI-funds and its decisions – while subordinate to federal law – are legally binding. The tasks of the G-BA include defining which medical services are to be reimbursed by statutory health insurances as well as managing and securing quality within ambulatory and in-patient care through the definition of legally binding guidelines, structures, and processes (G-BA, 2014e). The G-BA is comprised of a decision-making body and nine subcommitees[8] that deal with specific topics such as quality management. The decision-making body consists of 13 members that represent the central professional, hospital and SHI-bodies in German health care. The National Association of Statutory Health Insurance Funds (GKV-SV) – as the relatively most powerful actors within this body – is being represented by five members. The National Asso-

[7] As Germany is a federal republic, health care legislation is enforced by the regional ministries of health in each federal state. Yet, they do not possess any legislative power.

[8] As per July 2014.

ciation of Statutory Health Insurance Physicians (KBV) and the German Hospital Federation (DKG) are each represented by two members while the National Association of Statutory Health Insurance Dentists provides one member. Owing to its federal mandate, the G-BA is managed by a neutral chairman and includes two additional neutral members. Patient associations are not directly represented within the G-BA but have consultation rights and may make motions. The consultation processes of the G-BA further include official statements of third parties, which, depending on the regulation in question, may be other health care occupations, pharmaceutical companies, or scientific institutes.

While the G-BA is a federal body, its structure illustrates well that German health care is strongly influenced by the interests of (statutory health care) insurances and health care professionals who do not only shape health care policy through lobbying attempts but have become an integral part of the regulatory bodies. This system comes with specific advantages and challenges. On the one hand, the state is widely relieved from the strenuous task of providing guidelines specific enough to be applicable and relevant to health care routines on the operational level (Simon, 2013: 119). Further, as professionals are regular members of the G-BA, the practical feasibility of new guidelines is considered early in the process.

On the other hand, the G-BA has also been criticized for delaying the access to medical innovation due to its focus on cost containment. Generally, much of the criticism the G-BA has to face is directed towards its attempts to minimize health care expenditures. This is because cost-containment measures are most likely to affect the quantity and quality of services provided to patients as well as the working conditions of health care professionals and the potential revenue of pharmaceutical companies. For example, politicians blamed the G-BA for hindering the market launch of urgently needed drugs due to its opinionated consultation processes (Mißlbeck, 2011). Besides, patient associations have attacked the G-BA for jeopardizing public health due to inappropriate drug assessment (Hohle, 2013) and overly simplistic needs- and demand-based planning of ambulatory care (VdK, 2014).

Especially the health care professions have not only criticized the decision-making processes of the G-BA but also its very structure. The German Nursing Council (DPR), for example, demands the inclusion of nursing representatives into the joint self-government beyond occasional consultation (DPR, 2014c). Physicians, who are already represented within the G-BA by two members of the KBV, are particularly critical of the relative majority of the SHI-funds within the G-BA. According to Flintrop and Gerst (2010), the five SHI-representatives are more likely to reach consensus while delegates of the KBV and the DKG, as a less homogenous group, are often unable to build a coherent unity against the cost-conscious SHI-

representatives. Further, physicians questioned the legitimacy of the G-BA with regard to the regulation of professional work, claiming that decisions like the redivision of tasks between physicians and other health care professions (§ 63 c SGB V) clearly falls into the responsibilities of professional associations (Flintrop & Gerst, 2010: 172).

Hence, while the G-BA is the central federal body on the meso-level of German health care, it is by far not the only influential collective actor as the health care professions have high stakes in the economic and structural boundary conditions of their work. Overall, several hundred professional associations represent the interests of their members in German health care (Preusker, 2011). Among the most important are the German Medical Association (Bundesärztekammer: BÄK) and the German Nursing Council (Deutscher Pflegerat: DPR) which represent the medical and the nursing profession as the two major groups of the health care workforce.

The BÄK was founded as early as 1947 and comprises the 17 State Chambers of Physicians. Physicians are compulsory members in one of these Chambers as they are the bodies of professional self-administration and, as such, provide the code of medical ethics and oversee both professional training and practice. In contrast to the KBV, the BÄK does not only represent SHI-accredited physicians but all practicing members of the medical profession. Further, it is not primarily concerned with questions of reimbursement and not legally obligated to secure the nation-wide availability of medical services. The BÄK itself defines one of its main tasks as "safeguarding the professional interests of the medical profession" (BÄK, 2014b). Accordingly, the BÄK is often fiercely involved in political struggles whenever they perceive the interests of the medical profession to be threatened. Examples include debates with SHI-funds regarding the extent of doctors shortage in rural areas (Haverkamp, 2014), public demands to prohibit organizations that offer medically-assisted suicide (BÄK, 2014a), and opposition against governmental plans to grant SHI-funds the permission to recommend specific hospitals to their members (BÄK, 2012). The BÄK regularly publishes its positions on current political and medical topics in reports and resolutions and is frequently involved in the consultation processes of the G-BA. Hence, while the BÄK itself is not part of the Federal Joint Committee, it plays an important role in the political arenas of German health care, both through direct interaction with the BMG as lobbyist and as advisory participant in the G-BA's decision-making processes. [9]

[9] Further, the BÄK is also represented as advisory participant in the G-BA's subcommittee on quality management in healthcare (BÄK, 2013)

The counterpart of the BÄK on the side of the largest group of health care professionals, the nurses[10], is the German Nursing Council (DPR) which was founded in 1998. The DPR, like the BÄK, serves as umbrella association for currently 16 member associations, which, in contrast to the BÄK, are not regional sub-associations but distinct nursing organizations with slightly different thematic foci and specific stakeholder groups (e.g. catholic nurses). According to the DPR, it has been founded to "present the positions of nursing associations consistently, coordinate their political work, and speak with a single voice in the interest of professional nurses in Germany" (DPR, 2014a). Compared to the BÄK, the DPR is still far less central to the field of German health care[11] which may be owed to both, the subordinate role of the nursing profession in health care (Dent, 2002) and the relatively young age of this association. Yet, the DPR is gaining influence in health care, currently providing one advisory participant to the G-BA's subcommittee on quality management (G-BA, 2012a). As of 2014, the DPR has been heard in 91 decisions of the G-BA. While this is still considerably less than the BÄK, which has been heard 468 times, current developments like an intensifying nurses' shortage strengthen the DPR's position in politics and in the public.[12]

Overall, the meso-level is probably the most important political sphere in German health care for several reasons. Due to the corporatist structure of German health care, specific regulations that most directly affect the structure and contents of this sector are developed on this level, thus making it the most dynamic arena of lobbying attempts from professional associations and SHI-funds. Further, SHI-funds, hospitals, and physicians are all represented within the G-BA, making three of the most important stakeholder groups in health care not only lobbying 'outsiders' but decision-making 'insiders' of health care policy.

The micro-level of German health care is constituted by the provision of medical services by physicians, specialist doctors, and hospitals to individual patients under the restrictions of the regulative environment designed by the macro- and meso-level actors (Gerlinger & Noweski, 2012). The provision of medical services to German citizens, over 90 percent of whom are members of SHI funds (BMG, 2013)

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[10] In 2011, there were 826.00 nurses in Germany, 342.000 physicians, and 61.000 pharmacists (Destatis, 2011).

[11] The DPR is only participating in eight external healthcare committees (DPR, 2014d) while the BÄK reports being active in as much as 23 external committees (BÄK, 2013). Further, the BÄK works closely with the KBV within the Agency for Quality in Medicine (ÄZQ, 2014), thereby raising its chances to gain influence within the G-BA as both organizations pursue the common goal of representing (SHI-accredited) physicians' interests.

[12] For example, the petition „I want care!" that was initiated by the DPR in 2013 with the goal to achieve comprehensive reforms in the professional education and integration of nurses in federal bodies has been supported by over 40.000 citizens (as per 11.07.2014) (Westfellerhaus, Wagner, & Lemke, 2013).

due to mandatory health insurance and restrictive preconditions for private insurance, follows several main principles.

The first principle guiding the provision of health care in Germany is rooted in the Basic Law (Grundgesetz) which determines that the German state must provide social services to its citizens (Art. 20, Abs. 1; Art. 28 Abs. 1). This includes that the state ensures all German citizens access to adequate health care (Döring & Paul, 2010). Due to the state's legal obligation to provide all citizens, regardless of their income situation or health status, with equal access to health care, German health care is further designed according to the principle of solidarity. In this context, solidarity implies that the medical services received are independent from the payments of the respective insurant. In Germany, insurance premiums are paid by employees and employers to equal parts. The basis for calculating the premium is the respective income of each insurant but independent from demographic variables such as age, gender, or overall health status. The SHI-funds effectively redistributes insurance premiums between the rich and the poor as well as between the healthy and the ill by reimbursing the medical treatments of all insurants equally. For SHI-members, the direct contact with service providers such as general practitioners and medical specialists is cost-free (principle of benefits in kind) (Simon, 2013: 111). Further, each SHI-member receives medical treatment according to his or her individual needs as the provision of health care must generally be aligned with the populations' medical needs and may not be determined by economic performance indicators (Bäcker, Naegele, Bispinck, Hofemann, & Neubauer, 2010: 230). This principle of meeting need is supported by the federal government's legal obligation to guarantee treatment by securing the nationwide availability of in-patient and out-patient facilities (Döring & Paul, 2010).

While the German health care system has – as so called "Bismarck-System" – set an example for health care systems in Europe as well as in Japan, the ambition to provide all citizens with equal access to health care does not come without cost (Lameire et al., 1999). Given the general reimbursement policy, a common problem of health care systems with compulsory insurance and solidarity-based financing is the overuse of medical services by the population (Freeman & Moran, 2000: 39). In addition, Germany's expansion of public welfare between the 1960s and the 1970s was owed to overly optimistic prognoses on the future economic development of the country (Simon, 2013: 52). While the oil price crisis in the 1970s slowed down economic growth, health care expenditures have constantly increased.[13]

Accordingly, policy makers had to reconsider both the financing and the structure of health care to be able to meet their normative goal of securing high quality health

[13] Between 1970 and 2013, healthcare expenditures have risen from 6.0 percent to 11.3 percent of the German gross domestic product (OECD, 2014).

care to the German population. The results were extensive reforms that started in the 1970s and have continued until the latest restructuration laws in 2013. How these reforms have informed the mode of health care provision as well as the working conditions and relative positions of health care professionals will be elaborated on the following section.

2.2 Structural and Economic Changes in German Health Care between 1977 and 2014

As briefly touched upon in the last chapter, German health care has undoubtedly undergone significant changes over the past decades. As most Western health care systems, Germany had to deal with a plethora of demographic and economic changes since the 1970s that made a continuous restructuration of the health care sector inevitable. With an aging population and an extensive system of social security that was once considered one of the great achievements of post-war Germany (Simon, 2013), long-term financing of health care became a major concern for German politicians (Altenstetter & Busse, 2005). Starting with the 1977 reform on hospital financing (KVKG), German policymakers began to re-evaluate the financial capacity of SHI-members and allowed insurances to increase the share of mandatory deductibles. Further, drugs and medical treatments were increasingly evaluated against the background of their cost effectiveness. Until the 1990s, health care reforms in Germany did not alter the incentive or organizational structures in health care. When the cost-containment initiatives of the 1970s and 1980s failed because they had only selectively restricted reimbursement rates and had focused on minimizing the expenditures for specific services, politicians started to introduce structural changes to health care to promote an increase in the overall efficiency of the system. Table 2.1 provides an overview over the major reforms in German health care since 1977.[14]

[14] Sources: AOK (2014), own depiction and additions.

Table 2.1: Major Health Care Reforms in Germany between 1977 and 2014

Date	Regulatory Act	Main Contents and Implications	Economic Changes	Structural Changes
1977	Health Insurance Cost-Containment Act *(KVKG)*	• Reduction of reimbursable medical services • Introduction of the 'Concerted Action in Health Care': Service provides, federal, professional, and consumer associations had to develop cost containments initiatives in health care • Introduction of an earnings-based spending policy among SHI-funds; budgeting and efficiency auditing in medical services	✔	
1981	Hospital Cost-Containment Act *(KHKG)*	• Inclusion of hospitals into extant cost containment measures • Development of self-governance structures between hospitals and health insurance funds • SHI-funds granted a say in defining hospital per diem charges • Introduction of financial incentives to reduce hospital beds • Inclusion of the hospital sector into the 'Concerted Action'	✔	(✔)
1985	Hospital Restructuring Act (*KHNG)*	• Introduction of the possibility to finance rationalization investments through hospital per diem charges • Transfer of public financing of hospital to federal states; enlargement of federal states' authorities in hospital planning • Reduction of federal states' influence on the definition of hospital per diem charges; transfer of the negotiation of per diem charges to hospitals and the health insurance funds	✔	(✔)
1986	Federal Hospital Payment Regulation *(BPflV)*	• Introduction of flexible budgeting for hospitals with the possibility of making profit and losses; costs of inpatient-care still covered by predefine d per diem charges	✔	
1986	SHI Physician Need Planning Act *(GVKBP)*	• Introduction of restrictions in the admission of SHI-physicians • Self-governance bodies of physicians and SHI-funds enabled to suggest early retirement of physicians in oversupplied areas		(✔)
1989	Health Care Reform Act *(GRG)*	• Introduction of fixed charges for drugs • Strengthening of SHI-funds' participation rights in cost effectiveness auditing of physicians and hospitals • Strengthening of self-governance bodies' rights to enact guidelines for quality assurance • Introduction of a financial compensation scheme between SHI-funds of the same kind (e.g. insurance funds for craftsmen or salaried employees) • Enabling of contracts between regional SHI-fund-associations, SHI-physician-associations, and hospital-associations to improve cooperation between ambulatory and stationary care	✔	✔
1993	Health Care Structure Act *(GSG)*	• Increase of mandatory deductibles for insurants • Introduction of collective drug budgets in ambulatory care • Budgeting of compensation in stationary care including the abolition of the principle of net cost coverage; replacement of hospital per diem charges by service-oriented lump-sum reimbursement rates • Integration of ambulatory and stationary care through ambulatory surgery • Introduction of a general risk-structure compensation scheme among SHI-funds in 1994 • Introduction of free choice of insurance in 1996	✔	(✔)
1995	German Hospital Payment Ordinance *(BPVlV)*	• Budgeting of compensation in stationary care • Introduction of hospital compensation through case-based lump-sum reimbursement rates and mandatory deductibles	✔	
1997	First and Second Health Insurance Restructuring Act *(1. & 2. NOG)*	• Extraordinary rights of contract termination in case of rising SHI-fund premiums • Increase of mandatory deductibles (restricted for chronically-ill patients); reduction of reimbursement rates for dental prostheses; introduction of drug spending benchmarks within medical specialist groups • Introduction of cost-sharing and premium reimbursement as competitive strategies for SHI-funds	✔	(✔)
1999	Solidarity Improvement Act for Statutory Health Insurance Funds *(GKV-SolG)*	• Reduction of mandatory deductibles for chronically-ill patients for drugs and medical aids • Budgeting of selected sectors (e.g. ambulatory care, pharmaceuticals, stationary care) • Abolition of insurants' choice between reimbursement and benefit in kind	✔	
2000	Reform Act of Statutory Health Insurance *(GKV-GRG)*	• Implementation of integrated care structures between ambulatory and stationary care; possibility of selective contracts with SHI-funds • Introduction of general practitioner-centered care • Expansion of ambulatory care options in hospitals • Stepwise introduction of diagnosis-related reimbursement rates for hospital treatment • Increased cost-effectiveness auditing of medical treatment • Self-governance bodies of physicians and SHI-funds enabled to exclude ineffective diagnostic and treatment procedures reimbursement	✔	✔

Table 2.1: Major Health Care Reforms in Germany between 1977 and 2014 (continued)

Date	Regulatory Act	Main Contents and Implications	Economic Changes	Structural Changes
2001	Risk Structure Compensation Scheme Reform Act *(GKV - RSA)*	• Implementations of a morbidity-based risk-structure compensation scheme among SHI-funds	✔	
2003	Hospital Remuneration Law (*KHEntgG)*	• Implementation lump-sum reimbursement for hospital treatment based on German Diagnosis-Related Groups (DRGs)	✔✔	
2004	SHI- Modernization Act *(GKV -GMG)*	• Renaming of the ‚Concerted Action‘ into ‘Advisory Council on the Assessment of Developments in the Health Care System’ (SVR) including new responsibilities • Foundation of the Federal Joint Committee (G-BA) to replace the joint self-government of SHI-funds and SHI-physicians • Foundation of the Institute for Quality and Efficiency in Health Care (IQWiG) • Reformation of health care structures, including the promotion of integrated care, general practitioner-centered care, ambulatory care in hospitals, and structured disease-management-programs • Liberalization of drug market including mail order sale • Liberalization of contract law, allowing SHI-funds to close selective contracts with individual health care providers • Introduction of evidence-based medicine as benchmark for -reimbursable services • Introduction of quarterly ‘practice fees’ for insurants	✔	✔✔
2007	Act to Enhance Competition in Statutory Health Insurance *(GKV-WSG)*	• Implementation of compulsory health care insurance for all citizens • Increase of competition between SHI-funds through permission of selective contracting with health care providers, individualized service and fee options, and mergers between SHI-funds • Introduction of a health care fund in 2009 including standardized insurance premium rates • Foundation of the National Association of Statutory Health Insurance Funds to replace the SHI- sub-associations	✔	✔
2008	Long Term Care Further Development Act *(PfWG)*	• Improved services for citizens in need of long-term care and their family members • Increase of quality assurance measures in long-term-care facilities (e.g. mandatory expert standards) • Increase of transparency among long-term-care facilities through publication of services provided • Authorization of task-transfer from physicians to nurses	✔	(✔)
2009	The Act on the Further Development of Organisational Structures in SHI *(GKV - GKV-OrgWG)*	• Introduction of the possibility of insolvency of SHI-funds • Mandatory provision of general practitioner-centered care programs • Additional regulations on the allocation of resources from the central health care fund to individual SHI-funds • Mandatory tenders for individual contracts between SHI-funds and health care providers	✔	(✔)
2010	SHI Financing Act *(GKV-FinG)*	• Introduction of fixed absolute sums for mandatory deductibles for chronically-ill patients • Social compensation through reduction of premiums • Fixing of employers’ SHI- share on 7.3 percent • Cost reimbursement as optional insurance scheme	✔	
2010	Drug Market Restructuration Act *(AMNOG)*	• Mandatory price negotiations for drugs between SHI-funds and pharmaceutical companies based on (additional) benefit of drug (evaluated by the G-BA)	✔	✔
2012	Act on Care Structures in SHI (*GKV-VStG)*	• Alignment of ambulatory care need planning with regional age and morbidity-structure • Support of physicians in undersupplied areas		✔
2000	Reform Act of Statutory Health Insurance *(GKV-GRG)*	• Implementation of integrated care structures between ambulatory and stationary care; possibility of selective contracts with SHI-funds • Introduction of general practitioner-centered care • Expansion of ambulatory care options in hospitals • Stepwise introduction of diagnosis-related reimbursement rates for hospital treatment • Increased cost-effectiveness auditing of medical treatment • Self-governance bodies of physicians and SHI-funds enabled to exclude ineffective diagnostic and treatment procedures from SHI-funds’ reimbursement catalogues	✔	✔

Table 2.1: Major Health Care Reforms in Germany between 1977 and 2014 (continued)

Date	Regulatory Act	Main Contents and Implications	Economic Changes	Structural Changes
2001	Risk Structure Compensation Scheme Reform Act *(GKV - RSA)*	• Implementations of a morbidity-based risk-structure compensation scheme among SHI-funds	✔	
2003	Hospital Remuneration Law (*KHEntgG)*	• Implementation lump-sum reimbursement for hospital treatment based on German Diagnosis-Related Groups (DRGs)	✔✔	
2004	SHI- Modernization Act *(GKV -GMG)*	• Renaming of the ‚Concerted Action‘ into ‘Advisory Council on the Assessment of Developments in the Health Care System’ (SVR) including new responsibilities • Foundation of the Federal Joint Committee (G-BA) to replace the joint self-government of SHI-funds and SHI-physicians • Foundation of the Institute for Quality and Efficiency in Health Care (IQWiG) • Reformation of health care structures, including the promotion of integrated care, general practitioner-centered care, ambulatory care in hospitals, and structured disease-management-programs • Liberalization of drug market including mail order sale • Liberalization of contract law, allowing SHI-funds to close selective contracts with individual health care providers • Introduction of evidence-based medicine as benchmark for -reimbursable services • Introduction of quarterly ‘practice fees’ for insurants	✔	✔✔
2007	Act to Enhance Competition in Statutory Health Insurance *(GKV-WSG)*	• Implementation of compulsory health care insurance for all citizens • Increase of competition between SHI-funds through permission of selective contracting with health care providers, individual-lized service and fee options, and mergers between SHI-funds • Introduction of a health care fund in 2009 including standardized insurance premium rates • Foundation of the National Association of Statutory Health Insurance Funds to replace the SHI- sub-associations	✔	✔
2008	Long Term Care Further Development Act *(PfWG)*	• Improved services for citizens in need of long-term care and their family members • Increase of quality assurance measures in long-term-care facilities (e.g. mandatory expert standards) • Increase of transparency among long-term-care facilities through publication of services provided • Authorization of task-transfer from physicians to nurses within pilot projects	✔	(✔)
2009	The Act on the Further Development of Organisational Structures in SHI *(GKV - GKV-OrgWG)*	• Introduction of the possibility of insolvency of SHI-funds • Mandatory provision of general practitioner-centered care programs • Additional regulations on the allocation of resources from the central health care fund to individual SHI-funds • Mandatory tenders for individual contracts between SHI-funds and health care providers	✔	(✔)
2010	SHI Financing Act *(GKV-FinG)*	• Introduction of fixed absolute sums for mandatory deductibles for chronically-ill patients • Social compensation through reduction of premiums • Fixing of employers’ SHI- share on 7.3 percent • Cost reimbursement as optional insurance scheme	✔	
2010	Drug Market Restructuration Act *(AMNOG)*	• Mandatory price negotiations for drugs between SHI-funds and pharmaceutical companies based on (additional) benefit of drug (evaluated by the G-BA)	✔	✔
2012	Act on Care Structures in Statutory Health Insurance *GKV-VStG)*	• Alignment of ambulatory care need planning with regional age and morbidity-structure • Support of physicians in undersupplied areas		✔
2013	Patients’ Right Act *(PRG)*	• Implementation of ‘treatment contracts’ between health care providers and patients • Obligation of physicians to inform patients of treatment errors • Obligation of SHI-funds to approve or deny requested treatments within three to six weeks • Introduction of mandatory critical incident reporting systems and patient-oriented complaint management systems in hospitals		✔

*Notation: ✔✔ = Significant change, ✔ = Intermediate change, (✔) = Insignificant change

The Health Care Structure Act of 1992 initiated a cascade of health care reforms in Germany that led to an incremental, however comprehensive, restructuring of German health care. The main paradigm changes that the reforms of the 1990s entailed were a liberalization of the insurance market as well as the introduction of market-based incentive structures (Gerlinger, 2010). Forced memberships in specific SHI-funds based on one's occupation (such as the 'Techniker Krankenkasse' for technical occupations) were repealed; thus, SHI-fund members could now freely choose between different insurance providers. As the competition between SHI-funds increased, the key to their survival in the now liberalized market were low insurance rates as these became the main driver of market share (Gerlinger, 2010: 113). Accordingly, SHI-funds were forced to re-evaluate their receipts and expenditures. At the same time, fixed fees for hospitals (as well as budgets for ambulatory physicians) were introduced, which effectively created financial incentives to reduce rather than expand services. The financial risk of patient treatment was thereby moved to individual service providers who had to reduce costs by implementing more efficient modes of patient treatment (ibd.). Between 1993 and 1995, fixed fees were determined on the level of the individual hospital and budgets were tied to the overall income of the SHI-funds. After 1995, budgets became freely negotiable between hospitals and sickness funds. While the introduction of fixed-fees entailed a rising cost-consciousness and more efficient service provision on the hospital side, it also led to 'cherry picking', i.e. hospitals focusing on patient groups with profitable case fees. However, by 1995, less than one quarter of all hospital services was reimbursed on the basis of fixed fees (Wörz & Busse, 2005).

In 2000, policymakers decided to introduce a new system of fixed fees that was based on international examples and should include almost all cases in stationary care. In the context of the Hospital Financing Act of 2000, state actors ordered the corporatist organizations of the self-government (at this time the Associations of SHI-funds, the Association of Private Health Insurance, and the German Hospital Federation) to agree on an international DRG-based reimbursement system to be implemented in Germany. Eventually, the Australian AR-DRGs (Australian Refined Diagnosis Related Groups) were used as a reference frame for developing the G-DRG system. Within the G-DRG system, each hospital case is being assigned to one of multiple, clinically defined groups which reflect comparable treatment costs (Schreyögg, Tiemann, & Busse, 2006). Until 2003, hospitals could participate in DRG-based reimbursement on a voluntary basis; in 2004, cases were already coded into DRG-groups but hospitals still received individually negotiated budgets. Between 2005 and 2008, DRG rates were incrementally adapted from hospital-specific to base-rates for each federal state. By 2014, these were aligned with a nationwide DRG base rate. The introduction of the G-DRG system was probably one of the most influential cornerstones of the recent cost-containment policy in Ger-

man health care and led to a restructuration of the hospital landscape. While a frequently-quoted copious “hospital dying” could eventually not be observed (Fleßa, 2014; Lüthy & Buchmann, 2009; Meurer, 2011), the number of hospitals in Germany has decreased notably from 2.242 hospitals in the year 2000 to 2.017 hospitals in 2012. Additionally, the share of publicly-owned and non-profit hospitals decreased from 78.3 percent to 65.4 percent while the share of privately-owned hospitals steeply increased from 21.7 percent to 34.6 percent (Statista, 2014).

In addition to the ubiquitous cost-containment initiatives, service providers faced increasing pressures from the SHI-funds with regard to service agreements. In the years after 1995, the importance of collective contracts between SHI-funds and the Associations of Statutory Health Insurance Physicians further declined; by 2007 the Statutory Health Insurance Competition Strengthening Act (GKV-WSG) allowed SHI-funds to close contracts with individual service providers such as hospitals or groups of physicians in ambulatory care. Through this development, SHI-funds gained considerable influence in health care as the Associations of Statutory Health Insurance Physicians lost their former contractual monopoly and were no longer able to dictate the conditions of health care provision to the Associations of Statutory Health Insurance Funds (Gerlinger, 2002: 114). As Gerlinger (2002: 114) puts it, insurance funds have moved from “payer to player”, redefining the power relations between them and physician associations to their advantage.

With the introduction of competitive elements into SHI-fund regulation and the liberalization of service agreements, the foundations for a structural modernization of health care had been laid. Insurance funds’ interests became coherent with policymakers’ intent to create more efficient structures of service provision while physician associations have become restricted in their ability to effectively counter SHI-funds’ strive for cost-containment. A paradox feature of Germany’s health care reforms over the last years is an increase in both market liberalization and state intervention (Gerlinger, 2010: 124). In the course of the 2007 health care reform, policymakers introduced a state-regulated universal health care fund. Since 2009 insurants and employers have been paying their insurance premiums directly into this central health care fund. Individual SHI-funds are each allocated a specific share of this fund according to the number and health structure of their members. Additionally, insurance premiums have been set at a fixed rate for all SHI-funds, eventually bringing price-competition between insurance providers to an end (Bäcker et al., 2010: 227f.).

While the partial liberalization of the health care market held significant potential to raise efficiency in the provision of health care through selective contracting and increased competition between insurances, it also harbored the dangers of insufficient care and reduced quality of care as means of cost-containment (Gerlinger,

2010: 126). Accordingly, state interventions were primarily aimed at securing and enhancing the quality of medical care. Due to the state's legal mission to secure adequate health care to all citizens, it took extensive measures to control the quality of health care. Among these was a dense regulatory framework regarding quality management in hospitals, which included mandatory quality reports (§ 137 Section 3, No. 4 SGB V), the implementation of internal quality management systems, and the participation in external initiatives of quality control (§ 135a, SGB V). Additionally, new organizations like the Institute for Quality and Efficiency in Health Care (IQWiG) were founded to provide independent assessments of the medical quality of drugs, diagnostic tests and treatments, and clinical guidelines and programs (§ 139a, SGB V; IQWIG, 2014). Given that the reforms of the early 2000s mark an era in which the state extended its direct control of the modes of health care provision while shifting the negotiation of service agreements from the meso- to the micro-level, researchers have concluded that corporatism is eroding in German health care (Bandelow, 2004; Noweski, 2004). While it is true that the autonomy of the self-government has declined due to increasingly restrictive federal guidelines and the provision of health care is no longer exclusively negotiated between the two 'big players' (i.e. the Association of Statutory Health Insurance Physicians and the Association of Statutory Health Insurance Funds), it seems exaggerated to speak of a "downfall" of the corporatist system (von Winter, 2014: 171).

Still, the meso-level of German health care has been characterized by a notable transformation. The G-BA (see chapter 2.1), which was established in 2004, replaced the Association of Statutory Health Insurance Physicians and the Association of Statutory Health Insurance Funds as central corporatist bodies on the meso-level. While including representatives of both associations, the G-BA is not supposed to function as an arena for the negotiation of collective agreements between SHI-funds and service providers. Within the new structure of self-government on the meso-level, the G-BA's main task lies in enabling the liberalization and marketization of health care by creating the regulatory framework for micro-level-competition. By providing legally binding guidelines for the provision of health care on the micro-level, the G-BA's competences go far beyond those of the SHI-fund- and SHI-physician-associations. Accordingly, German health care is still very much structured as corporatist governance system (von Winter, 2014). However, the G-BA operates under strict federal supervision, weakening the role of classic, autonomous self-governance. In addition, the introduction of the G-BA led to a pluralization of interests; beside physicians and SHI-funds, hospital representatives are now regularly involved in the G-BA's decision-making processes while the interests of patients and other stakeholder groups are considered in official hearings. While the interests represented on the meso-level have become more fragmented and reaching agreement has become more difficult, the inclusion of several stake-

holders in the consultation- and decision-making-processes of the G-BA provides the new corporatist system with the necessary expertise to reliably assess the cost-benefit ratio of medical services and structures in health care (von Winter, 2014: 204). Also, through the representation of multiple interests, the G-BA obtains a higher legitimacy than the former corporatist system. This characteristic of the G-BA is of particular importance against the background of its regulatory role which comprises the exclusion of specific drugs and treatments from SHI-reimbursement catalogues (Gerlinger, 2010; Gerlinger & Noweski, 2012).

Overall, despite far-reaching reforms, German health care still reflects its historical roots, relying strongly on corporatist governance and aiming at the provision of comprehensive medical care to all citizens. Yet, economic and demographic changes forced policymakers to reconsider the modes of health care provision. As a result, central contracting between physician- and SHI-fund-associations has been replaced by more market-based modes of individual contracting between SHI-funds and service providers. The expansion of fixed-fee reimbursement in ambulatory and stationary care additionally shifted the focus from service expansion to rationing and economization. As the introduction of free market elements bore the risk of creating misincentives with regard to service quality, policymakers countered this threat by extending state-regulation, effectively creating a "state-domesticated competitive corporatism" (Gerlinger, 2010: 130).

These structural changes in health care naturally informed the relative position of health care professions in the political processes that shape this field. Despite increased liberalization and marketization, physicians remained the dominant stakeholders in German health care. As Altenstetter and Busse (2005: 138) emphasize, "the influence and authority of medical professionals as knowledge bearers and technological craftsmen have not declined, although physicians are subject to increasingly restrictive conditions. Neither has the medical profession lost the ability to police itself according to the rules, codes, and norms developed by corporatist medicine" (Altenstetter & Busse, 2005: 138). Physicians successfully claimed central positions in the newly established bodies of the meso-level-corporatist system. For example, both executive managers of the IQWIG are medical doctors (Kuhlmann, 2006: 65) and currently even one of the neutral members of the G-BA is a physician (G-BA, 2014c). In spite of physicians' major voice in decisions on appropriate structures, treatments, and quality indicators at the micro-level of health care, the acknowledgment of their expertise does not translate into market power in the same way as it did before the structural reforms that had been implemented between 2004 and 2007. As noted above, the Association of Statutory Health Insurance Physicians has lost its state-secured contracting monopoly. Further, while the traditionally high societal status of physicians has not suffered under recent reforms, their authority in questions of health care structuration has become fragile.

When the state started to introduce additional regulation to secure quality in health care, it also overstepped the boundaries of professional self-government. Specifically, the Health Modernization Act of 2004 included the regulation of medical continuing training (§ 95d and §137 Section 1 No. 2 SGB V). While the German Medical Association remained in charge of defining the contents of continuing education, legislators now determined that hospital and ambulatory physicians had to complete a certain quantity of additional training during a five-year-period. As a result, physicians may still obtain high degrees of autonomy in determining medical education and providing the benchmarks for quality management in medicine but their role as dominant, mostly autonomous collective actor in health care is no longer axiomatic.

The changes recently brought upon German health care, have, on the other side, opened up opportunities for the non-medical health care occupations. The multi-interest-structures of the G-BA attracted lobbying attempts of formerly marginalized stakeholder groups, most of all health care professions that have hitherto been subordinate to the medical profession (e.g. nurses, surgery receptionists, and paramedics) (Gerlinger, 2009; von Winter, 2014). Additionally, demographic changes like an aging and increasingly multimorbid population in combination with a notable doctors shortage lead to a re-evaluation of task divisions between health care occupations (Bergmann, 2009). A legislative reform in 2008 (the Long-Term Care Further Development Act) generally allowed the autonomous provision of medical treatment by nurses and other non-medical occupations within pilot programs, thereby strengthening their relative position in health care. These developments are further catalyzed by SHI-funds' constant strive for cost reduction. Trying to implement efficient service structures that allow high-quality medicine under restricted budgets, hospitals have increasingly adopted new modes of work division and are steadily expanding the task spheres of non-medical occupations (Gerst & Hibbeler, 2010). Hence, while in 2006, Kuhlmann (2006: 93) asserted that the "hegemony of the medical profession […] is accompanied by a weak position and a lack of qualification of other health occupation", recent regulatory changes forecast a more dynamic professional landscape that both shapes and is shaped by the restrictive regulatory framework of German health care.

The role of health care professionals in the institutional changes that have been characterizing German health care over the last decade will be further elaborated in the course of this thesis. The subsequent chapter will first provide an overview of how professionals generally relate to institutional dynamics; offering insights on what constitutes a 'profession' (section 3.1.), how professionals interact with the different contexts in which they are embedded (section 3.2), and how they affect and are in turn affected by processes of institutional change (section 3.3 and 3.4).

3 Theory: Professionals' Role in Institutional Dynamics

"The professions dominate our world. They heal our bodies, measure our profits, save our souls." Abbott (1988: 1)

Professions are important to society. They provide standardized and accepted rules on who is allowed to exert medical treatment, they regulate the quality and quantity of knowledge-intensive services like accounting, and they guarantee the effectiveness of courts (Freidson, 1988a; MacDonald, 1995). As the preceding chapter has shown, (German) health care is strongly influenced by professionals – not only through their daily work as physicians and nurses but also through their co-decision rights in central bodies of the self-government. Professionals' relevance in socially important areas like law and health care has been well reflected in sociological literature (e.g. Barber, 1963; Brown, 1973; Carr-Saunders & Wilson, 1933) while organizational scholars have shown little interest in the idiosyncrasies of professions for a long time. The study of professions and professionals has, however, recently aroused the interest of organizational scholars as a fast-growing area in institutional research.[15] While the professions have always been an omnipresent subject in institutional theory (Leicht & Fennell, 2008), professions and professionals have only recently moved to the center stage of institutional research as scholars have become increasingly interested in institutional change (e.g. Currie et al., 2012; Greenwood et al., 2002). As the institutionalization, the deinstitutionalization, and the change of professions are often particularly illustrative examples of institutional change processes (Kitchener & Mertz, 2012; McCann, Granter, Hyde, & Hassard, 2013), institutional research has renewed its interest in explaining the characteristics and peculiarities of professions and professionals (Leicht & Fennell, 2008) and their relation to institutional dynamics (Muzio et al., 2013; Scott, 2008; Suddaby & Viale, 2011). Yet, institutional perspectives on the professions are still surprisingly disconnected from the sociology of the professions. This relative isolation of the sociology of the professions and the study of professionals in organizational institutionalism has indeed been criticized (Muzio et al., 2013; Suddaby & Viale, 2011), but has yet to be addressed in conceptual and empirical research.

It is the goal of this chapter to provide an answer to the question on how professionals and institutional dynamics interrelate. To do so, I will integrate literature from the sociology of the professions and institutional research. I will begin this

[15] This rising interest in professions within organization research is well-reflected by special issues explicitly connecting institutional research and the sociology of the professions (Muzio et al., 2013) and has already culminated in the launch of the 'Journal of Professions and Organizations' at the beginning of 2014 (Brock, Leblebici, & Muzio, 2014).

chapter with a section on the conceptual evolution of professions and professionals, including the defining features of a profession and the social role of professionals (chapter 3.1). In chapter 3.2, I will provide an overview on the different contexts in which professional work takes places. Specifically, I will elaborate on how fields, organizations, and routines enable and constrain professionals' ability to exert agency. Following the explanation on what professions are and how professionals are embedded in different social contexts, I will provide a more in-depth theoretical analysis on the mechanisms that lead to professionals' constant and effective involvement in institutional change and stability (chapter 3.3). I will close this chapter with an integrated model on how professsionals shape institutional dynamics on and through different levels of their work (chapter 3.4). This model will provide a general understanding of the multifacetedness and context-specificity of professionals' role in institutional change and stability whereas chapters four to six will offer more in-depth analyses of selected aspects of professionals' institutional work on the field-, the organization-, and the routine-level.

3.1 Professions and Professionals

Professions have been defined in various ways. According to the Oxford dictionary (2014), a profession is "a paid occupation, especially one that involves prolonged training and a formal qualification" or, in the sense of a collective actor, "a body of people engaged in a particular profession". A more specific definition is provided by Burkart (2006: 470f.) in the encyclopedia of social theory. He defines professions as follows:

"Professions are occupational categories whose members have degrees of statuatory power and autonomy, because they successfully claim to solve better than others relevant problems of their clients or of society in general. The expertise of their members is validated by advanced university degrees, theoretical knowledge and technical skills. Profession is both a status category [...] and a category for a certain type of occupation."

Burkart's (2006) definition reflects two broad traditions of approaching the phenomenon of professions, which I will discuss in the following. Sociologists and institutional researchers alike differentiate between a functionalist, or "trait-based", approach and an interactionist, or "conflict-based", approach to the question on what characterizes a profession (MacDonald, 1995; Muzio et al., 2013).

Undeniably, Burkart's (2006: 407f.) definition favors the more recent interactionist approach by emphasizing the constructed nature of professionals' status. Yet, it also includes key characteristics of a profession like a formal education and scientific knowledge which have been the focus of trait-based researchers who sought to

identify specific sets of stable traits and functions in which professions' special role in society is founded. While both approaches have their merit, the following sections will focus on the interactionist approach as it lays the theoretical foundation to the conceptualization of professions as source and object of institutional dynamics (Scott, 2008b, 2010b)

The goal of this section is to provide an overview on how research on the professions evolved conceptually and what makes professionals the powerful actors that they are. I will first elaborate on how different conceptualizations of the professions within sociological and organizational research relate to institutionalist' view on professions as socially constructed entities (section 3.1.1). Second, I will discuss how the professions shape organizational life and how professionals become social actors who fulfill important roles in the dynamics of both their profession and the different contexts in which their professional practice is embedded (section 3.1.2)

3.1.1 Historical Perspectives on the Professions: From Functionalist to Interactionist Approaches

The study of professions has a long history in both sociological and organizational research. Given that professionals dominate societies' most important sectors like health care and law, it is not surprising that much research has been dedicated to explaining what distinguishes professions from regular occupations and how professions come into existence (Adams, 2015). The functionalist or 'trait-based' approach dominated the sociology of the professions from its inception in the first half of the 1900s to the late 1960s (Carr-Saunders & Wilson, 1933; Parsons, 1937, 1939). This perspective on professions is mainly concerned with identifying the characteristics which define a profession vis-à-vis non-professional occupations (Greenwood, 1957). Scholars who take a the trait-perspective on the professions mostly subscribe to the idea that professions are inherently stable entities with distinctive qualities (Parsons, 1939; Torres, 1991) such as "prolonged specialized training in a body of abstract knowledge" and client- rather than self-orientation (Goode, 1961: 308). Beginning with the works of Carr-Saunders and Wilson (1933), professions have been defined as occupations which are organized around a formalized body of scientific knowledge and additionally serve as a stabilizing force in society which protects a set of higher morals and values – the professional ethics – against erosion (e.g. Durkheim, 1957; Durkheim, 2013). While Carr-Saunders and Wilson (1933: 3) explicitly refrain from drawing "a line between professions and other vocations", they propose that typical professions can be described by a specific set of traits. Later research from the trait-based perspective even goes so far as to develop lists of "the characteristics of an ideal-type profession against which actual examples of occupational groups could then be assessed as more or less professional" (MacDonald, 1995: 3). The belief in a firm set of uni-

versal professional traits culminated in the development of occupational categories like “semi-professions” (Etzioni, 1969). These imply that the professional nature of occupations can be determined through their membership in randomly defined sets of structural and value-based criteria (MacDonald, 1995).

In addition to their focus on stable criteria of professionalism, early works in the sociology of the professions are united in their assumption that professionals’ high status is a legitimate function of their importance to society. For example, Durkheim (2013: 15) presents professional ethics as remedy to what he terms the impending “moral anarchy” associated with economic life in the era of industrialization. Merton (1982: 114) summarizes the normative foundations of professions as a “triad of human values” consisting of knowing, doing, and helping. While “knowing” and “doing” refer to the possession of scientifically derived knowledge and its application to solve socially relevant problems, “helping” describes the overarching, normative principle that guides professional conduct (Merton, 1982: 115). In contrast to most scholars from the functionalist tradition (e.g. Carr-Saunders & Wilson, 1964; Etzioni, 1969; Greenwood, 1957), Merton (1982: 118) acknowledges that professionals are not per se of moral superiority and may not always act in their clients’ best interest. Yet, he also points out that institutionalized altruism is a core feature of the professions that legitimizes their privileged position in society (ibd.: 117). Overall, functionalists prefer structural over process explanations of what constitutes a profession and conceptualize professionalism as almost natural phenomenon that is linked to specific traits and superior ethical standards that only few occupations possess.

The interactionist approach which has been developed at the beginning of the 1970s represents a counter movement to functionalists’ search for universal structural traits and intrinsic values that justify the professions’ superior status over regular occupations (Barber, 1963; Carr-Saunders & Wilson, 1933; Carr-Saunders & Wilson, 1964; Goode, 1957, 1961). Accordingly, the main research question shifted from ‘what are professions and why are they special?’ to ‘how do professions gain and maintain the special status that they are granted?’. The probably most influential works within the interactionist approach are those of Freidson (1970b, 1970a, 1988a) and Larsson (1977). Freidson’s (1970) studies on the medical profession question functionalists’ assumption that professionals are generally committed to moral integrity. By showing that medical professionals, as members of one of the most traditional and prestigious professions, are driven by self-interest rather than altruistic ideals, he put a sudden end to the idea of the noble professional who follows a higher calling (Freidson, 1970).

Freidson’s (1970) conceptualization of the professions is one that puts self-interest and the political quest for power at the center of professionals’ doing. The results of

his studies on the profession of medicine (Freidson, 1970b, 1970a) can be summarized as follows. First, professions do not occur 'naturally' but are the outcome of occupations' purposive actions to achieve dominance over adjacent occupations and external regulatory bodies. Second, while professions may legitimize their autonomy claims with their mission to secure the provision of high-quality professional services, their actual motives are often far less altruistic. According to Freidson (1970), professions form in an attempt to gain a market monopoly over profitable services. Rather than being community-oriented preservers of socially important knowledge and skills, professions strive to artificially create scarcity in distinctive areas of the labor market. By convincing the state (or other elite actors) that society will benefit from granting professional bodies the exclusive right to autonomously develop, organize and control professional services, professions gain market dominance over adjacent occupations. Eventually, and as we can observe in e.g. hospitals or law firms, organizations are obligated to hire specifically trained individuals to provide professional services. Hence, Freidson (1970b) conceptualizes professions as an outcome of specific, knowledge-intensive occupations' struggles to create market exclusiveness. By placing more emphasis on agentic behavior as the source of professions than on professions as inherently stable structures that 'somehow came into existence', Freidson's work laid important foundations to the study of professions as the result of social construction.

Larson (1977) draws heavily on Freidson's (1970) idea of professions as socially constructed entities that strive for a market monopoly. Yet, she offers a more fine-grained and more critical analysis of how occupations become professions. According to Larson (1977: xvii) "[p]rofessionalization is […] an attempt to translate one order of scare resources – special knowledge and skills – into another – social and economic rewards. The "professional project", as she terms it (Larson, 1977: x), is concerned with both, gaining market control and achieving superior social status. In opposite to Freidson (1970), Larson argues that professionalizing occupations mainly seek status which is based on the idea of the professions' moral superiority. This status, however, does not lead to actual power as the professions themselves are only reinforcing a broader class system rooted in the capitalist order (Larson, 1977).[16] Larson's model of professionalism is widely recognized and has advanced theory by drawing attention to the political nature of professionalization and the interdependencies between professions and wider institutional structures (Suddaby & Viale, 2011). However, there are also two major shortcomings in Larson's approach to professionalization. First, she implies that professional projects end once

[16] Larson's critical stance towards professional power is also owed to her focus on the profession of engineering that operates within the hierarchy of bureaucratic organizations. However, she also acknowledges the power of the medical profession that is rather in control of than controlled by bureaucracy. Yet, she also proposes medicine to be treated as an exceptional case in the sociology of the professions and not as ideal-typical instance of professionalization (Schudson, 1980).

an occupation achieves a "monopoly of competence [...] and a monopoly of credibility" (Evetts, 2003: 402; see also: Larson, 1977: 38), thereby restricting professional dynamics to the path of becoming a profession. Second, she focuses on the ideological foundations of professions, eventually depicting them as mostly powerless entities, subordinated to the bureaucratic systems of capitalism (Schudson, 1980).

Abbott (1988) offers a more dynamic and less ideology-focused view on the professions and the processes of professionalization. According to him, professions constantly engage in struggles to defend jurisdictional boundaries against adjacent occupations. He explicitly describes professions as open systems and the competition for monopoly not as a process that may reach final closure but rather as a constant, *inter*professional dynamic. Two aspects of Abbott's work are particularly important to the study of professions and their role in institutional change. First, he focuses on the importance of work and the division of knowledge and skill as basis for the development of regulatory boundaries between professions. Second, Abbott's approach to professions differs from earlier conceptualizations as he explicitly takes into account the interdependent nature of professions. In his view, no profession can be studied independently from adjacent professions. This is because professionalism is grounded on an exclusive body of abstract knowledge which depends on a profession's success in competing over (formally regulated) areas of expertise. In contrast to previous research, Abbott (1988) does not draw on the concept of dominance of certain occupations within specific fields of practice to explain professions (cf. Freidson, 1970). In his "system of professions", we also find subordinate professions (e.g. nurses) who would have been denied the status of a profession in former research. While he restricts his focus primarily to adjacent professions, Abbott's (1988) work gives rise to the notion that when professions change, so do adjacent social structures.

Larsons (1977) and Abbott (1988) both provide a richer understanding of the professions and professionalism than former functional or power-focused explanations and resonate well with neo-institutional researchers' idea of social construction as origin of seemingly stable structures like professions (Giddens, 1984; Lefsrud & Meyer, 2012; Scott, 2010a). While it is Larson's merit to carve out the symbolic dimensions of professionalization in the sense of gaining status, Abbott's work gives first hints on how professions and institutional change are intertwined. First, by pointing out that professions are embedded in complex systems of work division, Abbott convincingly argues that professions must not be studied in isolation as any change in a profession may affect adjacent occupations and vice versa. Second, like any other kind of institution, professions may also be deconstructed and disappear, giving rise to a re-structuration of the field in which they were embedded.

In conclusion, the sociology of the professions moved from conceptualizing professions as stable, naturally given entities to a dynamic view on professions as the result of social construction within a system of adjacent professions. Within this movement, we can observe a shift in focus from the professions as such to the process of professionalization and more abstract concepts like professionalism (Evetts, 2003, 2011; Freidson, 2001; Roberts & Dietrich, 1999; Torres, 1991), describing "the affirmation of expertise" (Larson, 1977: 144), or, in more general terms, "the idea guiding the culture (values, ethics, ideology) of the profession and the habitus of its members" (Burkart, 2006: 470). However, it might be misleading to consider professionalism a concept that is only employed by professionals. Oftentimes, non- or semi-professional occupations draw on this idea to legitimize their work as being 'professional' and eventually achieve the status of a full profession. Overall, the professions and their core ideas have become institutions on which actors draw – either as privileged members of these elite groups to defend and extend their status (Currie et al., 2012; Micelotta & Washington, 2013) or as members of occupations who attempt to gain status by emphasizing the extent to which professionalism shapes their work (Dent, 2002; Kitchener & Mertz, 2012; Neal & Morgan, 2000).

How professions can be conceptualized as institutions that shape organizational and social life will be further elaborated in the next section. As I will show, neo-institutional theory mimics the history of the sociology of the professions insofar as professions have moved from stable 'external' structures that cause institutional stability to a source of institutional change in the environments in which they are embedded.

3.1.2 Current Perspectives on Professions as Institutions and Professionals as Social Actors

The study of professions notably informed neo-institutional theory that began to flourish in the beginning of the 1980s (DiMaggio & Powell, 1983; Leicht & Fennell, 2008). Through neo-institutional research, the professions gained a new analytical dimension as both the source (DiMaggio & Powell, 1983) and, more recently, the object of social pressures (Adler & Kwon, 2013; Scott et al., 2000; Thorne, 2002).Within neo-institutional theory, institutions are commonly defined as entities that "*constitute regulations of actions that are relatively long-lasting and make rules of behaviour binding on the basis of values and norms, and sanctions. They are seen as forming the habitus of particular groups and as symbolically expressing a certain order*" (Rehberg, 2006: 280f.).

Professions are institutions insofar as they provide actors – in particular members of the respective profession – with collective and socially binding rules of appropriate behavior that are reinforced by law and socialization within the professional

community (Leicht, 2005: 604; see also: Leicht, 2014). Being a member of a profession is tightly linked to a specific professional habitus which is most obvious in traditional professions like medicine and law. Physicians, for example, are socialized into the role of widely autonomous decision-makers within the field of medicine, relying on scientific facts and guiding subordinate professionals like nurses (Hall, 2005). Individuals from the same profession have been observed to act and speak alike to an extent that scholars like e.g. Stelling and Bucher (1973: 661) have "often been tempted to define professional socialization as 'the decline of idiosyncracy'". Accordingly, the membership in a profession can be viewed as embeddedness in a tightly defined institutional framework that guides and standardizes each professional's behavior in a way that made institutional researchers think of these individuals as "almost interchangeable" (DiMaggio & Powell, 1983: 152). This standardization through professionalization is the basis for early institutionalist conceptions of the professions as source of normative pressure that furthers organizational isomorphism (DiMaggio & Powell, 1983). Through education and interaction in professional associations, individuals become strongly socialized into the professional norms that shape their behavior within and across organizations. Since the prime source of professional socialization lies beyond the sphere of the organization and its structural and cultural idiosyncrasies, organizations in fields with a high level of professionalization become increasingly similar (idb.). How normative isomorphism through professionalization unfolds empirically, has been shown by Slack and Hinings (1994) in their study on Canadian sport organizations. Through an increase in professional staff with a similar educational background, standardized hiring procedures and high internal mobility of the professional staff, the management of Canadian sport organization began to share common "ideological positions about the purpose of sport and the most appropriate type of organizational design to realize this purpose" (Slack & Hinings, 1994: 820). Similarly, Levitt and Nass (1989) find that the organization and content of college textbooks are more homogenous in academic fields with high degrees of professionalization as these fields have stronger assumptions on what defines the discipline and what is to be studied within it. Further, it has been shown that new practices diffuse more rapidly through organizations with a rising degree of professionals (Sutton, Dobbin, Meyer, & Scott, 1994).

In sum, early institutional works assigned professionals the role of a stabilizing force that leads to homogeneity within organizational fields. As enforcers of common professional norms who hold similar cognitive orientations, professionals shape the structures of their organizations in a similar way. Being more embedded in their professional networks than in their respective organization, professionals cause convergent change in their organizations according to the templates provided by their professional community (DiMaggio & Powell, 1983; Galaskiewicz, 1985).

As neo-institutionalism developed from a theory focused on convergent change in organizations and isomorphism in organizational fields to a theoretical framework that explained both change and stability in social arrangements, so did the role of professions and professionals within neo-institutionalism. While early neo-institutional research portrayed actors as mostly powerless and often even unaware of the stable social forces that shape their behavior, institutionalists had to acknowledge that actors, while socially embedded, are more than "cultural dopes" (Suddaby, 2010: 15) and that institutional change is often the result of individual or collective agency. Although any actor with sufficient resources and an interest in institutional change could become a so called "institutional entrepreneur" (DiMaggio, 1988: 14), professionals obtain a special position among institutional agents. Due to their embeddedness in their profession, professionals are commonly endowed with high societal status (Abbott, 1981: 828) and with symbolic resources like perceived rationality (Fournier, 1999: 285) and superior moral integrity (Postema, 1983: 37). As highly institutionalized fields are commonly organized around one or few dominant professions, professionals may shape whether, when, and how fields change. For example, in their study on the transformation of the field of professional business services Greenwood et al. (2002) show how professional associations shape field-level change through theorization. They illustrate that changes in the structure of accounting firms and the roles of accountants became institutionalized through their endorsement by two accounting associations. A key finding of their study is that professional associations provide normative justification to new structures and practices that facilitates diffusion. The endorsement of altered organizational forms was closely intertwined with their perceived "professional appropriateness" (Greenwood et al., 2002: 75). Hence, professionals' involvement in field-level change cannot be separated from the dynamics *within* their profession, as professions and other field-level institutions are inextricably intertwined.

The intimate relationship between professionalization and field-level change is also addressed in DiMaggio's (1991) seminal article on museum workers' influence on increasing field structuration (i.e. the institutionalization and structuring of fields (ibd.: 267)). The professionalization efforts of museum workers were intertwined with the legitimization of a new, functional form of museums that included educational aspects. As museum workers started to seek higher education and expanded their intraprofessional communication through professional associations, they gained expert status which allowed them to define appropriate organizational forms for museums. The progressive form of art museums as educational organization, in turn, created the demand for these highly-trained professionals who established the art museum as a taken-for-granted element in any larger city (DiMaggio, 1991: 288). In contrast to the study of Greenwood et al. (2002), DiMaggio (1991) analyz-

es a case in which professionals *initiated* change, both in their profession and the field. Yet, both studies illustrate that professions cannot be reduced to stable, external structures whose (arguably) homogenous members merely support the diffusion of given institutional forms and practices. Much rather, professionals may also actively drive field-level change which often includes a redefinition of their professional role. The observation that professionals are often prominent actors in the creation and change of organizational fields leads Scott (2008b: 219) to the conclusion that professionals are "lords of the dance", implying that they are the "most influential, contemporary crafters of institutions" (ibd: 223). Similarly, Suddaby and Viale (2011) argue that the professional project is in itself an endogenous mechanism of field-level change. As professionals are deeply embedded in their respective field, each attempt of expanding their areas of expertise and their jurisdictional boundaries will affect the structure of the field. As Suddaby and Viale (2011: 426) put it, "projects of professionalization reverberate throughout the field and influence, either directly or indirectly, the institutionalization project of other entities".

In conclusion, professionals are important social actors as they are in the position to promote both convergent and divergent change within organizations and fields. Due to their embeddedness in a profession, they are a mostly homogenous group with regard to their cognitive and normative orientation and support the reproduction of dominant templates of organizing. Hence, organizations that are primarily structured around one or few particular professions converge over time with regard to their structure and practices. Yet, professionals are also endowed with the legitimacy to promote changes that diverge from the status-quo. They may directly work towards changes in the structures and practices of a field or indirectly, though changes in their profession. In both cases, professional and field-level dynamics are closely intertwined as fields are structured around professions and professions are embedded in fields.

While it is indisputable that professionals are powerful agents who may exert significant influence on their institutional environment, current institutional research tends to overemphasize their political leverage as it largely focuses on dramatic instances of change on the field-level (DiMaggio, 1991; Galvin, 2002; Greenwood & Suddaby, 2006; Jespersen, Nielsen, & Sognstrup, 2002; Kitchener, 2002; Malsch & Gendron, 2013). The reality of many professionals is far from being a 'lord of the dance' (Scott, 2008b) as they find themselves embedded in the hierarchical structures of large organizations and as participants in carefully synchronized routines. Accordingly, I will dedicate the next section to a discussion of the different levels of professional work and elaborate on how they impact professionals' capacity of institutional agency.

3.2 The Embedded Nature of Professionals' Work

Professionals obtain a high degree of autonomy over their work and are deeply embedded in the social structures provided by their membership in a profession. Yet, the work of professionals necessarily takes place in contexts beside their professional community. We find professionals as political actors, e.g. as presidents of their chambers who seek to influence the regulatory environment of their work to their favor, or as collective actors (e.g. in the form of large professional service firms) that provide templates for legitimate organizational practices and interactions between different organizations of a field (Quack, 2007; Scott et al., 2000; Suddaby, Cooper, & Greenwood, 2007; Suddaby & Greenwood, 2005). On the field-level, professionals mostly act as representatives of their profession as an institution, seeking to maintain and extend (regulatory) boundaries and defining and redefining legitimate modes of professional training and practice. Professionals, however, are also increasingly embedded in the structures of large organizations (Adams, 2015; Bloor & Dawson, 1994; Leicht & Fennell, 1997; Suddaby, Gendron, & Lam, 2009). While this poses a stark contrast to the ideal-type of the autonomous, self-employed professional at the center of early research on the professions (Carr-Saunders & Wilson, 1964; Elliott, 1972; Freidson, 1970b, 1970a), the proportion of professionals in dependent employment is rising: physicians treat their patients within the structures of large hospitals (Dent, 2003, 2005; Doolin, 2001, 2002; Jespersen et al., 2002) and lawyers work as employees in law firms, legal departments of large corporations, and – together with accountants – in multidisciplinary partnerships (Suddaby & Greenwood, 2005). Within organizational structures, professionals often find themselves in dual roles (e.g. as physicians and hospital managers). Given the tensions that often exist between professional and organizational role expectations, organizations have increasingly become arenas for political action that provide new areas of professional influence while restricting classical, autonomous professional practice (Kirkpatrick, Dent, & Jespersen, 2011). The most immediate level of professional work is the routine level. Here, professionals apply their abstract knowledge and enact what is considered typical professional habitus (cf. Deverell, 2000). While this level of professional work provides a context in which 'professional behavior' can be directly enacted, routines commonly necessitate interprofessional collaboration, implying that 'professional behavior' is rarely enacted in isolation. Specifically, the successful execution of routines often relies on the common effort of different professionals and the support of administrative and management personnel (Goh, Gao, & Agarwal, 2011; Greenhalgh, 2008; Hilligoss & Cohen, 2011).

On each level of their work professionals are confronted with different challenges regarding the construction and the enactment of professionalism, facing new norms

and values, new roles, and new limits to their practice (Aldridge, 1996; Leicht & Fennell, 1997; Leicht, Walter, Sainsaulieu, & Davies, 2009). Conversely, each of these levels is also strongly influenced by professionals' work and offers distinct opportunities for agency.

The goal of this section is threefold. On the one hand, I will provide a general understanding of how professionals are embedded in different work environments and how these affect professionals' political and practice work. On the other hand, I will illustrate how the 'exertion of professionalism' takes place on the field-, the organization-, and the routine-level. Lastly, I will elaborate on how each of these levels constrains agency while also providing professionals with distinct opportunities to initiate and implement institutional change. As professionals' role in institutional dynamics is necessarily context-dependent, this chapter will provide a general understanding of why professionals' involvement in institutional change can take various forms and why it is often more than a political struggle about regulatory boundaries. The first section (3.2.1) will explain how professionals maintain and change the institutional foundations of organizational fields; the second section will illustrate how professionals adapt to and make use of their new roles within organizations (3.2.2), and the final section (3.2.3) will elaborate on how professionals are enabled and constrained within their daily working routines that are characterized by complex tasks and interprofessional collaboration.

3.2.1 Field-level: Professionals as Key Constituents and Political Actors

Organizational fields are defined as "organizations that, in the aggregate, constitute a recognized area of institutional life" (DiMaggio & Powell 1983: 148). According to DiMaggio & Powell (1983: 148), fields include "key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products". In short, fields are comprised of individual and collective actors who interact with each other and recognize each other as part of a delineable community with shared meaning systems (Scott, 2008a: 86). The aspect of common meaning systems is particularly emphasized by Greenwood et al. (2002: 59) who point out the socially constructed nature of fields. Fields are thus more constituted by actors' shared perceptions of common goals, norms on appropriate behavior, and interpretive frames than by clear industry boundaries (Wooten & Hoffman, 2008: 138).

Professionals play a key role in establishing, maintaining, and changing organizational fields as they provide the meaning systems that are essential to a field (Scott, 2008b). How fields are structured around specific professions can be best observed at the examples of health care and law. Especially the field of health care has almost exclusively been structured around the medical profession for a long time

(Scott et al., 2000). Physicians have established the criteria according to which medical services are to be offered, by whom, and how health care organizations like hospitals are to be structured (Scott et al., 2000). Essentially, fields often come into existence and become identifiable as such through the work of professionals who inhabit relevant regulatory bodies and other central organizations of a field and spread their principles of appropriate structure and conduct throughout the field (cf. Suddaby & Viale, 2011).

Due to the initial focus of institutional theory on organizational fields as arenas of isomorphic processes (Dacin, 1997; DiMaggio & Powell, 1983; Glynn & Abzug, 2002; Oliver, 1988), much of institutional research on the professions has – sometimes at the expense of more multi-level perspectives – studied professionals' role in field-level dynamics (e.g. DiMaggio, 1991; Galvin, 2002; Greenwood & Suddaby, 2006; Greenwood et al., 2002; Jespersen et al., 2002). As pointed out in section 3.1.2, professionals play a key role in creating isomorphism within organizational fields. But perhaps more importantly, professionals also act as collective political actors in fields, shaping them on a regulative, normative and cognitive level (Scott, 2008b: 225ff.). Professionals' influence on the legal regulation of organizational fields has already been a central theme in the early works of the sociology of the professions. In attempts to establish professional dominance, professionals engage in negations with state actors who grant them jurisdictional protection for certain areas of expertise and effectively exclude members of other occupations from providing the respective services (Freidson, 1970b, 1988a). Further, they determine the modes of professional training – often in collaboration with the state that provides professional training in public universities – and hence shape fields by creating a homogenous workforce (DiMaggio & Powell, 1983). They exert coercive power not only through shaping the jurisdiction of their profession but also by enforcing the criteria of lawful professional work. Physicians and lawyers may lose their licenses if they fail to comply with the standards provided by their professional associations and organizations may face legal sanctions when allowing non-professionals to provide professional services (DiMaggio and Powell, 1983: 152). Yet, professionals' influence on the field is far from being restricted to claiming formal jurisdictional 'sanctuaries' and forcing their peers and organizations to comply with their federally secured regulatory frameworks.

The normative influence of professionals on organizational fields is probably the most-theorized path of professional agency. Both sociologists and organizational institutionalists alike have emphasized the impact of professionals on the normative-moral foundations of a field (Durkheim, 2013; Leicht, 2014; Leicht & Fennell, 2008; Postema, 1983; Scott, 2008b). While sociological scholars – particularly in the first half of the 20th century – argued that professionals protect the morals and values of a society (see section 3.1.1), institutionalists focused more on *how* profes-

sionals shape a field's ideas on appropriate and desirable structures, processes, and goals. The first pathway through which professionals determine a field's normative orientation can be described as 'control from the inside'. As employees and executives in organizations, professionals apply their guiding moral principles – encoded in their training and enforced through peer pressure – to the structures and processes within their organization. In doing so, they create field-level isomorphism and thereby further reinforce the normative standards of their profession as appropriate ways of organizing work (see section 3.1.2). The second pathway of professionals' influence relies more on the political work of professional collectives such as professional associations and can be viewed as 'control from the outside'. Professional associations craft the standards and norms (while not legally binding) that professionals should follow to be considered a respectable member of the profession (Nerland & Karseth, 2015). These standards are then diffused through their enactment by professionals inhabiting organizations (Hallett & Ventresca, 2006), but also directly serve as guidelines for organizational design (cf. Satow, 1975).

Beyond designing and diffusing the normative standards that determine how organizations *should* be designed to be perceived as legitimate member of that field, professionals also influence the shared cognitive frameworks within fields. These cognitive frameworks comprise the taken-for-granted 'truths' of a field, including the automatic reproduction of structural arrangements and practices (cf. DiMaggio and Powell, 1983). According to Scott (2008: 224), professionals "exercise control by defining reality". Professional collectives do so by creating common knowledge bases and categories (Loewenstein, 2014; Schildt, Mantere, & Vaara, 2011), along which professionals and professional organizations interpret problems and evaluate potential solutions (Scott, 2008: 225). The extent to which professionals shape the cognitive underpinnings of a field is also reflected in the common language that differentiates professionals from clients and other occupations (Loewenstein, 2014; Stelling & Bucher, 1973). Through this common technical terminology meaning systems are created which help to differentiate 'insiders' from 'outsiders' of a field.

Despite the fact that the distinction between a regulative, normative and cognitive pillar of institutional environments seems to have a strong appeal to institutional researchers, it remains a conceptual one (Scott, 2008a). On the empirical level, professionals may create and reconfigure organizational fields through strategies that affect all three pillars simultaneously (cf. Suddaby & Greenwood, 2005). They may legally enforce the boundaries of their expertise that are based on a normative belief about what a professional of a certain kind should and should not be doing and cause a common understanding of what e.g. a physician or lawyer normally does and which structures commonly characterize hospitals or courts.

While professionals' have been identified as key actors in field-level-change through several empirical studies (DiMaggio, 1991; Greenwood et al., 2002; Scott et al., 2000; Suddaby & Greenwood, 2005), institutionalists have only recently begun to theorize the relationship between professionals and institutional change on the field-level. Suddaby and Viale (2011) develop a model that provides a comprehensive theorization of the linkages between professionalization and institutional change. Drawing on the sociology of the professions and institutional theory, they elaborate on how professionalization efforts do not only affect the boundaries between adjacent professions, but at the same time, reconfigure the structure of a field. Specifically, Suddaby & Viale (2011: 424) view the professional project as endogenous mechanism of institutional change as professionals' constant effort to maintain and extend their spheres of influence necessarily affect other actors and structures on the field-level such as the state, their clients, and the organizations in which they are employed (ibd.: 426). Drawing on extant research on the role of professionals in field-level change, Suddaby & Viale (2011: 426 ff.) identify four consecutive mechanisms through which professional projects shape organizational fields. First, professionals define a new, uncontested space by expanding their spheres of expertise and their jurisdictional boundaries. They do so by either creating entirely new areas to which their knowledge applies or by appropriating adjacent professions' or institutions' fields of work. Second, professionals populate these new spaces with new actors. They do so by creating and reconfiguring categories of organizations and occupations. As a result, new individual and organizational actors become legitimate providers of professional services. The advent of new actors, in turn, restructures a field's composition. Third, professionals promulgate new rule systems that redefine the boundaries of organizational fields. As proposed by Abbott (1988), professionals find themselves in constant struggles to defend and expand the boundaries of their expertise against adjacent professions and occupations. Suddaby & Viale (2011) extent this argument by pointing out that professional jurisdiction necessarily affects a fields' power structures and boundaries. According to them the "promulgation of new rules by professionals [...] serves as an extension and objectification of the power of the profession" (ibd.: 433) and becomes the "fabric of a field" (ibd.: 433). Lastly, professionals restructure fields by managing the reproduction of professional capital. Through their high status, professionals possess the power to shape the social order of a field. Their skills in manipulating a fields' social order are reinforced through their access to critical positions within organizations and fields. Professionals primarily use rhetoric and categorization to present changes as appropriate and create new cognitive frameworks through which a field is interpreted. They have been found to be "skilled rhetoricians" (ibd.: 435) who use language to "reproduce social, cultural and symbolic capital" (ibd.: 435). Categorization, in turn, is the mechanism through which pro-

fessionals define problems, rules of behavior and classes of actors. Mostly, they draw on their high status to define categories in a way that allows them to stabilize the social order that provides them with their superior status. In short, Suddaby & Viale (2011) illustrate that professionals' constant efforts to advance their professional project reverberates through a field as changes in a profession inevitably imply changes in the structure of a field. Yet, they also point out that professionals skillfully manipulate a fields' social order in a way that is conducive to their professional projects by drawing on their high social status.

However, the process through which professionals shape fields is neither deterministic nor without struggle. Interestingly, Scott (2008: 223), who views professionals as the "most influential, contemporary crafters of institutions", proposes several endogenous and exogenous changes that may affect professionals' potential to exert agency in their fields. As endogenous changes, Scott (2008: 229) mentions a greater division of labor, increasing mechanization and routinization, and the consolidation and formalization of knowledge. A greater division of labor introduces new actors to the field, including adjacent occupations such as nurses and chiropractors in the case of the medical profession. While Scott (2008: 230) presents these occupations as having settled with their parallel or subordinate role, recent empirical studies suggest that former semi- and non-professionals pursue their professionalization projects more consistently and more aggressively than formerly assumed (Carvalho, 2012; Goodrick & Reay, 2010; Kilpatrick et al., 2012; Reay et al., 2006). Given the increasing mechanization and routinization of their work and the formalization of their knowledge, formerly dominant professions such as medicine are likely to have their status challenged. First, adjacent occupations may begin to perceive themselves sufficiently qualified to exert formerly 'professional' services as the complexity and opacity of knowledge is reduced. Second, other stakeholders within a field such as clients or the state might become less willing to accept professionals' central position in defining the rules of a field as the central component of their status – a complex and somewhat esoteric body of knowledge – becomes 'demystified'. According to Scott (2008: 230), exogenous changes that affect professionals' agency within fields mainly stem from wider societal changes such as a rise in the number, size, and social power of organizations, changes in the nature of clients, and changes in the institutional logics of a field. Organizations have become increasingly larger over the last years and brought forward new, professionalizing occupations liked specialized managers. At the same time, members of established professions like lawyers discovered corporate actors as new type of clients, leading to stratification within the profession and a restructuration of professional organizations, which have become increasingly multiprofessional and less differentiated to accommodate to the needs of their clients. Again, while Scott (2008) remains silent on the effects of this development, a change towards the "managed professional

service firm" (ibd.: 231) may weaken professionals' position within a field as they cannot claim dominance over their organizations as easily as they could in mono-professional partnerships or professional bureaucracies that are structured around one or very few professions (see also section 2.3.3). This may affect their field-level influence insofar as organizations have been identified as a "primary vehicle" through which professionals exert agency in fields (Suddaby & Viale, 2011: 427). Losing their dominant influence within their organizations may hence decrease their political leverage on the field-level.

The last and arguably most prevalent change that professionals face today is a change in the institutional logics that govern an organizational field (Light, 2010). As societal meta-logics that describe generalized, field-independent ideas on how work and other instances of human behavior are supposed to the structured, have moved from frameworks like 'bureaucracy', 'professionalism' or 'public services' to market-focused, neoliberal ideas, so have professional fields (Scott, 2008: 232; see also section 3.3.1). As a consequence, professionals' work becomes increasingly assessed along market-based criteria such as efficiency. With privatization and managerial control being omnipresent principles in organizational life, professionalism is increasingly being questioned as most rational way to organize fields such as health care or law (McNulty & Ferlie, 2004). New classes of legitimate stakeholders (e.g. non-professional executives) and changing rationalization accounts now populate even the most traditional professional fields like health care (Harris, Brown, Holt, & Perkins, 2014; Ruef & Scott, 1998; Scott, 2004). Accordingly, while professionals remain powerful actors in many organizational fields, they have to account for these new elements to be able to defend their status (Leicht & Fennell, 1997; Leicht & Lyman, 2006; Leicht et al., 2009). Even though it is hard to imagine that professionals will ever lose their profound impact on highly institutionalized fields like health care and law, their 'natural' legitimacy is being challenged by alternative ideas of rational work design. The unquestioned dominance of professionals has hence become a phenomenon on the decline (Scott, 2004; Scott et al., 2000).

Overall, their strong embeddedness in organizational fields is both the reason that professionals may successfully shape fields and the cause of their loss in absolute power (e.g. Scott et al., 2000). Professionals are the cornerstones of multiple fields. Hence, changes in their jurisdictions, which result from their constant struggles with members of adjacent occupations over legally protected areas of expertise, inevitably reconfigure the structure of a field, including the distribution of power and the design of organizational forms. Further, professionals, due to their central position and the symbolic and material privileges associated with their exclusive and complex knowledge and supposedly higher morals, may directly manipulate the structures and meaning systems of field to promote their professional project.

Yet, current developments such as the rise of meta-logics like the free market as ultimately rational mechanism of organizing are at conflict with the traditional model of professionalism which promotes exclusiveness and autonomy in service provision rather than unrestricted market-transactions in professional services. Professionals' status within a field has hence shifted from a field constituent with largely unquestioned dominance to a collective actor among several who compete for interpretive authority in a field (McDonald, Cheraghi-Sohi, Bayes, Morriss, & Kai, 2013; Reay & Hinings, 2009; Scott, 2004). In the end, while some fields may have come into existence through the professionalization of occupational groups like physicians and attorneys, professionals are just as much shaped by their field as they shape it.

The conflicts between professionals and countervailing powers that are rooted in meta-trends like marketization become particularly obvious within an organization. Organizations may be instrumental for professionals' agency on the field-level (Suddaby & Viale, 2011: 427), but within organizations, professionals often struggle to adapt to hierarchical structures and the external control of their work (Leicht & Fennell, 1997; Marcus, 1985; Raelin, 1986, 1989; Reed, 1996; Thomas & Hewitt, 2011). The following section will hence elaborate on how professionals' agency is constrained but may – through the exploitation of new influence opportunities – also be enabled by their embeddedness in organizations.

3.2.2 Organization-level: Professionals between being Managed and being Managers

Despite institutionalists' assumption that professionals effectively shape organizations by applying their normative, professional standards to organizational structures and processes, research on professionals exhibits an ambivalent stance towards the relationship between professionals and organizations. A key concern is the compatibility of the traditionally autonomous professional work with the hierarchical structures of organizations (Hall, 1968; Sorensen & Sorensen, 1974). Organizations are generally defined as "systems of coordinated action among individuals and groups whose preferences, information, interests, or knowledge differ" (March & Simon, 1993: 2). The coordination of individuals and groups towards a common goal usually necessitates the definition of formal rules and procedures that have been associated with bureaucratic models of control (Weber, 1978). As external control is at conflict with professionals' assumed intrinsic motivation to provide high-quality services, early works on the professions conceptualized bureaucracies as explicit antithesis to professionalism. The ideal-type professional was the autonomous (medical) practitioner who was subject to informal peer control only (Carr-Saunders & Wilson, 1933; Parsons, 1939). Securing the normative basis of professionalism and being a salaried employee in a bureaucratic organization appeared

incommensurable (Engel, 1970; Marcus, 1985), and scholars perceived the increasing bureaucratization of professional work as a direct path to deprofessionalization (Ritzer & Walczak, 1988).

Even though much of the debate on how professionals and organizations interact circled around the assumption that bureaucracy restricts professional autonomy and necessarily leads to an erosion of professional values, scholars began to realize that more empirical studies are needed to fully comprehend the relationship between bureaucracy and professionalism (Barley & Tolbert, 1991) In her studies on predictors of medical professionals' perceived autonomy, Engel (1969, 1970) showed that a conflict between professional autonomy and bureaucracy may in fact exist. However, this conflict is not an absolute one and applies only to strong bureaucracies. Physicians felt most autonomous in settings with moderate bureaucracy. As Engel (170: 19) points out, it is important to acknowledge that bureaucracies are not always detrimental to professional autonomy but may function as a valuable resource, especially when compared to the situation of the former 'ideal-type' of the solo practitioner:

"Bureaucracies, especially professional bureaucracies, can serve the needs created by these alterations in professional practice by supplying those professionals who work within bureaucracies with funds, various kinds of equipment, technical personnel, and other physical facilities essential for contemporary professional performance, and with a stimulating intellectual climate for interchanging information and controlling quality of performance. These organizational characteristics will enhance the development and performance of today's professional. Working in isolation, he is less likely to have access to the social and physical features which bureaucracies can provide"(Engel, 1970: 19).

Similarly, Toren (1975) concludes that while tendencies of deprofessionalization are observable among most of the traditional professions, a rise in bureaucracy is not among the main causes for this trend. The idea that bureaucracies and professionalism can be complementary modes of organizing (Montagna, 1968) culminated in the theorization of the "professional bureaucracy" as a distinct organizational form (Mintzberg, 1979, 1980). The professional bureaucracy integrates elements of bureaucratic as well as professional control while favoring the professional model. Minzberg (1980: 333ff.) defines professional bureaucracies as organizations with little central control whose main coordinating mechanism is the standardization of skills through professional training. Control is exerted individually and collectively by professionals who constitute the operating core of this organization. Middle managers and operators of this organizational form, too, are professionals while the non-professional staff merely supports professionals' work by providing the necessary minimum of technical infrastructure. In Mintzberg's (1980: 334) words, "[f]or

the support staff of these organizations, there is no democracy, only the oligarchy of the professionals". Formal modes of coordination that are typically associated with bureaucracies are generally restricted to the supporting functions as professional work is supposedly too complex to be standardized. In Mintzberg's model, professionals are the dominant group within the organizational structure, restricting the influence of personnel outside the profession rather than the other way around. Yet, an empirical investigation of the control mechanisms in professional bureaucracies by Abernethy and Stoelwinder (1990) shows only partial support for Mintzberg's model. Contrary to Mintzberg's propositions, managing personnel with a professional background relied on formal tools of control (e.g. standard operating procedures or supervision) at least as much as administrative personnel. However, Abernethy and Stoelwinder (1990) do not view their findings as evidence for professionals being consumed by bureaucratic modes of control. As they point out, formal control mechanisms may be used to reinforce professionalism when they origin outside of the organization (e.g. standard operating procedures provided by professional associations) or when they allow for professional socialization (e.g. supervision by senior professionals as mode of professional training).

Overall, professionals seem to adapt well to bureaucratic settings when mechanistic bureaucracy is restricted to support functions while the operational core of the organization remains under professional control. As the findings of Abernethy and Stoelwinder (1990) suggest, professionals may even utilize formal control mechanisms as instruments to reinforce professional socialization within organizations. Hence, within professional bureaucracies, professionals' agency is not constrained but rather broadened as the organizational setting provides them with new sources of status and power. Professionals may dictate how non-professional support staff should support them but may also, as "supervisory elites" (Leicht & Fennell, 1997: 217), control their peers through both informal and formal structures.

However, the professional bureaucracy as organizational form under full professional control is on the decline. First, the organizational settings in which professionals work have become more diverse. Professionals work in such different organizational settings as the legal departments of multinational corporations, pharmaceutical companies, or not-for-profit organizations (Leicht & Fennell, 1997, 2001). Here, professionals are salaried employees, managed and controlled by non-professional administrative staff. Second, also classical professional bureaucracies such as large university hospitals or law firms are often under the control of professional managers rather than managing professionals. While organizational literature proclaims the rise of the post-bureaucratic era (Maravelias, 2003; McSweeney, 2006), these claims must not be confused with a decrease in formal control. Quite the opposite appears to be true: Today, professionals find themselves in a situation in which peer control is often not the primary mode of controlling and coordinating

professional work. Even medical services – commonly theorized to be too complex to be evaluated by non-professionals – have increasingly become subject to external evaluation (Hafferty & Light, 1995). The reasons that professionals are being held accountable by non-professionals can be found in legal and economic pressures (see section 3.2.1) that call for more complex organizational forms. Accordingly, classic professional bureaucracies that are structured around the normative foundation of a single or few dominant professions have evolved to multi-professional organizations under managerial control (Leicht & Fennell, 1997; Leicht et al., 2009).

With an increasingly diverse workforce, professional organizations tend to become political arenas (cf. Mintzberg, 1985) in which different professionals' claims of expertise often collide. One of the most striking features of modern professional organizations is the changing role of management. Formerly depicted as supporting staff under the control of professionals (Mintzberg, 1980), management staff are now engaging in professionalization efforts themselves (Leicht & Fennell, 1997; Noordegraaf, 2007; Noordegraaf & Van der Meulen, 2008). Accordingly, Leicht & Fennell (1997: 228) argue that the observable increase in managerial intervention within professional organizations is less the result of managers wanting to control employees but more a side-effect of their own professional project that includes the expansion of managerial autonomy. Within an organization, these efforts effectively result in power struggles between management and professionals as both strive to align organizational structures with what each of them consider 'good professional service'. Noordegraaf and Van der Meulen (2008: 1057), who draw on the example of medical services, subsume the different approaches of professionals and managers as follows:

"Medical specialists emphasize their professional knowledge, skills and service orientations to justify professional autonomy, whereas managers try to coordinate and standardize medical activities and to enhance professional output."

How these diverging goals play out in organizational reality is illustrated by several studies (Dent, 2003; Doolin, 2002; Raelin, 1986, 1989; Reasbeck, 2008). For example, Waring and Bishop (2010) show that implementing lean management – a typical managerial tool to increase efficiency – in a hospital sparked resistance among clinicians as managers were not considered to be capable of assessing clinical reality. Physicians further questioned managers' motives, juxtaposing their own concern for patient well-being to managers' presumed neglect of moral aspects in clinical care.

Professionals' relationship with the concept of managerialism is, however, not restricted to potential conflicts between professionals on the operative and managers on the administrative level of the organization. Given the increasing pressures to-

wards external accountability and efficient process design within professional organizations, professionals are pushed towards incorporating managerial conduct into their practice (Doolin, 2001; Thorne, 2002). Especially professionals in executive positions often find themselves in hybrid roles between their professional and their managerial responsibilities (Bourdieu, 1977; Iedema et al., 2004; Llewellyn, 2001; Vera & Hucke, 2009). This dual role has been theorized to put additional strain on professionals who may circumvent the enactment of managerial practices, e.g. by decoupling their actual conduct from formal requirements (Doolin, 2001). Yet, other research suggests that the integration of managerialism into their role repertoire may become a new avenue for professionals to exert influence in their organizations (Baker & Denis, 2011; Kirkpatrick et al., 2011; Thorne, 2002). In her study on the activities of clinical directors, Llewellyn (2001) found that instead of being overwhelmed with their additional managerial tasks, some clinical directors willingly occupied medical management (as opposed to non-medical management) as new area of expertise. Non-medical management, exerted by administrative staff, was dismissed as not being able to fully grasp the complexity of clinical work. According to Llewellyn (2001: 593), clinical directors were able to use their role as medical managers to become what she calls "two way windows". In this role, clinical directors could mediate the domains of management and clinical work to gain influence in both areas instead of jeopardizing their clinical authority for their managerial role and vice versa.

That organizational hierarchies offer multiple and more direct paths of influence than political struggles on the field-level is particularly attractive for members of lower-status professions and professionalizing occupations. Organizational hierarchies open up opportunities to attenuate professional hierarchies when subordinate professionals claim new areas of expertise (Kilpatrick et al., 2012). How subordinate professionals may utilize their organizational context as political arena has become particularly obvious in health care organizations such as hospitals. Here, most health care professions are subordinate to the medical profession and additionally often bound to their organizational context (e.g. hospital nurses). Yet, these professionals have also learned how to defend and expand professional spaces by claiming managerial positions within their organization. For example, in her study on how nurses incorporate managerialism into their professional role, Carvalho (2012) finds that nurses may utilize managerial roles in an attempt to free themselves from physicians' dominance. Nurses claimed that health care management has been an inherent part of nurses' training for almost a century while medical schools have not yet included managerial training in their curriculum (ibd.: 535). In doing so, they created a new avenue for nurses' professional project, increasing their autonomy from medical professionals and claiming new areas of expertise. Consequent-

ly, Carvalho (2012: 537) concludes that “nurses tried to expand their disciplinary boundaries by incorporating managerial roles”.

Given these findings on how professionals utilize organizational hierarchies to promote their professional projects, it is not surprising that Muzio and Kirkpatrick (2011: 391) view “organizations as sites for professional development”. Interprofessional relations within organizations obviously reflect professional hierarchies on the field-level, but also become additional arenas in which power-relations between different professions are enforced, weakened, or even turned around (Leicht, Fennell, & Witkowski, 1995).

In sum, organizational hierarchies both enable and constrain professionals’ agency. Early research on professionals in organizations emphasized the constraining nature of bureaucracy on professional work and implied that the bureaucratic control erodes professionalism (Ritzer & Walczak, 1988; Toren, 1975). While professionals proved to adapt well to bureaucratic settings (Suddaby & Viale, 2011: 426f.), appropriating its structures to enhance their power, organizations *do* put constraints on professional work. Today, constraining effects on professionals’ autonomy within organizations stem less from mechanistic bureaucratic structures but more from external demands of efficiency and accountability which put professionals under pressure to include managerial practices into their formerly self-controlled work (Dent, 2005; Doolin, 2001). Yet, the organizational hierarchy also offers new avenues for professionals to gain formal power and to expand their expertise, thereby reinforcing or gaining dominance. Hence, professionals’ organizational embeddedness may limit professional autonomy as much as it provides new spheres of influence and resources for agency.

3.2.3 Routine-Level: The Enactment of Professionalism

Routines are the most immediate level on which professionalism is enacted (Brown & Lewis, 2011). Routines are defined as “repetitive, recognizable patterns of interdependent actions, carried out by multiple actors” (Feldman and Pentland, 2003: 93). Organizational routines are comprised of ostensive and performative aspects. The ostensive aspects of routines include abstract ideas of a routine, a general perception on what to do when e.g. performing a medical operation. The performative aspect of routines describes concrete actions, carried out by routine participants at a specific time and space (Pentland & Feldman, 2005). The two aspects of routines are interdependent as the ostensive aspects of a routine enable routine participants to guide, account for, and refer to performances; the performative aspects, in turn, enable routine participants to create, maintain, and modify their representations of the routine (Feldman & Pentland, 2003: 106ff.).

Routines secure an organizations' survival by allowing for coordination between several individuals. They support the regularity of actions and help establish consistent, collective expectations on interdependent activities (Becker, 2004). In short, routines are coordination devices that help members of an organization to 'get the job done'. Yet, routines are not mindless repetitions, rigorously standardizing human behavior. Actors may reflect on their behavior when engaging in organizational routines; making them effortful accomplishments (Pentland & Rueter, 1994: 488). As such, routines do not only enable coordination but help to generate and sustain work-related identities. While for most employees "who we are" and "what we do" are inextricably intertwined, implying that occupational identity and work content are mutually constitutive (Nelson & Irwin, 2014), professionals are particularly reliant on their role within routines when developing their professional identity. Pratt, Rockmann, and Kaufmann (2006: 236) observe that, in contrast to non-professional employees, organizational membership is less constitutive of professionals' identity. Much rather, professionals are "defined by *what they do*" (ibd.: 236) much more than by their relative position within an organization. This importance of the routine-level for the development of professional identity is not surprising as it is within routines that professionals enact a key feature of professionalism: the application of complex knowledge to solve socially important problems in their clients' best interest (Carr-Saunders & Wilson, 1933).

This defining feature of professional conduct relates to both aspects of a routine. The ostensive part of a routine is the 'know that' while the performative part comprises the 'know how' (Feldman & Pentland, 2003: 103). In the context of professional work, the 'know that' relates to the routine participants' idea on what kind of knowledge is relevant to e.g. treat a patient with renal insufficiency or to provide legal advice in the case of tax evasion, what steps are to be taken (e.g. diagnostic procedures), and who is to exert which steps in the routine. The performative aspect, or the 'know how' relates to the actual, observable enactment of professional knowledge in an autonomous way that responds to the idiosyncrasies of the situation at hand.

The ostensive aspect of a routine automatically incorporates routine participants' professional identity since the idea on *what* is supposed to happen during a routine is dependent on *who* is exerting the routine (Feldman, 2000; Feldman & Pentland, 2003). For example, a nurse will exhibit a different representation of the treatment routine for a patient with renal insufficiency than a doctor. The ostensive aspect hence does not only provide a general scheme on how to behave to guarantee the consistent execution of a routine but also incorporates considerations about the appropriateness of actions against the backgrounds of one's professional identity (Brown & Lewis, 2011). The performative aspects of routines, that have to respond to the immediate situation in which professionals find themselves in, often include

adaption and improvisation and hence frequently deviate from the ideal-type representation of a routine stored in the ostensive aspect (Feldman, 2000; Feldman & Pentland, 2003). Yet, the performative aspects – through their function of creating, maintaining, and modifying ostensive aspects – relate to the ostensive aspects, thereby shaping professional selves. This adaption of professional identities through everyday routine performances is well illustrated by Pratt et al. (2006). In their study on medical residents, they find that young professionals adapted their identities in a way that solved tensions between their self-conceptualizations and the work they carried out. Especially young surgeons who viewed themselves as action-orientated felt that their working routines, which included considerable amounts of paperwork, threatened their identity as surgeons and even impeded the creation of the professional self of a 'true' medical doctor (ibd.: 246). As a result, interns engaged in the process of identity customization, including "splinting, patching, enriching" (ibd.: 253). Overall, Pratt et al.'s study (2006) shows that performative aspects add to the development of professional selves even when a distinct professional identity is already stored in the ostensive aspects. In their study, residents needed to revise their identity to resolve a perceived mismatch between 'who they were' and 'what they did'.

Explicitly employing an organizational routine perspective, Brown and Lewis (2011) further add to the observation that there is a close interrelation between routines and professional identities. Specifically, they find that lawyers carry out identity work (i.e. the formation, maintenance, reinforcement or change in distinctive ideas of the self (Sveningsson & Alvesson, 2003)) by discursively constructing ostensive aspects of their time reckoning and billing routine in a way that reflected their identity as accountable, disciplined professionals. In practice, the time reckoning and billing routine was, however, appropriated by lawyers through flexible adjustment of time records and bills, using "their professional judgement" rather than official specifications encoded in the routine (Brown & Lewis, 2011: 883). Interestingly, Brown and Lewis (2011) show how lawyers incorporated the constraining effect of routines into their professional selves while at the same time, using their professional autonomy to resist organizational routines in order to differentiate themselves from non-professional service providers. The authors conclude that ostensive aspects of the rigorous time reckoning and billing routine were integrated into professional identities in a way that made them a part of the 'productive lawyer' rather than an aspect of external control. The performative deviations, in turn, served as a reassurance that lawyers are still, despite of their being controlled, self-reflexive professionals.

As these examples demonstrate, routines simultaneously enable and constrain professional agency as the duality between structure and agency is an inherent part of routine dynamics. Ostensive aspects develop from experience gathered in routine

performances; performative aspects are held consistent by their alignment with the generalized idea of the routine that is stored in the ostensive aspect (Pentland, Feldman, Becker, & Liu, 2012). The constraining effect of organizational routines on the work of professionals results from both their coordinative and their symbolic function. As coordination devices, routines discipline individual agency through shared ostensive aspects which ensure that routine participants have similar perceptions on what is to be done by whom and when. To be able to reduce uncertainty in a collaborative environment, individual preferences have to be subordinated to shared understandings of how the work of all routine participants is interrelated (Greenhalgh, 2008). Beside their coordinative function, routines uncover social orders and underlying (power) relations between actors. For example, in his study on technological changes in radiology departments, Barley (1986: 87) illustrates this everyday enactment of social orders within routines as follows:

"*The radiologists' dominance was routinely enacted as x-ray techs and radiologists […] went about their daily work […]. Most interactions between members of the two groups involved a radiologist giving a technologist orders, which the technologist then carried out*."

Professionals need to adhere to routines as these are commonly created and shaped by other actors of the same profession (Savage & Langlois, 1997). A lack of conformity to what is considered appropriate behavior within a professional routine (e.g. a surgical operation) may not only jeopardize the coordination between actors but may also risk participants' status as legitimate members of a profession, able to address tasks in a manner that is considered adequate against their professional background. As noted above, their professional identity is dependent upon exerting a routine in a specific way. Meeting the expectations of their peers while participating in a routine is a key aspect of professionals' socialization. It reinforces both a specific professional identity and the ostensive aspect of a routine in general, leading to an increasing structuration of routine exertions by stabilizing professionals' (mutually constitutive) perceptions on 'who they are' and 'what they do'.

Beside of being accountable to their peers, professionals find themselves under increased pressure to accommodate external demands for industry-like standardization of their routines to secure a consistent service quality. While professionals have formerly been theorized to not standardize their routines (Savage & Langlois, 1997), rising task-complexity and the pressure towards external accountability have significantly reduced the scope of professional agency within routines. As professional work becomes ever more complex, service provision in professional organizations also becomes more fragmented. For example, the number of medical specialties and sub-subspecialties is constantly rising (Kimberly & Evanisko, 1981) and new specialist occupations like wound managers (Miner, Gibbons, Jeffres, &

Brandon, 1995) additionally expand the number of actors involved in health care routines. As competences are distributed among several routine participants with different professional backgrounds, each of them has to be disciplined and restricted in his individual autonomy as a lack of coordination between routine participants would lead to a breakdown of the routine (cf. Currie & White, 2012; Ferlie et al., 2005). As Savage (1994: 135f.) puts it, "*an individual practitioner's decisions are constrained by the capabilities of the network as a whole, because their productive activities must be implemented within the system"*. Artifacts like formal rules or technological infrastructure have been considered useful to integrate different specialties into a consistent organizational routine (DeHart-Davis, 2009; Greenhalgh, 2008). While it is unlikely that professionals like physicians or lawyers will ever be degraded to mere executors of externally defined rules, the reliance on binding guidelines on how to proceed when confronted with a specific task puts constraints on professional autonomy. This trend towards the standardization of professional routines is further reinforced by initiatives to design professional service firms more industry-like and by calls for the reduction of outcome variance in sectors like health care (Rozich et al., 2004; Timmermans & Almeling, 2009), which are often further promoted by lawmakers or external accreditation initiatives (Shaw, 2000).

Despite their coordinative and social functions that require the limitation of individual agency, routines also provide professionals with the opportunity to exert influence in their organizations. Professionals' participation in organizational routines is conducive of agency mostly through the performative aspects. Naturally, routine performances rarely fully conform to their ideal-type representations. Hence, it is not uncommon that routine participants have to adjust their routine exertions according to unanticipated task demands and idiosyncratic situations. This is particularly true for professionals as actors who work in settings in which they commonly encounter high levels of uncertainty and must apply their professional judgment to be able to best serve their clients' interest (Faraj & Xiao, 2006; Savage & Langlois, 1997). In addition, their high autonomy allows professionals to deviate from 'ideal-type'-routines to a greater extent than non-professional actors without having their status questioned. Mediated by participants' learning and evaluation processes, routine performances may modify ostensive aspects (i.e the ideal-type representation the interrelated work processes of several routine participants). Hence, professionals' adaption of routines may also induce changes in their and the roles of other routine participants. By the selective retention of specific routine performances, professionals' actions may maintain or change power relations in an organization by defining and redefining who is to do what and when within a routine (Brown & Lewis, 2011: 875). Yet, as routines are collective accomplishments, this kind of agency is a distributed one; it is often unintentional and only gradually changes routines. How routines change as feedback from routine performances is incorporated

in the ostensive aspects of a routine is well illustrated by Feldman (2000) in her study on the routines of housing services in a university. Feldman (2000: 626) emphasizes that “[t]he participants in the routines, for the most part, were professionals who exercised discretion in the way they performed their tasks”, thus providing an example that – while not situated in the stereotypical context of medical or legal work – shows how decision autonomy, as a typical element of professional work, informs routine dynamics.

Among the routines that were changed was the hiring routine for student housing staff, which was changed from a very decentralized routine to a centralized and well-structured hiring process. While routine participants agreed that the routine was supposed to become far more efficient through the changes, the outcomes of the new routine were assessed differently. Central administrators valued the chance to create a specialist system by training the now uniformly qualified staff. Building directors, on the other side, felt that a lack of complementary skills and perspectives among the staff might impede their problem solving skills. As the outcome of the changed routine was unsatisfactory for the building directors, they began to evade the new, centralized routine, thereby again altering the hiring routine according to their perceptions on what would create a more favorable outcome (i.e. a less uniform staff) (Feldman, 2000: 622).

As this example shows, changes in routines do heavily depend on how routine performances and their outcomes are evaluated against participants’ normative ideals of appropriate process and outcomes. Yet, when routines change, they may also alter underlying interpretive schemes (Rerup & Feldman, 2011), enabling the development of new normative foundations within an organizations’ working processes. This mechanism becomes particularly obvious when formerly subordinate or new professional groups improve their status by changing their role within routine performances. For example, in their study on how nursing practitioners institutionalized their professional role in Canadian health care, Reay et al. (2006: 989) find that their everyday-interaction with medical and nursing colleagues was a small but important part of successfully integrating the profession of the nursing practitioner into the working processes in health care. By proving that colleagues benefited from the inclusion of nursing practitioners in their working routines, they laid the foundation for their profession to be considered a regular part of the working routine which eventually fostered the institutionalization of the new profession.

In sum, organizational routines enable and constrain professionals’ agency in several ways. First, as routines function as coordination devices that secure the overall functioning of organizations, they constrain individual practitioners by providing relatively stable ideas on who needs to do what and when in order to complete a task. Second, routines are the most immediate level on which professionals prove

their capability of adhering to appropriate professional conduct, thereby constraining their potential to diverge from existing routines. In addition, recent trends towards standardization in professional organizations restrict professionals' leeway within the exertion of routines. Yet, routines also hold significant potential for agency. While the kind of agency, exerted in the everyday work of professionals, is rarely as dramatic as the political lobbying attempts on the field-level and often unintentional, routine performances necessary include individual and collective agency. As highly autonomous professionals adapt their routine performances to the specific tasks and circumstances they find in their daily work, they create starting points for routine change. Through the selective retention of specific elements of routine performances, ostensive aspects develop and change, thereby often also changing the roles and power relations of routine participants. In short, routines help develop and shape professionals' identity as professionalism is most immediately enacted in routines; they 'keep professionals on track' in a coordinative as well as normative sense; but they also serve as site for agency as professionals are particularly autonomous and even expected to apply their knowledge in a very case-specific way when exerting a routine.

3.3 The Engagement of Professions with Institutional Dynamics

As discussed in the preceding chapters, professions are a socially constructed category of occupations which is linked to a distinctive status. Professions as institution are deeply embedded in highly-institutionalized fields like law and health care. Hence, change and stability in such fields cannot be explained without taking the role of the professions into account. As professions change, so do fields and vice-versa (Muzio et al., 2013; Suddaby & Viale, 2011).

However, the professions are abstract entities that do not 'act' independently from their members. Professionals, in turn, may act as individual or collective institutional actors, within or even through the organizations in which they are embedded. As explained in section 3.1.2, professionals may enable convergent and divergent changes in their institutional environment. However, the mechanisms by which professionals engage in institutional dynamics are complicated, non-deterministic, and occur on several, intertwined levels of professionals' work (Smets et al., 2012). In addition, professionals are neither free from organizational constraints nor uncontested in their status and power (Leicht & Fennell, 1997; Leicht & Lyman, 2006). Currently, most professionals find themselves in situations in which they have to respond to several stakeholders within and beyond their own profession: State interventions in professional fields are expanding, the organizational embeddedness of professionals has become the norm rather than the exception, and professionals

have to adapt their practices to external efficiency demands and their embeddedness in multi-professional teams. Yet, their increasingly restrictive work environments are not to be confused with a lack of power in shaping institutional norms and structures. Professionals regularly define and redefine work relations, organizational structures, and the cognitive frameworks of a field as they try to advance their professional project (Currie et al., 2012; Kirkpatrick et al., 2011; Kitchener & Mertz, 2012). They do so through deliberate political interventions but also through emergent adaptions in their everyday work, making their involvement in institutional dynamics often invisible and sometimes unintentional (Smets & Jarzabkowski, 2013). As professionals are constantly embedded in several institutional structures, e.g. their profession and their organization, they are more likely to experience tension between different cognitive frameworks and normative ideals. As an effect, they regularly engage in institutional dynamics, often to either expand or defend their spheres of influence as professionals.

The goal of this chapter is to elaborate on how professionals become both agents and objects in processes that lead to institutional stability and change. This theoretical analysis of how professionals change and are being changed by institutional dynamics serves as important foundation to the following chapters, including the empirical studies in chapters 4.3, 5.3 and 6.3 as it provides the reader with a general understanding of the complexity and variety of professionals' agency.

The first section will employ an institutional-logics perspective to explain how professionals incorporate different mindsets and normative orientations into their work, thereby spreading multiple logics throughout their institutional environments while also constantly mutating the relationships between different logics. The second section will provide an overview on how professionals exert agency through 'institutional work'. The concept of institutional work is particularly suitable to uncover how professionals shape institutional dynamics on every level of their work as it emphasizes that "institutionalization and institutional change are enacted in the everyday getting by of individuals and groups who reproduce their roles, rites, and rituals at the same time that they challenge, modify, and disrupt them" (Lawrence et al., 2011: 57). Accordingly, the institutional work perspective provides a holistic picture of individual and collective institutional agency while avoiding the notion of overly powerful, disembedded 'heroes'(Hardy & Maguire, 2008) .

3.3.1 Professionals as Carriers of Multiple Institutional Logics

The 'institutional logics'-perspective in neo-institutional theory (Thornton, Ocasio, & Lounsbury, 2012) provides a particularly suitable theoretical framework to illuminate professionals' role in institutional dynamics within the different contexts of

their work as it allows to account for a pluralism of cognitive frameworks and normative orientations to guide actors' behavior.

Institutional logics are defined as "the socially constructed, historical pattern of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 1999: 804). They help actors to interpret and structure social situations and to find appropriate behavioral responses against the background of their professional and organizational role (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011: 318). Logics are "locally instantiated and enacted in organizational fields as in other places such as markets, industries and organizations" (Thornton & Ocasio, 2008: 119). Further, institutional logics do not magically 'appear' as guiding principles that diffuse from the field-level to the organization- and routine-level, but are constructed through interaction, that is, any kind of social interaction on one or more of these levels (Friedland, 2013). Actors, as Greenwood et al. (2011: 342) point out, "are 'carriers'[…] and thus 'represent' and give voice to institutional logics". Through their daily work, which is guided by one or multiple logics, actors render institutional logics visible and maintain or alter their relevance in specific situations (Smets, Morris, & Greenwood, 2012: 892). Human interaction within organizations and routines constitutes what McPherson and Sauder (2013: 185) refer to as "ground-level processes that make logics relevant and consequential", implying that institutional logics may guide, yet do not exist independently from social interaction. Put simply: logics are both behavioral guidelines that inform individual and organizational action and aggregates of the symbolic implications of social interaction in organizations and routines (cf. Giddens, 1984).

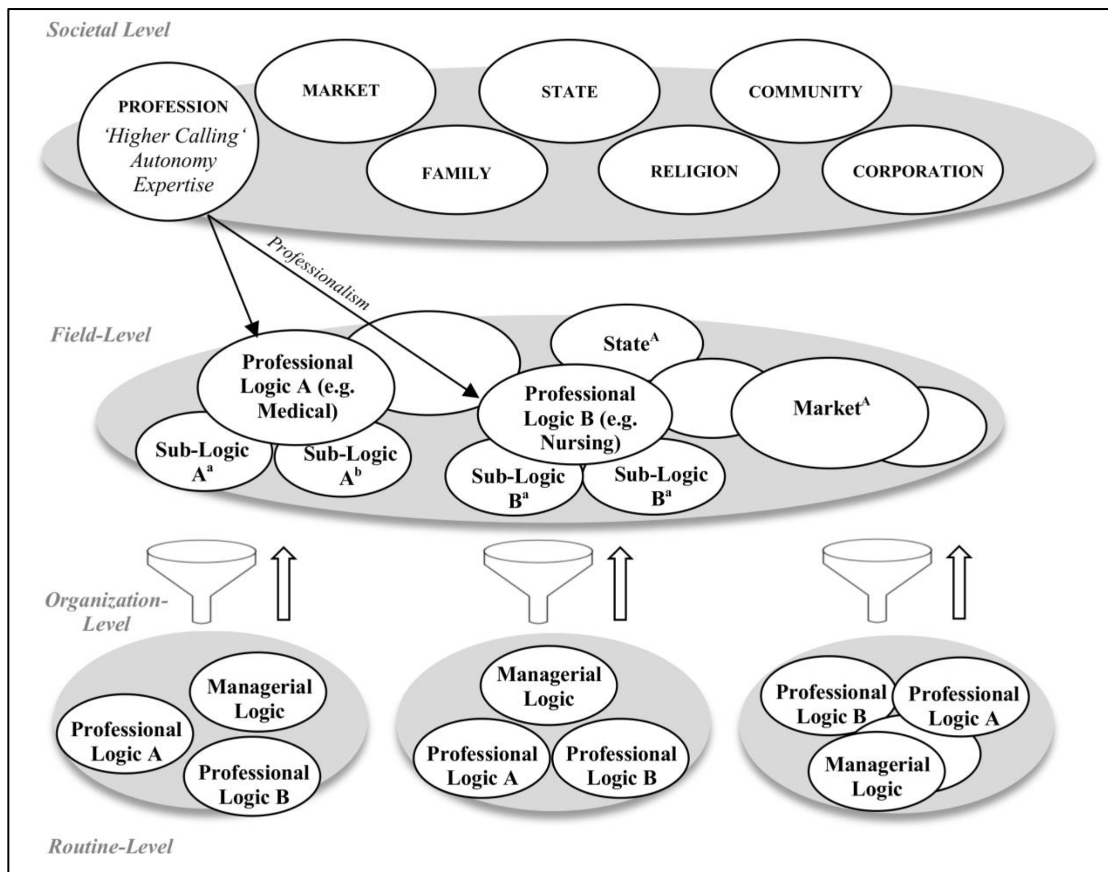
Institutional logics have, however, been used ambiguously in institutional research. Hence, I deem it necessary to first elaborate on how the concept of logics will be employed in the course of this thesis before going into more detail on how professionals are carriers of multiple logics. Most scholars agree that the concept of logics has been introduced by Friedland and Alford (1991) who argue that contemporary Western societies comprise several distinct "institutional orders" (ibd.: 244), each of which applies to a specific societal sector. Their conceptualization of institutional logics comprises five symbolic systems with distinct notions of meaningful goals and appropriate social interaction. These are the logics of capitalism, family, (bureaucratic) state, democracy, and religion (ibd.: 248). Today, scholars commonly distinguish between six or seven ideal-type logics along which societies are structured. Interestingly, it is the logic of professionalism which is most commonly added to Friedland and Alford's (1991) original framework (e.g. Thornton & Ocasio, 2008: 104), owing to the importance of professionalism for the organization of work and institutionalists' particular interest in this central institution of modern

societies (Lander, Koene, & Linssen, 2012; Leicht & Fennell, 2008; Malsch & Gendron, 2013; Micelotta & Washington, 2013; Muzio et al., 2013; Quack, 2007; Scott, 2008b; Suddaby & Viale, 2011). Reviewing several empirical studies on institutional meaning systems, Thornton (2004: 44-45) provides a condensed framework of six societal sectors that can be distinguished according to their concepts of reality (i.e. their logics) that include different goals and behavioral norms. These are markets, corporations, professions, states, families, and religions. Aside from additions like the community logic (Besharov & Smith, 2014: 366), these societal logics have become widely accepted as central pillars along which most societies are being structured (Lounsbury & Boxenbaum, 2013; Thornton & Ocasio, 2008; Thornton et al., 2012; Zilber, 2013). Societal logics are, however, highly abstract, nominal categories to conceptually differentiate general principles of organizing that may help to find order in the complex realities of organizational fields.

While scholars have elaborated on the difference between societal and field-level logics on a conceptual level (Thornton and Ocasio, 2008: 104), most empirical studies fail to explicitly address the difference between the abstract guiding principles of societal sectors and the specific frameworks of appropriate structures and practices that shape human behavior in organizational fields. A notable exception that differentiates between societal logics as ideal-types and empirically identifiable logics on the field-level are McPherson and Sauders (2013), who find in their study on logic complexity in drug courts, that local manifestations of four societal logics simultaneously shape the working processes in the organizational field of drug courts (see also chapter 6.2). Specifically, the state logic was specified as a "logic of criminal punishment", the logic of the profession as "logic of rehabilitation", the community logic as "logic of community accountability", and the corporate logic as "logic of efficiency" (ibd.: 173). On the one hand, this distinction illuminates how societal logics translate into specific cognitive frames and behavioral norms that structure organizational fields. On the other hand, it helps to disentangle the sometimes confusing multiplicity of logics that characterizes empirical research.[17] Figure 3.1 provides a schematic overview on how societal logics are empirically instantiated as field-level logics and how the enactment of logic constellation in organizations and routines is, in turn, aggregated into field-level logics.

[17] For example, scholars have identified the managerial logic (Scott, 2004) and the logics of efficiency and accountability (Adler and Kwon, 2013), the logic of bureaucracy (Freidson, 2001), or the commercial logic (Harris et al., 2014) as counterlogics of professional logics. While in the following, I will use the original terms of the authors quoted, I urge the reader to keep in mind that field-level logics are local instantiations of specific societal logics.

Figure 3.1: Levels of Institutional Logics



The differentiation between abstract, societal logics and field-level logics has important implications for the study of professionals' role in institutional dynamics. Generally, all professionals can be conceptualized as carriers of the societal logic of professionalism (Bledstein, 1985: 5). The logic of professionalism is commonly defined as "the creation of a social space that is independent and autonomous from both the state and the market" (Suddaby et al., 2009: 410) and as "a 'social trustee' ideal that links expert knowledge with higher social purpose" (Suddaby & Greenwood, 2005: 44; see also: Brint, 1994). Consequently, the societal logic of professionalism describes a *general* principle of organizing that prefers peer-control and normative commitment over formal mechanisms of coordination and legitimizes professionals' autonomy from outside-control via the complexity and the societal importance of their work (Evetts, 2003, 2011; Fournier, 1999). Given that the logic of professionalism has been viewed as explicit antithesis to other principles of organizing like the bureaucratic or the market logic (Freidson, 2001), research on professionals and institutional logics has focused much on how professionals defend 'their logic' against other logics that penetrate the respective organizational field (Reay & Hinings, 2009; Suddaby & Greenwood, 2005; Thornton, Jones, & Kury, 2005). However, specific ideas of professionalism may vary largely between pro-

fessions and fields. This applies to the definition of a professions' area of expert knowledge (Schildt et al., 2011) and the contents of their normative belief system, including how the 'higher calling' of profession is defined in a specific field. For example, a lawyer would naturally define the social purpose of his profession differently than a doctor while neither of these actors would consider themselves less of a professional. Further, scholars have even identified distinct sub-logics within a profession such as the logics of science and care as two competing types of medical professionalism (Dunn & Jones, 2010; see also chapter 4.2). Consequently, extant notions of professionals as carriers and defenders of the (societal) logic of professionalism are not only overly simplistic but also seem to disregard that different professional groups may promote different professional logics (Keshet, Ben-Arye, & Schiff, 2013; Kilpatrick et al., 2012; Kirkpatrick et al., 2011; Kurunmäki, 2004; McDonald, Campbell, & Lester, 2009; Timmons & Tanner, 2004), that is, different local instantiations of the logic of professionalism.

While the differentiation between the abstract notion of professionalism and specific professional logics that are actualized in routines, organizations, and fields remains a conceptual one, it helps to view professionals as contextually embedded actors who share some general features but are a more heterogeneous class of actors than previous conceptual work on the professions suggests (Freidson, 1989; Scott, 2008b).

This general insight is important against the background of most professionals' current working environments (see also sections 3.2.2 and 3.2.3) that impede the enactment of their professional logic. For example, if the logic of medical professionalism was fully enacted in health care "[p]hysicians would practice medicine alone or in association with other physicians" (Goodrick & Reay, 2011: 378). This, however, is rarely the case as physicians are increasingly being employed in large hospital corporations in which they have to fulfill additional organizational roles. This ambiguity of roles entails a multitude of logics around which professionals have to organize their behavior, thereby inhibiting the application of 'pure' professionalism (Doolin, 2001; Farrell & Morris, 2003). Further, political changes in most professional fields foster marketization and competition, leaving even self-employed professionals little leeway to fully align their practice with their idealized concept of professionalism as a publicly protected principle of service provision exclusively guided by the norms provided by professional associations (Goodrick & Reay, 2011; Harris et al., 2014; Harris & Holt, 2013; McArthur & Moore, 1997; Scott, 2004). Hence, while professionals are undeniably carriers of their professional logic it is by far not the only logic affecting their practice. In contrast to non-professional actors who can more easily detach themselves from their occupational background to fulfill different organizational roles (cf. Pratt et al., 2006), professionals face a

constant state of multiple embeddedness with their professional logic providing the 'baseline' of their cognitive and behavioral repertoires.

While the existence of multiple logics has been well-accounted for in field-level research (Green, Babb, & Alpaslan, 2008; Greenwood, Díaz, Li, & Lorente, 2010; Purdy & Gray, 2009; Scott, 2004), the simultaneous influence of several logics on professionals, as a group of social actors within the field, has so far received less attention. A notable exception is provided by Goodrick and Reay (2011) who draw on a historical case study to illustrate that the work of pharmacists was consistently guided by a multiplicity of logics. The authors identify five eras between 1852 and 2011 in which different constellations of logics affected the professional work of pharmacists. The professional logic, the corporate logic, the market logic, and the state logic all affected pharmacists' work over time while only one era is characterized by the existence of a dominant logic (the market logic). Interestingly, the professional logic, while relatively strong since 1945, never achieved absolute dominance in the work of pharmacists. This finding underlines the importance of conceptualizing professionals as carriers of multiple logics who have privileged access to the logic of professionalism and commonly utilize this logic as discursive figure (Fournier, 1999; Jones & Livne-Tarandach, 2008; Thomas & Hewitt, 2011; Turkoski, 1995), but may indeed be primarily guided by another logic. Another important finding of Goodrick and Reay (2011) relates to the idea that different logics can coexist within a group of social actors through the process of segmenting and through cooperative relationships between different logics. Goodrick and Reay (2011: 402) describe segmenting as a process through which different aspects of professional work are guided by different logics. In their study, they find that e.g. pharmacists' education and accreditation was primarily structured according to the professional logic while the corporate logic prevailed in the context of pharmacists' increasing employment in large grocery chains. Cooperative relationships between logics, in turn, imply that professionals' may simultaneously be guided by two or more logics within the same aspect of their work. In Goodrick and Reay's (2011: 402) study, this was the case when the increasing importance of the market logic, including a more aggressive advertisement of pharmaceuticals, led to better-informed customers that more strongly valued pharmacists' scientific knowledge, thereby strengthening the relevance of the professional logic in pharmacists' work. In sum, professionals are likely to be confronted with an enduring multiplicity of logics which they need to incorporate into their political and everyday work. Depending on time and context, they may even be primarily guided by non-professional logics, implying that professionals' role in institutional dynamics is more complex, ambiguous and contingent than them being mere defenders of their professional logic against external influences (Currie et al., 2012; Micelotta & Washington, 2013; Muzio & Ackroyd, 2005; Noordegraaf, 2007; Relman, 2007).

As Muzio et al. (2013: 703) point out, the "coexistence, copenetration, sedimentation, and hybridization" of different types of logics within professionals' work may even produce distinct "forms of professionalism", thereby confirming the idea that non-professional logics are not necessarily external to a profession but often become an integral part of professionals' work.

How actors and professionals in particular balance the different logics that they carry within their roles as e.g. politicians, practitioners, managers, or employees depends on their relative embeddedness in a logic, which may vary over time. Accounting for the specific role of professional socialization as powerful process of familiarizing actors with a professional logic, Pache and Santos (2013) provide a comprehensive framework on individuals' responses to competing institutional logics. According to the authors, individuals' response to competing logics is contingent upon their degree of adherence to different logics. Actors may be novice, familiar, or identified with different logics which may result in the ignorance, compliance, defiance, combination, or compartmentalization of these logics (Pache & Santos, 2013: 12ff.). Professionals are normally highly identified with their professional logic as "[p]rofessions act as powerful conduits of logic identification" (Pache & Santos, 2013:10) because the norms encoded in professional training provide them with "ready-to-wear templates about how to behave" (ibd.: 7). Hence, professionals can be assumed to always be aware of and willing to comply with the demands of their professional logic. Yet, as elaborated above, this does not imply that professionals exclusively adhere to the professional logic. As traditionally 'professional' fields like law and health care become increasingly influenced by market and corporate logics, (Brown & Amelung, 1999; Dunn & Jones, 2010; Reay & Hinings, 2009; Ruef & Scott, 1998; Scott et al., 2000), professionals become familiarized with new belief systems that may persistently provide additional, sometimes conflicting, templates for appropriate behavior. Being familiar or even identified with more than one logic induces more complex reactions towards different logics than complying with one and resisting another logic. In their model, Pache & Santos (2013) identify combination and compartmentalization as two strategies by which actors balance two logics. Combination refers to the integration of two or more logics within their work. Incompatibilities between these logics may be resolved through the combination of selective elements from each logic or through the synthesis of both logics into a new set of norms or practices (ibd.: 14). Compartmentalization describes the selective adherence to different logics across time and context. This strategy corresponds to what Goodrick and Reay (2011) describe as 'segmenting' (see above) and illustrates particularly well that embeddedness in multiple logics may lead to a permanent state of forced agency. As professionals commonly find themselves at the interstices of several templates for appropriate behavior while unable to fully distance themselves from the professional logic that

remains an inherent part of their identity (Chreim, Williams, & Hinings, 2007; Fagermoen, 1997; Pratt et al., 2006), they are less likely to take given institutional arrangements for granted. This increased reflexivity of actors through multiple embeddedness has been identified as a necessary precondition for the exertion of institutional agency (Battilana, 2006, 2011; Battilana et al., 2009). Further, as professionals become aware of the multiple social expectations imposed on them, they have to strategically balance different templates for legitimate behavior (Llewellyn, 2001; Witman, Smid, Meurs, & Willems, 2011). Having to choose between several sets of norms, values and practices inevitably induces agency which, in turn, fosters institutional dynamics (Smets & Jarzabkowski, 2013). These dynamics occur as actors repeatedly comply with one logic while ignoring or resisting another logic or as they create new institutional arrangements and practices (such as ‘clinical management’ (Thorne, 2002)) through the integration of several logics.

However, it would be misleading to conceptualize professionals as passive carriers of multiple logics who exert agency only as a means to resolve tension between the different roles they have to fulfill. Having a repertoire of several logics at hand allows professionals to selectively combine elements of different logics in a way that helps them promote their interests. As Goodrick and Reay (2011: 405) explain, “actors attempt to use societal logics as a ‘tool box’ to fit their interests”, making the embeddedness in several logics not only a source of tension but also an expansion of available legitimization accounts to defend or promote specific roles, practices, and structural arrangements.

Overall, being carriers of multiple logics puts professionals in a special position to exert agency within the different contexts of their work as it enhances their reflexivity and provides them with additional symbolic resources. Hence, it is not surprising that we find professionals so often as initiators and central agents within institutional dynamics on different levels of their work. A particularly important insight of this section is the idea that while professionals are strongly socialized into their professional logic, professional work may very well be structured around other logics. As an effect, professionals, commonly conceptualized as promoters and defenders of their professional project (Suddaby & Viale, 2011), may claim spheres of influence by drawing on legitimizations accounts that differ from those provided by the logic of professionalism. In the following sections, I will further elaborate on how professionals make use of their unique status to work towards the creation, maintenance, and change of institutions through both, political and practice work.

3.3.2 Professionals as Institutional Workers

As elaborated above, professionals often find themselves in institutionally complex situations that necessitate the incorporation of several logics into their work. By

actively choosing which norms, practices and ideological foundations should guide their daily work, their organizational roles, and their profession as such, professionals exert institutional work. Institutional work is generally defined as "the practices of individual and collective actors aimed at creating, maintaining, and disrupting institutions" (Lawrence et al., 2011: 52). As such, institutional work covers all instances of agency that may affect institutional dynamics, regardless of their actual outcomes. Institutional work provides a holistic perspective to professionals' role in institutional dynamics as it explicitly includes the "myriad, day-to-day equivocal instances of agency", that are often "simultaneously radical and conservative, strategic and emotional, full of compromises, and rife with unintended consequences" (ibd.: 52f.).

Recent institutional research has emphasized that professionals are powerful institutional workers who reconfigure fields as a 'by-product' of their constant struggle to defend and expand their jurisdictional boundaries (Suddaby & Viale, 2011; see also section 3.2.1). While linking processes of professionalization and institutionalization within the wider field has provided an important insight into why professionals are so often found to be central actors in institutional change processes, this line of research exhibits two major 'blind spots'. First, professionals' institutional work has often been conceptualized as inherently political, carried out at the field-level and aimed at securing and extending the jurisdictional boundaries of their profession (DiMaggio, 1991; Greenwood et al., 2002; Kirkpatrick et al., 2011; Kitchener, 2002; Kuhlmann, Allsop, & Saks, 2009; Lawrence, 2004; Noordegraaf & Van der Meulen, 2008; Quack, 2007; Scott, 2008b). Second, despite sociologists' rejection of the notion that professionals are necessarily dominant actors within a field (Abbott, 1988), institutionalists have so far focused on the institutional work of high-status professionals (Castel & Friedberg, 2010; Dunn & Jones, 2010; Greenwood & Suddaby, 2006; Greenwood et al., 2002), thereby feeding the idea that professionals are basically elite actors who excel in shaping organizational fields due to their reputation and power (Kellogg, 2012; Scott, 2008b).

Accordingly, despite its rising relevance as conceptual explanation for institutional change and stability, institutional work as a bottom-up and *multifaceted*, sometimes ambiguous kind of institutional agency, has yet to be fully utilized within the study of professionals' role in institutional dynamics. Bringing a more holistic perspective to professionals' institutional work is particularly relevant as recent empirical studies highlight that professionals' role in institutional dynamics is neither limited to elite professional nor is professionals' institutional work necessarily a political or even a conscious effort to advance their professional project. For example, Reay et al. (2006) provide a case study on how former nurses, as a professional group whose status within health care is traditionally subordinate to physicians, successfully established the role of the nurse practitioner in the health care system of Al-

berta, Canada. Their strategies to legitimize their new role transcended the field-level and unfolded as an interdependent and situated cascade of three microprocesses: the cultivation of opportunities for change, the fitting of a new role into prevailing systems, and the provision of proof of the new role's value (Reay et al., 2006: 984ff.). These processes included political action such as the integration of the professional group of nurse practitioners into the existing nursing associations to secure nurse practitioners' independence from the medical profession. Yet, especially the processes of fitting the new role into existing systems and proving its value took place at the organization- and routine-level. Nursing practitioners institutionalized their role by integrating official job descriptions into the HR systems of the local health care organizations; they further used their experience in health care to carefully establish trustful relationships with their colleagues from other professional groups in the context of their daily work (ibd.: 987f.). Eventually, achieving these "small wins" (ibd: 990) accumulated into the institutionalization of new ways of working in Alberta health care. While the results of this study illustrate well that professionals' institutional work is far more diverse and context-specific than the often studied political disputes about field-level structures and practices (Greenwood et al., 2002; Suddaby et al., 2007), it covers a case in which members of a new professional group carry out institutional work to advance their professional project. Yet, professionals' institutional work may also be triggered by non-political causes such as the mundane attempt to do their everyday work within institutionally complex settings.

Integrating institutional logics and institutional work perspectives, Smets and Jarzabkowski (2013) illustrate how professionals who are confronted with multiple, contradicting logics engage in institutional work to balance these logics in a way that allows them to go on with their daily work. Specifically, the authors present a case study on German and English lawyers in a multinational law firm who constantly navigate between the logics provided by different national jurisdictions and diverging ideas of legal professionalism. They identify four cycles in which lawyers managed and resolved the rivalry between different logics through institutional work. In cycle one, lawyers strove to separate local and foreign practices by purposely maintaining their usual ways of providing services while dismissing foreign practices as irrelevant and strange in the context of their work. However, as this intentional separation of practices proved to be unsustainable within collaborative work relationships, German and English lawyers had to actively engage in a re-evaluation and balance of their diverging logics. Thus, in cycle two of their institutional work process, they began to construct the two logics as contradictory, attempting to de-legitimize foreign work practices while trying to present the respective local practice as 'the right way' to complete transactions. These constant struggles about the appropriateness of the respective local practices interfered with the

provision of legal services to their international clients, causing inefficiencies and delays, and culminating into what Smets and Jarzabkowski (2013: 1299) describe as "work-level crisis". As working processes broke down and client satisfaction was increasingly at stake due the perceived incommensurability of the different sets of practices, lawyers began to review the sources of conflict and started to experiment with the different practice templates. In this third cycle of institutional work, compatibility between the different logics was constructed as lawyers improvised around given work problems, thereby generating hybrid practices that reflected elements from both logics. In the last cycle of lawyers' institutional work, the formerly improvised practices were formalized and integrated into official organizational structures such as training programs. As an effect, the two different logics of legal professionalism were constructed as not only compatible but complementary, providing lawyers with practices that were superior to any of the original practices.

An important insight which Smets and Jarzabkowski (2013) derive from their case study is the limited projectivity of institutional agency in the face of an institutionally complex workplace. While being embedded in complex constellations of logics triggers actors' reflexivity and potential to intentionally promote or impede institutional change, their institutional work efforts are not necessarily purposive attempts to shape their institutional environment. Smets and Jarzabkowksi (2013: 1304) argue that actors may lack an elaborate vision of future institutional arrangements and engage in institutional work simply because they are "practical people doing practical work to get a job done". This idea is especially relevant in the context of professionals' institutional work as the political nature of their agency is regularly (over)emphasized and their involvement in institutional dynamics often reduced to the conscious effort of promoting their professional project (Suddaby & Viale, 2011).

Overall, we find that professionals' institutional work is context-specific and can take multiple forms, ranging from highly visible, projective strategies on the political level (e.g. Greenwood et al., 2002) to practical improvisations that may unintentionally generate new institutional structures and practices (Reay et al., 2013; Smets & Jarzabkowski, 2013; Smets et al., 2012).

While scholars have only recently begun to explicitly account for professionals' multiple contextual embeddednes when explaining when, why, and how they exert institutional work (Adler & Kwon, 2013; Currie et al., 2012; McCann, Granter, Hyde, & Hassard, 2013), I would like to point out that professionals' embeddedness in both material and ideological systems is a key to understanding the antecedents and processes of their institutional work (see also section 3.3.1). Specifically, I suggest that there are four major aspects to account for when studying when, why, and how professionals exert institutional agency.

First, professionals' institutional work always relates to both, their profession and their institutional environment as professions are deeply embedded in organizational fields. While theoretical models have focused on how professionals' institutional work changes the contents and boundaries of their profession, causing concomitant or subsequent change in the organizational field (Suddaby & Viale, 2011), professionals' institutional work is not always explicitly aimed at developing their profession. This is, for example, the case when individuals who happen to be professionals promote new working structures within their organization without having an explicit political agenda (Smets & Jarzabkowski, 2013) or when they react to sudden changes in their working context (Barley, 1986; Edmondson, Bohmer, & Pisano, 2001). Yet, as professionals are representatives and "inhabitants" (Delbridge & Edwards, 2013; Hallett & Ventresca, 2006) of their profession as an institution in itself, any systematic change in the content or context of their work will inevitably affect their profession. We can see this, for example, when professions develop 'along the way' of professionals responding to new practical challenges (Smets et al., 2012). In short, professionals' institutional work will always directly or indirectly contribute to the change or stability of their profession while the development of a profession will, in turn, affect surrounding institutions.

Second, as noted above, professionals' embeddedness in multiple institutional logics serves as enabler of institutional agency as it induces reflexivity. Professionals may, for example, begin to actively re-evaluate institutional arrangements when constellations between their professional and other institutional logics shift on the field-level (Reay & Hinings, 2009; Scott, 2004) or when the normative values and beliefs provided by their profession collide with those provided by their organization (Dent, 2003; Doolin, 2001). With a rising number of cognitive and normative templates for the structuration of professional work, professionals become more likely to envision new and creative institutional arrangements as the taken-for-grantedness of given structures and practices decreases in the face of feasible alternatives (cf. Battilana et al., 2009). Additionally, the existence of multiple logics in their work environment is likely to increase professionals' motivation to engage in institutional work. While low-status professionals like nurses or health care technicians are often motivated to take institutional action when they perceive an alternative constellation of logics to be conducive of raising their status (cf. Carvalho, 2012), high-status professionals like physicians are frequently found to engage in institutional work when changes in the salience of given logics or the emergence of new logics threaten their status (Currie et al., 2012; Scott et al., 2000). Hence, as inhabitants of their profession, members of organizations and participants in specific routines, professionals do not only become aware of alternative institutional logics on a daily basis but at the same time acquire a set of avenues through which they can promote their professional project.

Third, professionals may effectively utilize their embeddedness in material environments when engaging in institutional work. The probably most prominent example of how professionals used their organizational embeddedness to advance their professional project is provided by DiMaggio's (1991) study on museum directors who reshaped the organizational form of their museums from private collections to public educational institutions to raise the relevance of their expertise and eventually their professional status in the organizational field of art museums (see also Suddaby & Viale, 2011). Apart from being "vehicles" (Muzio et al., 2013: 710) through which professionals can exert institutional work on the field-level, organizations often serve as the as the major arena for professionals' attempts to change institutions. While this is particularly true for organization-bound professions like human-resource managers (Muzio et al., 2013: 710), members of classical (semi-)professions have been found to initiate institutional change within the boundaries of their organization (Dent, 2002). As elaborated in section 3.2.2, organizations are particularly attractive sites for institutional work for professionals who lack status at the field-level. As organizations offer an additional avenue to gain status and resources through hierarchical position, low status professionals like, for example, nurses are more likely to pursue institutional changes at the organizational level first (cf. Battilana, 2011). Commonly, these changes comprise the appropriation of new roles and task responsibilities that eventually translate into new regulatory structures on the field-level (Dent, 2002; Deverell, 2000; Reay et al., 2006). Accordingly, their organizational embeddedness provides professionals with both, a vehicle to induce change on the field-level and a distinct site for professional development.

Lastly, professionals' embeddedness in different ideological systems, i.e. institutional logics, has been identified as a symbolic resource which they can draw on to promote their interests (Goodrick & Reay, 2011). While having access to multiple logics is not an exclusive feature of professionals and other groups of actors have also been shown to generate convincing legitimization accounts by leveraging several cognitive and normative frameworks (Maguire, Hardy, & Lawrence, 2004), professionals are uniquely able to frame new institutional arrangements as rational or dismiss them as irrational (Green & Li, 2011; Suddaby & Greenwood, 2005). This is because professionals are adept in using discursive means since the development and maintenance of a profession depends on the construction of compelling arguments as to why a distinct group of actors should hold exclusive control over specific areas of knowledge-intensive work (Freidson, 1988a; Suddaby & Viale, 2011). However, being embedded in a profession can also serve as a powerful resource in itself as it grants professionals a discursive advantage: While professionals are generally endowed with higher legitimacy due to the public perception that they are particularly reasonable individuals with high levels of moral integrity, their

privileged access to the logic of professionalism provides them with a distinct repertoire of discursive means (Richardson, 1985; Suddaby & Greenwood, 2005). One of these discursive means is the concept of professionalism itself which has become a synonym for rationality and high service quality to an extent that practices and actors may lose legitimacy simply by being depicted as 'unprofessional' (Fournier, 1999; McKinlay, 1972). Further, professionals occupy distinct "spaces of reason" (Schildt et al., 2011: 84). Drawing on Putnam's (1975) idea of a division of linguistic labor, Schildt et al. (2011) argue that society leaves the definition, maintenance and control of specific spaces of reason to professionals. Such spaces of reason are accepted domains of professional expertise which include, for example, notions on how sickness and health are to be defined or what constitutes a 'gene'. Having authority over spaces of reason endows professionals with power over specific areas of social life as their vocabularies and associated meaning systems restrict other actors' capacity to change the cognitive and normative premises of this area. As Schildt et al. (2011: 84) point out, "even governments cannot intervene in areas like health care or economy unless their actions are rational in the context of accepted 'truths' of medical science or economics". Loewenstein (2014) further elaborates on why professionals' distinct vocabularies provide means for institutional action by pointing towards the coordinative function of words and categories. While non-professional actors rarely grasp the detailed meaning of such words as 'heart attack, they have a basic understanding of how these words are to be used and what reactions are reasonable when encountering a situation that falls into the category of a 'heart attack' (ibd.: 9f.). Accordingly, non-professionals commonly borrow professional vocabularies for the purpose of coordinating action. However, as they lack the expertise and hence the legitimacy to find labels for examples of real-life-situations and entities, they rely on professionals to provide classifications for them (ibd.: 10). As words play an important role in constructing reality (Berger & Luckmann, 2007), their labeling power gives professionals considerable leverage in institutional dynamics. Their institutional work efforts are facilitated as other actors actively seek professionals' words to be used as tools for coordination and signals of legitimacy (Loewenstein, 2014: 10). In this sense, being embedded in a profession provides an important symbolic resource for maintaining or changing institutions as it endows individual and collective actors with the power to discursively construct categories and the relations between them.

In sum, being aware of professionals' multiple embeddedness in material and ideological systems is crucial to understanding how and why they exert institutional work. One the one hand, professionals' institutional work often has more profound effects on organizations and fields than the institutional agency of non-professionals. As professionals 'inhabit' professions (cf.Hallett & Ventresca, 2006), their institutional work efforts inevitably affect the institutional foundations of their

profession. This happens either directly, through politically motivated institutional work to advance their professional project (Larson, 1979), or indirectly by pragmatic institutional work that changes the content and immediate context of professionals' work and eventually the profession itself (Deverell, 2000; McCann et al., 2013). Professions, in turn, are central institutional pillars of organizational fields. Hence, as they change, so do surrounding institutional structures (Suddaby & Viale, 2011). As a result, professionals' institutional work always relates to their profession *and* the wider institutional environment.

On the other hand, being embedded in multiple ideological systems, one of which is their professional logic, is likely to induce reflexivity, making professionals comparatively more prone to actively engage in the change and maintenance of institutions (Delbridge & Edwards, 2013; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013). In addition, having access to multiple logics serves as a "tool box"(Goodrick & Reay, 2011:405) when promoting institutional change or stability. Within this "tool box", professionals possess a particularly valuable tool as their affiliation with the logic of professionalism endows them with authority over "spaces of reason" (Schildt et al., 2011: 84) in which they define vocabularies and categories. As other actors commonly draw on professionals' meaning systems to organize reality and even seek professionals to provide words for unlabeled instances of reality (Loewenstein, 2014), professionals are in a particularly favorable position to create, maintain and change institutions.

Compared to the institutional work efforts of non-professionals, professionals' institutional work has more impact on the field as it relates to the profession *and* surrounding structures, is more likely to occur due to increased levels of reflexivity, and is more likely to be successful as it rests on a unique configuration of material and symbolic resources.

3.4 Changing Professionals – An Integrated Model

Despite recent attempts to distinguish professionals' institutional work along clear categories (Lefsrud & Suddaby, 2012; Suddaby & Viale, 2011), the preceding chapters should have shown that professionals engage in institutional dynamics in multiple ways and on multiple levels of their work. Accordingly, professionals' institutional work is far more diverse than extant models suggest and needs to be studied against the background of their material and their ideological embeddedness. In particular, while institutionalists' focus on politically motivated institutional work on the field-level (Scott, 2008b; Suddaby & Viale, 2011) resonates well with sociologists' idea of professional projects as ongoing negotiations about the regulatory boundaries of professional work (Abbott, 1988, 1995; Larson, 1979), it restricts our understanding of how professionals shape institutional dynamics to

highly visible political strategies. Attempts to integrate institutional theory with the sociology of the professions have proven to be a useful starting point to gain a fuller understanding on when, why, and how professionals become institutional workers (Brock et al., 2014; Muzio et al., 2013; Muzio, Kirkpatrick, & Kipping, 2011). However, research integrating these perspectives has largely focused on professionals' carefully arranged strategies to gain or maintain status and influence on the field-level (Galvin, 2002; Greenwood & Suddaby, 2006; Greenwood et al., 2002; Kitchener & Mertz, 2012; Scott et al., 2000; Suddaby & Greenwood, 2005). Further, institutionalists commonly emphasize professionals' high status within a field as a main component of their institutional leverage (Greenwood et al., 2002; Scott, 2008b), implying that dominance within a field is an inherent characteristic of professionals – a notion that had already been criticized by Abbott (1988).

Hence, we lack a comprehensive model on professionals' institutional work that (1) takes into account their multiple embeddedness in different logics, that (2) provides an integrated perspective on professionals' institutional work as a large spectrum of strategic and non-strategic efforts to shape their institutional environment on the field-, organization-, and routine-level, and that (3) allows for a conceptualization of professionals' institutional work that does not rely on their dominance within the field. Accordingly, it is the goal of this chapter to develop an integrated model on professionals' institutional work that broadens our understanding of when, why, and how professionals engage in institutional dynamics without losing sight of their ideological and material embeddedness or excluding professionals who lack dominance on the field-level.

In the first section, I will elaborate on the idea of professionals' institutional work as 'boundary work'. Boundaries and boundary work obtain a prominent role in the sociology of the professions with researchers emphasizing that professional projects are constant struggles of defending and extending jurisdictional boundaries against adjacent professions (Abbott, 1988, 1995). Institutional researchers have also acknowledged the vital role of boundary work for the creation of shared concepts of reality and the importance of boundaries for institutional change and stability (Lawrence, 1999; Lawrence, 2004; Zietsma & Lawrence, 2010). Given the importance of boundaries for the creation and maintenance of both the professions themselves and the institutional contexts in which they are embedded, I argue that the notion of boundary work provides a useful lense to study professionals' diverse forms of institutional work. However, as I will further explain in the following, professionals' multiple roles and the increasing complexity of their work contexts (Leicht & Fennell, 1997) call for a conceptualization of professionals' institutional work as a form of boundary work that comprises the purposeful and selective inclusion and exclusion of logics to create (or prevent) new institutional structures and practices.

In the second section, I will develop a conceptual model on professionals' institutional work as boundary work that takes place in fields, organizations, and routines. To do so, I will elaborate on how professionals' attempts to balance and skillfully manipulate the boundaries between institutional logics on the different levels of their work become visible as change and stability in the field, their organizations, and their routines. Further, I will illuminate the interrelations between the three levels of professionals' work, thereby drawing attention to the multi-level nature of professionals' institutional work. The resulting model will provide a general conceptual framework on professionals' role in institutional dynamics and will serve as a starting point to the in-depth analyses of chapters 4, 5 and 6 that include self-contained empirical studies on selected aspects of professionals' role in the institutional dynamics of German health care.

3.4.1 Professionals' Institutional Work as Boundary Work

Professionals exert institutional work in various ways, depending on the level on which they promote institutional change or stability (Smets et al., 2012) and the logics available to them at a given time (Goodrick & Reay, 2011). Despite the great variety of professionals' institutional work, ranging from the collective political agency of professional associations (Greenwood et al., 2002) to the everyday enactment of professionalism in the face of task pressures (Smets & Jarzabkowski, 2013), I argue that any instance of professionals' institutional work represents a form of 'boundary work' (Fournier, 2000; Gieryn, 1983).

In sociological and organizational research, a boundary most generally refers to "a distinction that establishes categories of objects, people, or activities" (Zietsma & Lawrence, 2010: 191). Accordingly, boundary work describes the creation of categories and relations between those categories. These categorization processes typically involve the explicit or implicit definition and juxtaposition of ideologies and material objects to establish a sense of sameness or difference (Gieryn, 1983). In short, boundary work is about the demarcation of 'insiders' from 'outsiders' to give order to a specific area of social life.

The concept of boundary work is intimately intertwined with the existence and the development of the professions and has been identified as an integral part of any professional project (Abbott, 1988, 1995; Larson, 1979). Professionals draw boundaries when they negotiate their regulatory spheres (Abbott, 1988; Cooper & Robson, 2006; Suddaby et al., 2007), they draw boundaries when they choose their professional group as relevant peer group within organizations (Ferlie et al., 2005), and they draw boundaries when they defend task spheres against members of adjacent occupational groups in the context of organizational routines (Apesoa-Varano,

2013; Hall, 2005; Mitchell, Parker, & Giles, 2011; Salhani & Coulter, 2009; Snelgrove & Hughes, 2000).

While the boundary work of professionals has primarily been studied as their political endeavors to achieve and protect a monopoly over specific services through legal regulation (Abbott, 1988, 1995) and the demarcation of task spheres in their workplace (Allen, 1997; Apesoa-Varano, 2013; Brown, Crawford, & Darongkamas, 2000; Chreim, 2012; Denis, Lamothe, Langley, & Valette, 1999), professionals create and enact boundaries in more complex and ambiguous ways than defining 'who gets to do what'. Fournier (2000) provides an overview on the different kinds of boundary work that professionals exert. She suggests that professionals' boundary work should be studied as both the constitution of a professional field and the appropriation of this field through what she calls the "labour of division" (ibd.: 72). This labour of division comprises the construction of boundaries between different professional groups, the construction of boundaries between the professional and the client, as well as the construction of boundaries between the profession and the market. Fournier's (2000) tentative framework on the different kinds of professionals' boundary work offers an important insight that may help to advance both the sociology of the profession and research on professionals' institutional work. Her conceptualization of boundary work does not only relate to the turf battles between different professional groups (see Abbott, 1988) but also includes the demarcation of professionalism from non-professionalism. More specifically, Fournier (2000: 77) points out that "professions have sought to situate themselves outside the commercial logic of the market", implying that the boundaries professionals seek to establish are often between symbolic systems rather than groups of social actors per se.

Further elaborating on the general idea of professionals' boundary work as the definition of 'insider'- and 'outsider'-logics rather than the demarcation of boundaries between actors, I argue that whenever professionals seek to change, maintain, or disrupt institutions, they automatically engage in boundary work between different institutional logics. This is because any shift in the institutions surrounding professionals – from everyday practices to the profession itself – entails the restructuring of boundaries between professionalism and (elements of) other logics which professionals are exposed to (cf. Goodrick & Reay, 2011). The notion that professionals' institutional work can generally be conceptualized as an instance of boundary work provides a valuable conceptual extension to both the sociology of the professions and institutional theory as it offers an integrated view on the political and pragmatic processes through which professionals shape social life while accounting for their own embeddedness in complex constellations of logics (Dunn & Jones, 2010; Freidson, 2001; Goodrick & Reay, 2011).

Specifically, I argue that institutional work generally comprises the implicit or explicit management of relations between logics since shifts in institutional structures and practices are achieved through the inclusion and exclusion of logics as guiding principles and meaning systems for fields, organizations, and individual actors (Scott, 2004; Scott et al., 2000; Thornton et al., 2005; Waldorff et al., 2013). For professionals, this management of logics is necessarily boundary work as their multiple embeddedness in their professional logic and additional institutional logics, such as the market or the state logic (Freidson, 2001), require them to purposefully integrate and separate logics when creating, maintaining, or disrupting institutions on different levels of their work. This includes the definition of a logic's scope of application as well as the selective combination of logics within their profession (Goodrick & Reay, 2011) and the structures and practices of their work environment (Dunn & Jones, 2010; Galvin, 2002; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013). A prominent example of how professionals purposely shift the boundaries between formerly separate logics can currently be found in most Western health care systems, where medical and nursing professionals dynamically include or reject typical elements of the managerial logic to advance their professional projects (Carvalho, 2012; Kirkpatrick et al., 2011).

While early work in the sociology of the professions and research on professionals' involvement in institutional change suggests that professionals' institutional work is mostly an ideal-typical creation and defense of a sphere in which the dominance of their professional logic is unquestioned (Freidson, 1970b; Scott et al., 2000), the increasing hybridization of professionals' working contexts calls for a different perspective on professionals' institutional agency. As multiple and conflicting logics enter professional fields like health care (Scott, 2004), professionals' institutional work has shifted from the 'classic' forms of boundary work between idealized conceptions of professionalism versus the market or the state logic (Freidson, 2001), or the reinforcement of regulatory boundaries that separate different professional groups (Abbott, 1988) to a more complex and contingent construction and deconstruction of boundaries between norms, beliefs, and value systems (i.e. logics). That said, we can observe how professionals change institutions through boundary work between different logics on a daily basis, e.g. by integrating different logics to create hybrid practices (Smets & Jarzabkowski, 2013; see also section 3.3.2) or by purposefully excluding new field-level logics from their professional role (cf. Doolin, 2001). Even the professions themselves – as the main object of professionals' institutional work – are often based on constellations of several broader societal logics, which professionals enact, mutate, or reject over time, thereby disrupting, maintaining, or changing their profession (Goodrick & Reay, 2011).

The notion of professionals as boundary workers who mediate and catalyze rather than initiate institutional change through the skillful combination of existing logics

resonates well with recent notions of professionals "as 'behind the scenes' ringmasters, rather than 'center stage' musclemen" (Lefsrud & Suddaby, 2012: 322). While professionals have been shown to create new institutional structures, especially when first establishing or promoting their professional status (Dent, 2002; Goode, 1961), professionals rarely introduce new logics to a field but rather function as mediators who spread, translate, and manipulate constellations of logics in their roles as political actors (Kuhlmann, 2008), members of organizations (Doolin, 2001; Iedema et al., 2004), and routine participants (Deverell, 2000; Reay et al., 2013; Smets & Jarzabkowski, 2013). Hence, depicting professionals' institutional work as boundary work between given institutional logics helps account for their embeddedness in multiple systems of reason while not underrating their important role as institutional agents.

While boundary work as a form of institutional work can essentially be reduced to the inclusion and exclusion of logics as principles according to which institutional structures and practices are to be designed, professionals' boundary work (like any form of institutional work) may take various forms, leading to the replacement of one dominant logic by another (Scott et al., 2000) as well as the co-existence of several logics in fields (Dunn & Jones, 2010), organizations (Bode & Maerker, 2014; Castel & Friedberg, 2010), and routines (McPherson & Sauder, 2013). How professionals exert boundary work within the different contexts in which they operate will be the subject of the following section. Specifically, I will elaborate on how the context in which professionals exert boundary work determines whether the purposeful application, integration, and separation of logics become visible as professional project, role enactment, or routine dynamics.

3.4.2 Professionals' Boundary Work in Context – An Integrated Model

As elaborated above, I define professionals' institutional work as a specific kind of boundary work. This boundary work relates to the integration and separation of available institutional logics to shape institutions like the professions, organizational structures, or working practices and the demarcation of spaces in which particular constellations of logics should be applied.

While I argue that any kind of professionals' institutional work can be conceptualized as boundary work, the integration, separation and application of logics constellations is highly context-dependent. As Zilber (2013: 89) points out, the study of institutional work generally requires contextualization as actors are enabled and constrained by the environment in which they operate (see also section 3.2):

"To appreciate the creativity actors use in constructing their positions and resources (again as part of their institutional work), we need to think of actors, actions, and the institutional contexts within which institutional work is carried out. An

institutional context determines 'what types of actors can exist as well as what they can do' (Hwang & Colyvas, 2011, p. 64), but actors may also construct this context."

On the one hand, the contexts in which professionals' institutional work takes place – including fields, organizations, and routines – determine the potential objects of their boundary work, that is, the kind of institution created, maintained, or disrupted through the purposeful integration and separation of logics as design principles. While, for example, changes in professional jurisdiction may have their origin in incremental routine changes (cf. Smets et al., 2012) and routines may be altered in response to the institutionalization of new professions in the field (Currie et al., 2012; Kroezen, Mistiaen, van Dijk, Groenewegen, & Francke, 2014; Reay et al., 2006), each level of professionals' work comprises a distinct set of institutions (Dopson, Fitzgerald, & Ferlie, 2008). Accordingly, while institutional dynamics can originate on every level of professionals' work, context-specific institutions like organizational roles or habitualized ways of working are most accessible for institutional work efforts at the location of their primary enactment (cf. Dopfer, Foster, & Potts, 2004; Jarzabkowski, 2004; van Dijk, Berends, Jelinek, Romme, & Weggeman, 2011). On the other hand, contextual embeddedness determines the constellations of logics which professionals have to respond to and, at the same time, the set of logics that is utilizable as 'tool box' for the exertion of institutional agency (Goodrick & Reay, 2011:405; see also section 3.3.2). For example, their organizational embeddedness might detach professionals from some of the logics that characterize the field as a whole while it may simultaneously increase the relative salience of other logics (cf. Pache & Santos, 2013). This is because organizations and organizational routines – while nested in the logic systems of fields – are not ideal representations of field-level structures (cf. Durand, Szostak, Jourdan, & Thornton, 2013). Here, owners and managers function as 'gateways' that determine which logics become most salient in their organization (Beckert, 1999) as they set up the structures and goals that reflect which core assumptions and norms should guide organizational members.

While classic neo-institutionalism would predict otherwise, suggesting that organizations within a field become increasingly similar in their strive for legitimacy (DiMaggio & Powell, 1983), a controlled deviance from the logic constellations within a field may create strategic advantages and hence become a reason for organizational decision-makers to create an organizational environment that – while resonating with the legitimacy expectation of a field – does not perfectly reproduce the logics that constitute the field as a whole (Durand et al., 2013). Further, as professional organizations become increasingly multi-professional due to the integration of additional professional groups and the professionalization of former occupations, the representation of specific professional logics may be skewed when compared to the

field-level. This trend is observable especially in health care where medical dominance is weakened as professional groups who are subordinate in the field-level hierarchy (e.g. nurse practitioners or technicians) have increased their leverage as physicians are highly reliant on their services to complete their daily work (Barley, 1986; Kilpatrick et al., 2012; Timmons & Tanner, 2004). Accordingly, organizations within professional fields may combine specific professional, market, state, bureaucratic, and other logics in idiosyncratic ways (Zietsma, Greenwood, & Langley, 2014). They may sponsor a constellation of logics that favors market over professional logics (like e.g. privately-owned hospitals) or may even selectively exclude logics that characterize the field (cf. Besharov & Smith, 2014; Waldorff, 2013; Waldorff et al., 2013). Further, logics themselves become altered through translation processes as the abstract frameworks on the field-level are enacted as concrete roles and practices, expressed in specific codes of conduct, and reflected by organizational structures. Through these processes of structuration logics are naturally altered and adapted (Czarniawska, 1997). Hence, every organization needs to be understood as an institutional context of its own; it is embedded in and (partly) reflects the field but never represents an ideal reproduction of the field-level as political arena. While this should not imply that organizations do not provide a space for political action, this space is biased and often fuzzy with regard to the logics involved, more immediately linked to concrete work demands, and rarely allowing professionals to act exclusively as representatives of their professional logics as they have to additionally fulfil their respective organizational roles (see also section 3.3.1).

The same holds true for the routine-level, on which logics are represented in the ostensive aspects of professionals as routine participants, guiding their "attention to alternative schemas for perceiving, interpreting, evaluating, and responding to environmental situations" and providing them with "a set of rules and conventions […] for deciding which problems get attended to, which solutions get considered, and which solutions get linked to which situations" (Thornton & Ocasio, 2008: 114). On the routine-level, logics are rarely enacted as ideal-types due to the demands and restrictions that actors face when engaging in routine performances to address concrete tasks. Still, routines are embedded both in fields and – more immediately – in their organizational context and the ideological and material foundations that these contexts provide (Weber & Glynn, 2006: 1650).

Routines are embedded in a field through the professional background of their participants. For example, the multi-professional routines that are characteristic for the provision of health care will be structured according to what physicians, nurses, and other health care professionals consider appropriate, thereby uniting aspects of several professional logics (Greenhalgh, 2008). In addition, the organizational context provides routine participants with organizational roles that may position routines within an even more complex constellation of logics, as actors' organizational roles

and professional roles are often diverging, sometimes even conflicting (Doolin, 2001; Llewellyn, 2001; Thorne, 2002). Beside the ideological background of routine participants that places routines at the intersection of multiple logics, routines are heavily reliant on their material embeddedness in organizational structures. Exemplary structures that inform actors' ostensive aspects and shape routine performances are artifacts such as IT-systems and formal rules (Becker, 2004). While fulfilling the function of coordinative mechanisms, they also convey specific logics according to which routines *should* be carried out and thus transport organizational worldviews to the most immediate locus of professional action. Dense frameworks of formal rules that are accompanied by elaborate control and sanctioning mechanisms are, for example, indicative of a dominant bureaucratic logic that is supposed to be enacted within an organization's routines. Consequently, the routine-level comprises a multiplicity of logics which actors (have to) include and separate in their daily struggles to address the tasks at hand. On the routine-level, logics become fuzzy as they cannot be enacted in the sense of ideal-types. Much rather, the organizational routine provides a context in which professional backgrounds, organizational roles, and structural artifacts congeal and provide a seemingly endless repertoire of potential logic combinations that can be used to guide actors' performances. Therefore, changes in the relative salience of logics are more common and occur more rapidly than on the organizational or the field-level. This is because, while routines provide a context in which professionals prove their capability to put their professional logic into action (see section 3.2.3), routines are exerted to address tasks, that is, specific tasks within specific circumstances that may necessitate routine participants to act more 'professional', more 'bureaucratic', or more 'market-oriented' to achieve a favorable outcome in a given routine iteration (cf. Harris et al., 2014). However, and in explicit contrast to the field-level, routine participants rarely consciously set out to enact or reject an 'institutional logic' but integrate their concepts of appropriate conduct – which are strongly informed by the logics characterizing the field- and the organizational level – in a way that helps them to 'get things done' (Smets & Jarzabkowski, 2013). As such, the routine-level is arguably the most relevant level for the kind of agency that researchers have described as "more immediate ongoing, messy institutional work at the stage in which no one knows – neither the actors nor the researcher – whether these actions would result in maintaining, creating, or changing the institutional order" (Zilber, 2013: 88).

So, while the routine-, the organization-, and the field-level are nested systems, they provide distinct contexts for professionals' boundary work as (i) the relative salience of specific institutional logics may vary between these levels and (ii) each level provides specific enabling and constraining conditions that shape how logics are represented and to which extent they can be used to exert agency. Accordingly, professionals exert boundary work differently on the different levels of their institutional

environment. A key characteristic along which the boundary work differs is the extent to which the resulting institutional dynamics have a political or pragmatic quality. While neither of these levels is purely political or practice-driven and professionals may shape institutional dynamics on each of these levels simultaneously, the conceptual separation of the field, the organization and the routine as arena of institutional agency is helpful to understand the contextuality of professionals' boundary work.

Boundary Work on the Field-Level

On the field-level, professionals typically exert agency as collective actors, mostly occupied with shaping, defending and extending the sphere of their professional logic as an ideal-type. As the resulting political struggles with other field constituents are often normative and concerned with the basic principles on how a field or a profession within a field should be designed, concrete tasks and organizational challenges may be used as discursive figures but are rarely the prime concern of political stakeholders when engaging in institutional work. On this level, professionals and other important stakeholders within a field, shape and enact institutional logics in the ideal-typical way in which most institutional researchers use the concept (Dunn & Jones, 2010; Hinings, Greenwood, Reay, & Suddaby, 2004). Field-level-actors often fulfill the roles of representatives and advocates of 'pure' logics like their professional logic, the state logic, or the market logic (Freidson, 2001). They try to in- and exclude logics as guiding principles of a field with a deep awareness and specific normative ideas on what defines professionalism, the state, or the market (or other logics), and – while not always successful in weakening a competing logic (i.e. positioning this logic at the periphery or outside of the field boundaries) – create well-observable, distinct boundaries between each of these logics (Lounsbury, 2007; McDonald et al., 2013; Pouthier, Steele, & Ocasio, 2013; Scott, 2004). Professionals' boundary work on the field-level commonly becomes visible as their professional project. A professional project can be viewed as an attempt to extend and secure the boundaries in which a specific professional logic is seen as appropriate principle of organizing work (Larson, 1979). This is usually achieved by defining specific task spaces, translating these into legitimate areas of professional control and securing them against adjacent professions and other actors through jurisdiction (Abbott, 1988).

How professionals promote and secure their status within a field by establishing and reinforcing the boundaries between the professional, the market, and the state logic while expanding the scope of application of their professional logic has already been illustrated by classic sociological works on professionalization (Abbott, 1988; Freidson, 1970b; Larson, 1979). Also, recent studies on professionals' institutional work illustrate that the field-level often becomes an arena in which professionals

defend the boundaries between their professional logic and other logics (Muzio & Ackroyd, 2005). Especially the exclusion of market logics from professional work has emerged as a recurring theme in the study of professionals' institutional work, since marketization and rationalization have become societal megatrends that increasingly affect professional fields (Aldridge, 1996; Bode, 2015; Giaimo & Manow, 1999; Leicht & Lyman, 2006; Relman, 2007).

However, while professionals commonly act as defenders of their professional logic within the political struggles on the field-level that eventually determine the status and power of the different field constituents, recent studies show that professionals may also exert boundary work in the sense of a selective *in*clusion of new logics into their profession (Blomgren, 2003; Kurunmäki, 2004). This is the case when new logics provide professionals with complimentary legitimization accounts for the advancement of their professional logic and thereby become instrumental to the promotion of their professional project. Kirkpatrick et al. (2011) provide a particularly illustrative case study on how both the nursing and the medical profession sought to integrate the managerial logic into their profession in order to defend and advance their claims of dominance in the Danish hospital field. While Danish legislators introduced management reforms, they left the design of managerial structures widely unspecified, aiming at a "model of inspiration" (ibd: 496) rather than hard reforms. This approach allowed for local adaptions in the decentralized Danish hospital sector and resulted in a re-evaluation of the status relation between doctors and nurses. Physicians, who traditionally enjoyed a higher status in the professional hierarchy, sought to defend their privileged position and buffer their clinical work from being controlled by non-medical managers. Nurses, on the other side, perceived a potential involvement in hospital management as an opportunity to emancipate from their subordinate status as assistant profession to medicine by occupying key positions within the organizational hierarchy (i.e. taking over managerial roles). They embraced the newly introduced managerial logic as inherent part of their profession, claiming that even basic nursing education included far more administrative knowledge than most physicians could acquire through additional training (ibd.: 496). While eventually physicians succeeded in further expanding their dominance in the field of health care by promoting a shared management model led by a physician, the managerial turn in the Danish hospital field also supported the professionalization of nurses who were able to defend their right to participate in hospital management. Thus, both nurses and physicians profited from including the managerial logic into their profession. As Kirkpatrick et al. (2011) point out, this selective inclusion of the managerial logic into health care professions is a rather rare occurrence as physicians and nurses usually try to distance themselves from any economically motivated action. Yet, their case study shows that professional associations "articulate new 'institutional logics' to support (or legitimate) their claims" (ibd.: 500),

thereby underlining that even on the highly political field-level, professionals' boundary work can be more complex and differentiated than a mere exclusion of non-professional logics from their profession.

Boundary Work on the Organization-Level

Compared to the field-level, the relationships between logics become more blurry on the organization-level as professionals need to fulfill the roles of executives, middle-managers, employees, and – last but not least – members of their profession (see section 3.2.2) against the background of given organizational goals and structures. Within the boundaries of an organization, professionals have to respond to both, their role in the organizational hierarchy and their professional role as e.g. nurses, physicians, or lawyers. Fulfilling these multiple roles requires professionals to balance diverse sets of logics on which different role concepts rest (Doolin, 2001, 2002; Kirkpatrick et al., 2011; Thorne, 2002). Hence, boundary work in the sense of a selective and contingent in- and exclusion of institutional logics is an inherent part of role enactment (cf. Chreim, 2012; Chreim, Langley, Comeau-Vallée, Huq, & Reay, 2013; Iedema et al., 2004) even though actors may not necessarily be aware of the underlying ideological frameworks they represent by fulfilling their organizational roles in a specific way. This is because, within organizations, technological and market requirements may urge actors to enact their roles in a way that allows them to efficiently respond to the organizational challenges within their area of responsibility, thereby often superseding normative and political considerations (McCann et al., 2013). Nevertheless, in the process of enacting their organizational and professional roles, professionals – consciously or unconsciously – also enact or reject specific constellations of logics, thereby working towards institutional stability or change.

Chief physicians, for example, have to balance their professional role as member and representative of the medical profession and their organizational role as executive (Witman et al., 2011). To enact this dual role "as both caregivers and administrators, [they] must balance two competing logics" (Arman, Liff, & Wikström, 2014: 283). Depending on the technological and institutional context provided by their organizational embeddedness, they may decide to orientate their role more towards managerialism or professionalism, thereby strengthening or weakening the influence of each of these logics in their organization. However, and in contrast to designing their profession on the field-level, professionals do not have unlimited discretion over how they integrate different logics into their organizational roles (Kitchener, 2000). In their study on how different logics were balanced in psychiatric care units, Arman et al. (2014) find that psychologists refused to include managerial elements into their role but were eventually forced to align their work with efficiency considerations rather than the idea of holistic care that was essential to their professional

logic. The result of this permanent role conflict was a hierarchization of logics through which both the professional and the managerial logic prevailed within the psychiatric care units. However, the managerial logic dominated psychiatrists' organizational role despite their continuous and aggressive attempts to primarily enact their professional logic. Further research suggests that intra-organizational dynamics such as individual career prospects may lead professionals to balance logics differently when enacting their organizational role than they do as collective, political actors on the field. A study by Vera and Hucke (2009), for example, shows that physicians' attitude towards managerial skills correlates with their career success in hospitals. Specially, given that modern hospitals are increasingly reliant on employees who willingly internalize result-orientation and a focus on efficiency, assistant physicians with a positive attitude towards managerial skills were more likely to be promoted. This finding further strengthens the assumption that professionals may draw different boundaries between logics on the organizational level than on the field-level as their contextual embeddedness determines not only the relative salience of logics, but also provides distinct incentives and sanctions for enacting specific logic combinations.

In addition to the – more or less successful – in- and exclusion of logics from their given organizational roles, professionals exert boundary work on the organization-level when they acquire new roles and infuse these roles with new constellations of logics. The organizational hierarchy is often conducive to professionals' pursuit of status and influence as it provides an additional system of super- and subordination (see section 3.2.2). Especially in health care, professionals try to occupy executive roles in an attempt to increase the relevance of their professional logic within their organization (Carvalho, 2012) and to hamper the expansion of managerial logics to the operational core of professional organizations (Kirkpatrick et al., 2011; Waring & Currie, 2009). Examples include physicians who defend medical dominance in hospitals by what Thorne (2002: 23) describes as acquiring the "tools and techniques of [their] oppressors", that is, the assimilation of managerial roles. While first reluctantly taking over managerial roles that have been imposed on them, clinical directors began to utilize their new organizational role as an avenue to promote medical professionalism as dominant logic within their organizations. Here, medical professionals purposefully engaged in fuzzying the boundaries between managerial and professional logics, securing their power by including the managerial logic into medicine while infusing management with the logic of medical professionalism. Similarly, Doolin (2001) provides a case study on clinical leaders in a New Zealand hospital who, in their role as frontline managers, marginalized the managerial logic in favor of their professional logic, thereby undercutting organizational change initiatives.

In sum, professionals' boundary work on the organization-level exhibits some similarities to their boundary work on the field-level as – due to their strong embeddedness in their profession – professionals often seek to defend and extend the spaces in which their professional logics prevail. Yet, given the multiple roles that professionals have to fulfill as organizational members, professionals' agency within organizations often lacks the ideal-typical, political nature that characterizes their institutional work on the field-level. While the redefinition of organizational roles through the selective in- and exclusion of logics may be utile in promoting professional projects on the field-level, e.g. by providing additional rationales for altered jurisdictional boundaries, organizational embeddedness forces professionals to address challenges that lie beyond the mere protection of professionalism. As managers, professionals become responsible for securing organizational survival; as employees, they have to obey organizational control mechanisms and respond to organizational incentives such as career prospects. Accordingly, within organizations, professionals exert institutional work by interpreting and enacting their organizational roles along the lines of several logics, some of which are forced upon them by their organizational membership.

Boundary Work on the Routine-Level

On the routine-level, professionals often exert boundary work between logics in iterative, adaptive processes that occur along the everyday accomplishment of their work (McPherson & Sauder, 2013). As routines are embedded in the logic constellations of a field and an organization, routine participants' ostensive aspects include these logics as cognitive and normative orientations that guide professionals' performances. How logic constellations on the field are integrated into professionals' everyday routines is illustrated by Harris and Holt (2013) who provide a qualitative case study on how dentists enact business-like health care, commercialism, and medical professionalism as three logics guiding the field of dentistry in the UK. The authors find that dentists are fully aware of the complex logic constellations in which their practice is embedded. Still, instead of aligning their work with only one logic while rejecting the others, dentists' routine performances are guided by elements of several logics, creating a dynamic that provides the grounds for subtle, adaptive institutional change on the routine-level. As Harris and Holt (2013: 68) emphasize, professionals integrate and balance field-level logics in their routine "not merely in an 'uneasy truce' of one bloc set against another […] but are interweaving threads running throughout their everyday activity". Accordingly, routine scholars' observation that routines are effortful accomplishments rather than mindless repetition (Feldman, 2000; Pentland & Rueter, 1994) extents to professionals' mindful in- and exclusion of logic elements into their work as they design routines that generate favorable outcomes while reflecting what they consider appropriate professional conduct.

However, institutional dynamics on the routine level do not only occur when professionals mindfully integrate different logics but also when they intentionally reject new logics as guiding principles for their routine performances. Given their high autonomy in executing their work, this may result in the effective decoupling of actual routine performances from normative prescriptions on the field-level and from organizational structures if professionals disagree with the respective value-systems. Specifically, professionals' strong bond with their respective professional logic may affect the dynamics through which routines evolve and new practices become institutionalized. As professional identity is developed and enacted in working routines (see section 3.2.3), professionals may actively work towards the exclusion of market or corporate logics from their working routines because they consider the corresponding principles of work organization as inappropriate. This selective enactment of available logics may cause a decoupling of actual routine performances from routine prescriptions, which results in long-term institutional change or maintenance. As Novotná (2014) shows in her study on the implementation of integrated treatment programs for mental health and additions in a hospital in Ontario, professionals may even increase their workload to prevent a managerial logic from dominating their routine performances. She finds that clinicians who strove "to remain faithful to their professional standards of care" (ibd: 271) deliberately worked overtime and offered uncompensated therapy sessions within their treatment routines to provide their patients with what they considered good professional service.

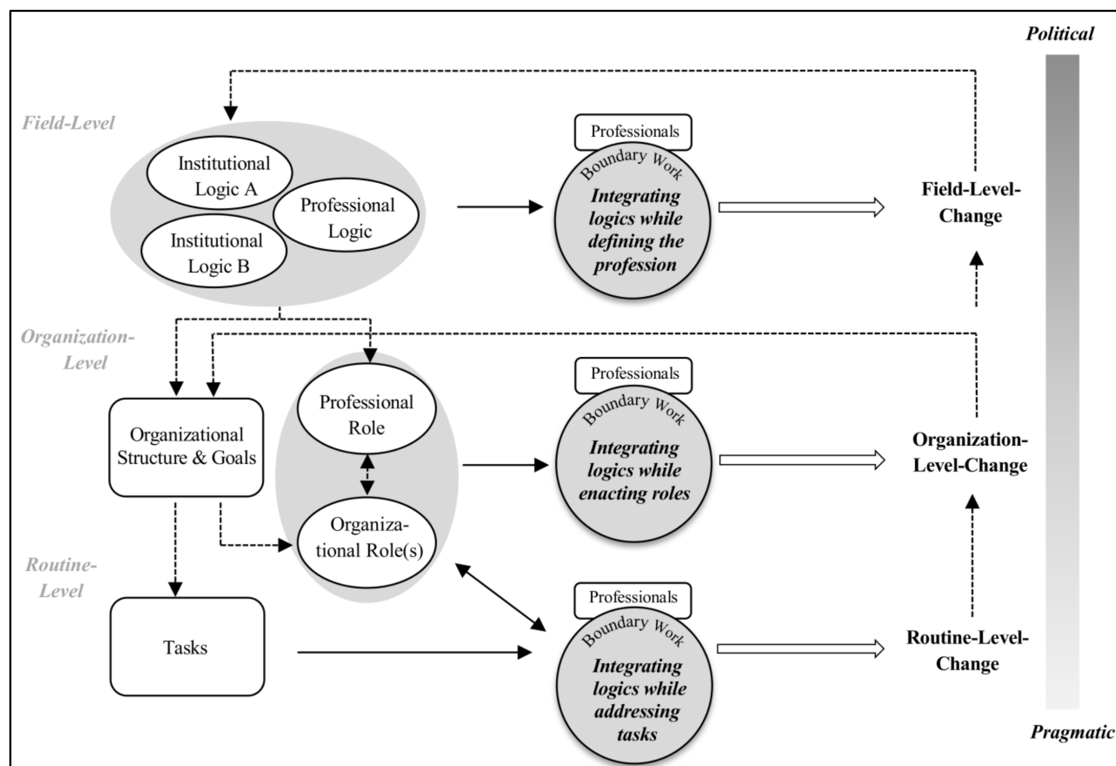
While institutional dynamics on the routine-level often result from professionals responding to immediate task requirements (Harris et al., 2014), performances are always interpreted against the logic constellations encoded in the ostensive aspects. Hence, learning from routine performances, while often a pragmatic process and rarely evaluated against wider political implications, does not occur in a normative vacuum. On the other side, learning from performances typically induces modifications in routine participants' ostensive aspects and – as illustrated by Smets and Jarzabkowski (2013) (see section 3.3.2) – may result in the mindful integration of several logics into the ostensive aspects of routine participants when they prove to produce more efficient working processes or more favorable outcomes.

In sum, professionals' institutional work on the routine-level is fuzzy and results from an interplay between logic constellations stored in the ostensive aspect of a routine and routine performances that may necessitate improvisation, induce practical learning, and eventually cause modifications in professionals' abstract, normative ideas on appropriate performances. Thus, while professionals in- and exclude logics to achieve change or stability in their routines through the mindful adaptation of their ostensive aspects, new logic constellations may 'creep up' on their routines as they repeatedly adapt their performances to unforeseen task and context conditions or when the outcome of their performance remains below their aspiration lev-

els (cf. Feldman & Pentland, 2003; Levitt & March, 1988: 324; Lounsbury & Crumley, 2007; Rerup & Feldman, 2011).

While this thesis will provide separate analyses of professionals' institutional work on the field-, the organization-, and the routine-level to account for the idiosyncrasies of each level that shape when, why, and how professionals engage in institutional agency, it is important to acknowledge that the field, the organization, and the routine are mutually intertwined. Thus, institutional work on each of these levels needs to be viewed as a potential precursor of institutional dynamics on the levels above and below. Just as institutional pressures diffuse from the field-level to affect organizational structures and routines (DiMaggio & Powell, 1983; Tolbert & Zucker, 1983), norms and practices develop and become institutionalized 'on the ground', that is, through human interaction within routines (Lounsbury & Boxenbaum, 2013; Zilber, 2013). New practices are infused with meaning through processes of theorization (Reay et al., 2013), are being integrated into the structures and roles that characterize organizations (Smets & Jarzabkowski, 2013), and eventually become aggregated into delimitable institutional logics as abstract categories that define fields (Smets et al., 2012). Figure 3.2 provides an integrated overview of how the different levels on which professionals engage in institutional work are intertwined and summarizes the different kinds of 'boundary work' between logics that professionals exert on each level.

Figure 3.2: Professionals' Institutional Work as Boundary Work in Context



4 Professionals and Field-Level Change

Professionals' institutional work has been theorized to be a key mechanism of institutional dynamics on the level of the organizational field (Muzio et al., 2013; Suddaby & Viale, 2011), which is defined as a "community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside of the field" (Scott, 2008a: 86). Accordingly, on the field-level, professionals act as collective agents, either through the organizations in which they are employed or through their professional associations (Greenwood et al., 2002; Lounsbury, 2002; Suddaby & Greenwood, 2005). As elaborated above, professionals' impact on the structures, practices, and hierarchies of a field generally stems from their interest in advancing their professional project and can be conceptualized as boundary work between different institutional logics which are integrated, mutated, or dismissed through political strategies and tactics. It is the field-level on which the professions are defined and the general relationship between professions and other actors are negotiated (Freidson, 1988a; Muzio et al., 2013). The organizational field provides a common institutional environment in which organizations interact and strive for legitimacy by adopting and adapting to the norms, standards, and values promoted in the field (DiMaggio & Powell, 1983). Hence, institutional dynamics on the field-level have a profound impact on organizations and individuals as, through diffusion processes, they affect organizational goals and structures and eventually the routines that lie at the core of any organization. Accordingly, the role of professionals' in institutional change and stability on the field-level has received much scholarly attention (DiMaggio, 1991; Dunn & Jones, 2010; Greenwood et al., 2002; Malsch & Gendron, 2013; Micelotta & Washington, 2013; Muzio & Ackroyd, 2005; Muzio et al., 2013). However, while professionals' grand political strategies to promote or prevent field-level change have been the subject of extensive scientific scrutiny, less attention has been brought to how contextual conditions enable and constrain professionals' agency. In particular, professionals are generally considered high-status actors within a field and agents who shape rather than being shaped by the norms, values, and cognitive frames of the field (Muzio et al., 2013; Muzio et al., 2011; Suddaby & Viale, 2011). Further, field-level dynamics are often reduced to the highly visible struggles between proponents and opponents of change that are based on competing normative arguments (Pieterse, Caniëls, & Homan, 2012; Suddaby & Greenwood, 2005). Thus, literature on professionals' institutional work on the field-level is still scant in fine-grained and contextualized views on when, why, and how professionals alter the logic constellations that define organizational fields.

This chapter sets out to expand our understanding on when, why, and how professionals exert institutional work on the field-level by focusing on how their contextual embeddedness enables and constrains professionals' attempts to promote specific constellations of logics in a field. Specifically, the goal of this chapter is to broaden theoretical perspectives on professionals' institutional work by elaborating on how professionals' relative status affects their use of institutional strategies while providing an empirical insight on how professionals' institutional work shaped the German health care system. In the first section, I will elaborate on the changes that characterized the field of German health care over the last decade and foreshadow how these changes affected and were informed by different groups of health care professionals. In doing so, I will provide empirical background information to the study presented in the third section. The second section comprises a concise literature review that will illustrate when, why, and how professionals generally engage in institutional dynamics on the field-level. Specifically, I will provide an integrated overview of empirical findings on the antecedents that cause professionals to defend or redefine the boundaries between different institutional logics in their profession and in the field and the processes through which they eventually disrupt, create, and maintain institutions. Further, I will discuss the shortcomings in extant literature that I seek to address with the empirical study presented in the third section. The final and main part of this chapter includes a case study on how professional and state actors employed vocabulary construction as a means to either protect or decrease medical dominance in German health care. This study expands literature by shedding light on how low-status professionals like nurses reinforce existing power relations in a field through the utilization of high-status-actors' vocabulary spaces.

4.1 Setting: Marketization and International Models of Professionalization in German Health Care

The changes that German health care faced over the last decades are typical for Western health care systems (Freeman & Moran, 2000; Lameire et al., 1999, see also chapter 2). Against the background of demographic and technological challenges and the proliferation of economic rationalization in all areas of public service, the logic constellations that guide the field of German health care have drastically shifted and brought forth a state of institutional complexity in which neither of the available logics is dominant. Bode (2015: 2ff.) argues that this state of "institutional ambiguity" is rooted in the simultaneous expansion of community and market logics, specifically, human rights universalism and micro-economic rationalization, and affects public services all over the world. In Germany, human rights universalism is well-reflected in the long-standing tradition to provide all citizens with

equal access to high quality health care, mostly through the implementation and expansion of mandatory health care insurance (see section 2.1). Micro-economic rationalization, or the advent of the market-logic within German health care, is in turn, a relatively current change which is best illustrated by the introduction of prospective payment schemes for patient care in the beginning of the 2000s (budgeting in ambulatory care and the G-DRG-system in inpatient care) that increased cost-pressures for providers and simultaneously challenged the logic constellations according to which health services should be provided (Schmid, Cacace, Götze, & Rothgang, 2010).

The logic of medical professionalism has long been dominating the provision of health care in Germany (Kuhlmann, 2006) and while the medical profession has remained a central social actor in German health care, occupying key positions in the corporatist governance system (see section 2.2), the introduction of the market logic to the field threatened key aspects of medical professionalism. While in retrospective payment systems, individual practitioners had full autonomy over providing their patients with what they considered to be adequate medical services, prospective reimbursement rates limited this aspect of professional autonomy (Neubauer & Pfister, 2008). Even though physicians' autonomous provision of medical services as such was not challenged, the above-mentioned cost containment initiatives restricted their potential to exclusively align their work with professional ethics (Weiss, 2011). Accordingly, the conflict between 'medical ethics' and 'business ethics' became a key concern in the discourse between federal actors and medical associations (Offermanns, 2007). Representatives of the medical profession publicly warned that economic considerations are likely to encroach on autonomous medical practice, thereby jeopardizing professional values and patient well-being (Stiefelhagen, 2002) and the German Medical Council published guidelines on how medical professionals are supposed to resist economic pressures and secure their professional integrity (BÄK, 2007). Similarly, the simultaneous expansion of the state logic, reflected in federally prescribed quality indicators and the founding of public institutes of quality control (§ 139a, SGB V; IQWIG, 2014), evoked resistance among the medical profession which sought to defend peer control and public trust in their expertise as appropriate means of control in the field of health care. In particular, recently planned pay-for-performance schemes that link reimbursement rates to medical outcome quality have faced stark opposition from the medical profession who rejected output-oriented, quantifiable quality measures and the resulting open price-competition (Bode, 2014). Having medical services evaluated by external parties – in this case federal institutes – has been described as "quality paternalism and incapacitation of the treating physician" that exploits phy-

sicians and "robs them of their identity" (Armstrong, 2013)[18]. Accordingly, while the introduction of the market logic and the expansion of the state logic have been accepted by the medical profession as the 'state of things' in German health care, the protection of medical work against the intrusion of non-professional logics remains a dominant theme in the political work of the medical profession. The agendas of the German Medical Assembly during the last decade bear witness that economic pressures and external restrictions of medical practice became a key concern of professional politics, covering topics such as the "De-bureaucratization of medical practice" (107th German Medical Assembly, 2004, Bremen) and "The medical profession – a free profession today and in the future" (112th German Medical Assembly, 2009, Mainz).

However, the general increase in economic pressures together with demographic challenges did not only cause institutional complexity through the co-existence of the market logic, the state logic, and the logic of medical professionalism (cf. Freidson, 2001) but also induced a fierce competition between representatives of different professional logics. While in Germany the dominant role of medical professionalism is still widely in place, the shifting focus from medically appropriate to economically efficient modes of service provision gave formerly subordinate professions the opportunity to expand the influence of their professional logic in the field. In particular, the nursing profession strived to enhance their role in German health care from an auxiliary profession, almost instrumental to the enactment of medical dominance, to an equally important professional actor (Klakow-Franck, 2010; Ulsenheimer, 2009). Nurses' professional project included both an expansion of their task spheres within bottom-up initiatives (Bachstein, 2005; Spickhoff & Seibl, 2008; Zimmermann, 2011) and lobbying attempts towards a regulatory redefinition of nursing tasks, including the autonomous provision of formerly medical tasks (Schramm & Hollitzer, 2012; Schramm, 2007) as well as the legal accreditation of a formal code of conduct for the nursing profession (Höfert, 2008). Further motivated by nurses' professional projects in other European countries (Groenewegen, 2008; Sheer & Wong, 2008; Spitzer & Perrenoud, 2006), German nurses sought to integrate their professional logic into the political sphere of German health care by establishing professional bodies (DPR, 2014a), increasing homogeneity and organization within the profession (RbP, 2013), and lobbying for the inclusion of nursing as self-governed profession into the corporatist system on the meso-level (DPR, 2014c; Fleischmann, 2009; Heynemeyer, 2012). While scholars pointed out that German nurses' professional project had only limited success and that the professionalization of nursing is still far less advanced when compared to other European countries (Kuhlmann et al., 2009), nurses' attempts to gain status

[18] Translated from German by the author.

induced considerable inter-professional struggles about task spheres and regulatory boundaries, thus intensifying institutional dynamics on the field-level (Conradi, 2012; Klakow-Franck, 2010)[19].

The situation found in German health care can be described as relatively typical, both with regard to field-level dynamics in modern professional fields and when compared to changes in other Western health care systems (Blomgren, 2003; Dent, 2005; Jespersen et al., 2002; Leicht et al., 2009). As will be further elaborated below, professionals' institutional work in the field-level is often induced by direct environmental pressures (e.g. cost pressures and multimorbid patients) and wider societal changes, in this case the rationalization movement in public services, which create opportunities and threats for professional projects. In German health care, the status of the medical profession was threatened by both, the replacement of professionalism by market logics and nurses' claims to be recognized as equal profession, including their appropriation of formerly medical tasks (Di Luzio, 2008; Spitzer & Perrenoud, 2006). For nurses and other non-medical health care professions, the marketization and economic rationalization of German health care opened a window of opportunity to promote their professional projects as (i) the dominance of medical professionalism was no longer taken-for-granted and (ii) the newly arisen institutional complexity provided additional legitimization accounts (e.g. appeals to economic efficiency) that could be leveraged to institutionalize new roles, structures, and practices (cf. Lounsbury & Boxenbaum, 2013).

How nursing professionals promoted their professional project and how their contextual embeddedness enabled and constrained their effort to expand the influence of nursing professionalism in the field of health care will be discussed in further detail in chapter 4.3. Specifically, this chapter provides an empirical case study on how nurses, physicians, and federal actors employed vocabulary construction as means to promote or prevent change in the logic constellations guiding German health care. Before giving this more detailed account on how nurses and physicians sought to moderate change in German health care, I will provide a concise literature review on when, why, and how professionals generally engage in institutional work on the field-level. Accordingly, the following chapter includes an overview of antecedents and processes of professionals' involvement in field-level change and stability.

[19] A more detailed account of these inter-professional struggles will be provided in chapter 4.3.

4.2 Theory: Professionals' Role in Field-Level Change

As elaborated in previous chapters of this thesis (see section 3.2. and 3.4), the organizational field is the most political context of professionals' work. Here, professionals act as collective agents – e.g. in the form of professional associations – changing their profession and other field-level institutions (e.g. ideas on appropriate organizational forms) through often well-observable political strategies. To fully understand and appreciate the diverse roles that professions and professionals play in the institutional dynamics of an organizational field, it is important to consider when, why, and how professionals engage in the reconfiguration and conservation of logic constellations to disrupt, create, and maintain field-level institutions. Hence, in the following chapter, I will discuss and integrate empirical findings on the antecedents and the processes of professionals' institutional work on the field-level[20].

Early neo-institutionalism emphasizes that actors are embedded in taken-for-granted belief systems that allow for an automatic reproduction of existing institutions but make the active, reflective, and purposeful creation, maintenance, and disruption of institutions an exception (Zucker, 1977, 1987). While current research has loosened the strict assumptions of early neo-institutionalism, embracing the idea that institutional dynamics are often the result of actors' reflective engagement with their social context (Lawrence et al., 2013; Lawrence et al., 2009a), this does not imply that actors continuously or mechanically become active proponents or opponents of institutional change.

As discussed earlier, professionals are often particularly involved in episodes of institutional upheaval on the field-level (see section 3.3) and their professional project has been conceptualized as inherently dynamic process (Abbott, 1988) and thus as endogenous mechanism of field-level change (Suddaby & Viale, 2011). However, active and purposeful engagement in institutional dynamics (as opposed to the habitual reproduction of institutions) commonly presupposes an increase in actors' reflexivity and motivation (Battilana et al., 2009; Heugens & Lander, 2009;

[20] The literature reviews in this and section 5.1 are based on neo-institutional research on professions, professionals, and institutional change between the years 1977, the time of the earliest "neo-institutional" publications (Meyer & Rowan, 1977; Zucker, 1977), and 2014. Specifically, I searched the database Web of Science for empirical and theoretical articles in peer-reviewed journals that contained one of the following keyword phrases in their full text: "profession*" AND "institutional change"; "profession*" AND "institutional entrepreneurship"; "profession*" AND "institutional work"; "profession*" AND "institutional logics". In total, the searches generated 203 articles. In a second step, I excluded any publication that (i) was not a conceptual or empirical research paper (e.g. call for papers or book reviews), (ii) did not refer to the term "institutional" in the sense of organizational institutionalism (e.g. institutional economics), and (iii) only mentioned the search terms in passing. The references of the remaining papers were then searched for recurring citations which were also considered for the following review that focuses on selected, particularly illustrative and relevant studies.

Lawrence et al., 2009a) that is induced or amplified by contextual conditions like wider social developments (DiMaggio, 1988; Emirbayer & Mische, 1998; Garud, Hardy, & Maguire, 2007). Hence, in the next section I will first elaborate on when and why professionals are more likely to work towards change or stability in the logic constellations that guide their profession and the field before discussing the processes through which they eventually generate institutional change and stability.

Antecedents: When and Why Professionals engage in Field-level Change

The antecedents of any actors' institutional work can generally be divided into the ability to reflect upon formerly taken-for-granted institutional arrangements and the motivation to become actively involved in defending existing or promoting new institutions. As professionals are permanently confronted with their embeddedness in a profession which becomes an integral part of their identity (Doolin, 2002; Mitchell et al., 2011; Ogilvie, 2012; Pratt et al., 2006), they are likely to evaluate institutional arrangements on the field-level from both their professional and their organizations' perspective (e.g. the hospital or law firm in which they practice), thus obtaining higher degrees of reflexivity than non-professionals who can fully subscribe themselves to one logic system.

To actually engage in institutional change by combining institutional logics into new constellations to guide an organizational field, professionals, however, do not only need to become aware of alternative logic constellations but also motivated to exert agency (cf. Battilana et al., 2009). Both reflexivity about their institutional context and motivation to promote or hinder change in this context are commonly triggered when a field provides new opportunities or threats for a professional project.

Threats to a professional project may arise when environmental jolts like technological developments (Currie, 2012), changes in the roles and preferences of clients (Wolinsky, 1988), or shifts in wider societal logics (Adler, Kwon, & Heckscher, 2008) question the appropriateness of given institutional structures and practices. Often, it is representatives of the dominant profession who engage in institutional work when they perceive their high status being threatened. Such threats come into existence, e.g. when the status of a specific profession is being challenged by adjacent professions (Allen, 1997; Kitchener & Mertz, 2012) or when the appropriateness of professionalism as organizing principle is being questioned (Scott, 2004; Scott et al., 2000).

Especially traditional professions like medicine, law, or accounting have commonly been conceptualized as being 'under threat' by either adjacent professions who seek to encroach on their jurisdictional monopoly or new templates of organizing promoted by state actors or corporations (Relman, 2007; Thornton et al., 2005). What professional collectives (e.g. professional associations) perceive as threat to their

professional project may range from carefully orchestrated domination strategies of other field-level actors (Ackroyd et al., 2007; Jespersen et al., 2002; Kirkpatrick et al., 2011; Malsch & Gendron, 2013) to such mundane material entities as buildings that may challenge institutional orders through their symbolic meanings (Jones, Boxenbaum, & Anthony, 2013; Jones & Massa, 2013). Yet, threats that induce agency among professionals share their potential to destabilize the logic constellations on which professionals' power rests and hence frequently result in maintenance work (Micelotta & Washington, 2013; Savage & Robertson, 1999).

An illustrative example on how external shocks shifted the relative salience of logics in a field and thereby threatened the position of a profession can be found in the ENRON scandal that culminated in increasing financial and political pressures in the field of accounting and evoked harsh public criticism towards the accounting profession, challenging the appropriateness of accounting professionalism as organizing principle. Several studies have investigated how the aftermaths of this shock lead to a reconfiguration of the field, including the effects on the accounting and the legal profession as two central professions to provide professional business services (Covaleski, Dirsmith, & Rittenberg, 2003; Greenwood & Suddaby, 2006; Greenwood et al., 2002; Suddaby et al., 2007). In particular, accounting professionalism was publicly questioned as it clearly failed to live up to the moral superiority that justified autonomous conduct, leading to maintenance work by professionals who sought to buffer professional autonomy from increasing state regulation (Covaleski et al., 2003: 349).

Yet, threats to a profession cannot be broken down to an archetypical process of shocks followed by external actors challenging the appropriateness of a profession's position in a field or the rationality of their conduct. As the works of Dunn and Jones (2010) and Ramirez (2013) illustrate, environmental jolts and subtle shifts in the wider social environment may cause a 'threat from the inside' when they produce or accentuate heterogeneity within the profession (see also: Lounsbury, 2007; Townley, 2002).

Dunn and Jones (2010) provide a comprehensive study on how different societal, political, and demographic developments interacted to create a tension between the science and the care logics as guiding principles of medical education. They find that external stakeholders as well as subgroups within the profession had different ideas on how future physicians are to be trained. These different stances towards medical education induced a contest between the proponents and opponents of each logic and threatened the consistency of medical education and socialization. The authors illustrate that agency among professionals in the form of in- or excluding the care logic as legitimate guiding principle of medical education was initiated and catalyzed by a variety of contextual conditions. First, health care reforms, an expan-

sion in public health, and an increase in community-based schools to counter doctors shortage between the 1960s and the 1970s led to a stronger emphasis of the care logic in medical education. This caused an increase in women entering the medical profession and, in turn, further strengthened the relevance of the care logic in medicine. The tension between the two available logics was further exacerbated as public health, through jurisdictional competition with professional bodies, increasingly became a "threat to the medical profession" (Dunn & Jones, 2010: 123). Second, specialization in the medical profession both between scientifically-oriented physicians and physicians with a focus on patient care as well as between different clinical subspecialties led to heterogeneous stances towards the proliferation of the care logic. This further reinforced perceived incompatibilities between the science and the care logic in medical education. As the two camps within the medical profession also competed for public funding of their respective medical schools, a 'peaceful co-existence' of two logics seemed impossible within the field and hence fostered institutional work efforts on both sides. However, while the competition between logics created a powerful motivator for medical professionals to engage in institutional work to exclude either the science or the care logic from medical education, both logics persisted in an "uneasy tension" (idb: 139).

Dunn and Jones (2010) illustrate two important points that help understand when and why professionals engage in field-level change. First, their study underlines that 'threats' from the outside of a profession are usually triggered by an interplay between several political and societal developments that cause shifts in the institutional order and introduce new field-level stakeholders that challenge professionals' regulatory monopoly. Second, and perhaps more importantly, their study sheds a critical light on the assumption that professions are homogenous entities, showing that internal stratification can amplify external threats and cause tension in the profession itself. In contrast to neo-institutionalists' conceptualization of professionals as source of field-level isomorphism and the underlying assumption that professionals are "almost interchangeable" (DiMaggio & Powell, 1983: 152; see also section 3.2.1), Dunn and Jones (2010) show that internal stratification and different normative beliefs within professional subgroups may not only occur as temporal incoherence but also persist over time and become a strong motivator for institutional action. While external pressures have been shown to be important drivers of professionals' institutional work, it is tensions between professional subgroups that pose a threat to the internal consistency and hence to the political power of a profession in the field. As the study of Dunn and Jones (2010) demonstrates, professionals' exert institutional work is thus boundary work (see section 3.4.2) in the sense of both, excluding 'outsider' logics (e.g. the state logic) from the profession and balancing different logics within the profession.

How tensions within the profession may motivate institutional work is further illustrated by Ramirez (2013) whose study focuses on how threats to the cohesion of the British accounting profession came into existence when professional subgroups experienced unfair hierarchies within the profession. Specifically, he discusses how wider institutional changes challenge the "orders of worth" (Ramirez, 2013: 845) within a profession and thereby motivate institutional work. For the British accounting profession, such a change occurred through the proliferation of monitoring instruments which reflected the corporate logic that dominated large accounting firms. Professionals from small accounting firms felt treated unfairly as their internal processes more strongly relied on professional peer-control and autonomy and lacked the formalization that was typical for large accounting firms. To prevent internal stratification of the profession and avert the "risk of imploding" (ibd: 836), the ICAEW – as largest British accounting body – began to redefine monitoring practices for small accounting firms to reflect their sense of self-control and their idea of appropriate professional conduct. By re-integrating the professional logic into the newly introduced control mechanisms which reflected a general "accountability turn" (ibd: 851) in professional fields, the ICAEW was able to maintain a sense of community within the profession. Overall, Ramirez' (2013) study further demonstrates that professions may erode from the inside and that the institutional work of collective professional actors like professional associations to secure a professions' dominance within the field may originate from perceived inequality within the profession itself.

In sum, the perception that the profession is being 'under threat' is a strong motivator for professional collectives to engage in institutional work on the field-level. Interestingly, threats, especially to the dominant professions of a field, may originate from the inside of a profession when different subgroups of a profession follow different agendas. These different agendas may translate into fierce intraprofessional struggles when external changes provide additional incentives to work towards the in- or exclusion of specific logics within the profession (see Dunn & Jones, 2010). Yet, as the power of a professional collective within a field strongly relies on their ability to defend their status against external parties (Ackroyd et al., 2007; Child & Fulk, 1982), internal homogeneity is a political resource. Hence, professional associations may exert institutional work to reverse unfavorable logic shifts and repair internal inconsistencies to reduce, as Ramirez (2013: 836) so eloquently put it, their "risk of imploding".

However, while internal coherence is crucial for a profession to become and remain an institution within an organizational field, sociologists and institutionalists alike have emphasized that professional collectives shape fields when they compete over jurisdictional boundaries and corresponding task spheres (Abbott, 1988; Allen, 1997; Fournier, 2000; Martin, Currie, & Finn, 2009; Suddaby & Viale, 2011).

Threats to the profession thus occur and induce agency – mostly among the dominant profession of field – when members of low-status professions and professionalizing occupations claim new areas of expertise and propose new logic constellations that may destabilize another professions' status (Nancarrow & Borthwick, 2005; Snelgrove & Hughes, 2000).

Hence, threats to the status of a profession often arise when members of another profession perceive the opportunity to increase their status within a field. While often two sides of the same coin, perceived threats and opportunities to a profession are distinct stimuli for institutional agency among professional collectives. The opportunity to increase their status may motivate both high- and low-status professions to actively manipulate the logic constellations of a field. Yet, such opportunities are often more relevant to subordinate professions and professionalizing occupations as achieving 'full' professional status is commonly associated with higher gains in autonomy, prestige, and resources than securing and expanding an already dominant position within a field (cf. Abbott, 1988).

Especially professionalizing occupations may perceive an opportunity to gain status when wider societal trends both induce a more reflexive stance towards their subordinate status and provide a context in which professionalization efforts resonate well with shifts in overarching societal logics. Kitchener and Mertz (2012) describe such a situation for the professionalization projects of dental hygienists. Before the 1970s, dental hygienists had regularly been employed in dentist offices and their work had been controlled by dentists as the unquestionably dominant profession in the field of dentistry. However, in the spirit of feminist and civil rights movements that began to shape the American society by the 1970s, dental hygienists, a predominantly female occupation, "began to demand more respect, equality, and rights within the realm of paid work" (Kitchener & Mertz, 2012: 375). While inspired by wider societal trends, their professional project was further catalyzed by economic considerations. With an increase in dentist offices, the field of dentistry began to face an oversupply of dental services. Combined with the recession during the 1970s and the introduction of set-fee-payment systems, dentists had to reconsider their cost-structures. This resulted in part-time work and independent contracting as the predominant form of hygienists' employment, raising their motivation to emancipate from dentists' control. Eventually, hygienists were able to reduce the influence of dentists' professional logic in the field and to successfully institutionalize alternative organizational archetypes that allowed them to autonomously provide dental services in niche markets such as nursing homes.

Kitchener and Mertz's (2012) study illustrates well how several contextual conditions interlock to create a sense of opportunity that motivates professionals to engage in institutional work. First, wider societal developments helped dental hygien-

ists to both recognize that the subordinate position of their profession was neither natural nor inescapable and provided a favorable background against which they could legitimately express their claims for professional autonomy. Second, economic pressures created a sense of urgency that added momentum to their professional project. Third, niche markets provided a space from which hygienists could exclude the professional logic of dentists while not risking harsh opposition in the initial stage of their professionalization efforts[21].

Overall, antecedents of professionals' institutional work on the field-level can be categorized into wider social dynamics like shifts in values and economic developments, intraprofessional dynamics, and interprofessional dynamics that activate perceptions of opportunity or threat among professional collectives. As illustrated by the empirical studies discussed above, professional actors are usually motivated to engage in institutional work when several of these dynamics interact to create a situation in which a professions' status is 'at the crossroads'. Threats and opportunities for the status of a profession do, however, not only relate to its political and economic position in a field but also to its normative consistency. While professionals have been shown to engage in institutional work to establish and defend their profession as a source a of power (Freidson, 1988a; Muzio & Ackroyd, 2005), professions are also a source of identity for the individual professional (Chreim et al., 2007; Fagermoen, 1997). Thus, professionals may engage in institutional work not only in attempts to achieve dominance in a field (cf. Freidson, 1970b) but also to keep their profession aligned with the normative orientation of its members (Goodrick & Reay, 2010). Accordingly, while antecedents of professionals' institutional work can be reduced to whether they induce opportunities or threats to the profession, it is important to note that (i) different antecedents may interact in idiosyncratic ways to foster or hamper professional projects, and (ii) that these may trigger different kinds of opportunities and threats (i.e. economic, political, or ideological). Hence, as also underlined by scholars' focus on in-depth case studies of professional projects (e.g. Covaleski et al., 2003; Dent, 2002; Elston, 1991; Kitchener & Mertz, 2012), professionals' institutional work needs to be studied with a deep awareness of the context in which it takes place.

Having discussed when and why professionals become engaged in institutional work on the field-level, I will now proceed to explain in more detail the strategies and processes through which professional collectives manipulate the logic constellations of a field.

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[21] Similar cases in which wider societal developments created opportunities for professionals to redefine their status within a field were observed in such different fields as French gastronomy (Rao, Monin, & Durand, 2003), U.S. finance (Lounsbury, 2002), and U.S. healthcare (Galvin, 2002).

Processes: How Professionals engage in Field-level Change

As elaborated in the preceding chapters (see section 3.3 and 3.4), professionals are endowed with a distinct set of resources that allow them to take a prominent role in processes of institutional change. In particular, their privileged access to professionalism as symbolic resource as well as political skills acquired from their central position in professional fields bring forth a distinct set of processes through which professionals' manipulate the logic constellations of a field.

Micelotta and Washington's (2013) study on the maintenance work of the Italian registered professions and the legal profession in particular illustrates how professionals make use of their high status and their central position in societies to prevent change within their profession. In their longitudinal case study, the authors provide a detailed account on how the Italian government's enactment of EU-regulation to foster transparency in professional services throughout the European Union failed due to the opposition of the regulated professions. Specifically, Italian professional associations reversed these governmental reforms through what the authors call "repair work".

In Italy, the system of the professions differs considerably from those in Anglo-Saxon countries. First, Italy has a strict hierarchy between regulated and non-regulated professions with the classic professions (e.g. medicine and law) enjoying special protection by the state. These are organized in so-called "Ordini" in which individual professionals have to be registered and which are granted the right of full self-regulation (ibd.: 1142). Second, the legal profession obtains a special status in Italy as it is not only a regulated profession but also centrally involved in governmental processes. For example, their professional association – the National Forensic Council (NFC) – is being "formally consulted in juridical matters and located in Rome at the Ministry of Justice" (ibd.: 1142). Lastly, the authors describe the Italian legal profession as highly conservative, with their codes of conducts prohibiting any market-like coordination of their practice such as the free negotiation of fees (ibd.: 1143). Accordingly, the new laws on the liberalization of professional services – which increased competition and transparency among the regulated professions (e.g. by abolishing fixed fees and allowing advertisement in professional services) – faced strong resistance as they broke the professions' regulatory monopoly over their services. In particular, the governments' quick implementation of these laws without consulting with the professions first was perceived as "simply unacceptable" (ibd.: 1149).

The regulated professions, spearheaded by the legal profession, responded to this regulatory shock with four intertwined forms of institutional work, each of which was aimed at re-excluding the market-logic from the regulation of the professions. The authors identify "re-asserting the norms of institutional interaction" as the first

strategy through which professionals sought to reverse the reforms that had been imposed upon them (ibd.: 1149). This form of institutional work was very drastic and illustrates well how professionals can leverage their central position in society to promote their professional project. The NFC incited their members to go on strike and to organize protests on the street. The resulting upheaval of legal professionals thus became highly visible and critically affected the functioning of the Italian legal system as trials had to be interrupted due to lawyers being on strike (ibd.: 1149). As the authors point out, the protests reached a magnitude that "threatened to paralyze the country" (ibd.: 1143).

However, while lawyers exploited their central position in the Italian society to articulate their disagreement with the reform content and process, they also suggested negotiations with the government to achieve a cooperative revision of the reform. Revealing a conciliatory stance, the government agreed to retract the laws in question and to invite the professions to public hearings before developing new reforms (ibd.: 1150). In the course of these hearings, the Italian regulated professions engaged in what Micelotta and Washington (2013: 1150) describe as "re-establishing the balance of institutional power". While the non-regulated professions supported the planned reforms in order to gain status, representatives of the regulated professions argued for the maintenance of their professional autonomy and the strict separation of regulated and non-regulated professions (ibd.: 1151). Against the background of the government facing an internal crisis at the time of these negotiations, the Ordini began to further substantiate their role as legitimate regulatory institution of the professions by pointing towards the government's current inability to lead a reform process. As representatives of the regulated and non-regulated professions fought over dominance in the reform process, hearings slowed down considerably. Eventually, the government failed to establish its control over the process and the associations of the non-regulated professions started to resign (ibd.: 1152).

The advent of the NFC – as the Ordine of the most influential Italian profession – in the hearings marked a further turning point in the debate. Micelotta and Washington (2013: 1153) describe this episode as "regaining institutional leadership" and note that the NFC's involvement in the process "turned out to be the death blow" for the government's reform plans. Due to its special position in the Italian society, the legal profession was able to successfully argue for their right to develop a separate reform for their profession. The resulting delegation of the reform design into the hands of the NFC enabled the legal profession to regain control over the necessary changes in their profession. In the subsequent process of "reproducing institutionalized practices" (ibd.: 1154), the NFC re-established their regulatory power and autonomy while working around the guidelines of the European Union. Specifically, representatives of the legal profession argued that the commercial values that were promoted in the new EU legislation would jeopardize the integrity of the pro-

fession and put young lawyers in an unfavorable position as they did not have the power to negotiate adequate fees for their services under free market conditions (ibd.: 1155). While the Ordini of the legal profession adapted their codes of conduct, they were accused of "ceremonial compliance" by the EU (ibd.: 115). Interestingly, the NFC urged the government to take their side against the EU and defend the autonomy of the professions. The government, however, remained unwilling to mediate between the EU and the legal profession (ibd.: 1156). In the absence of governmental intervention, the reform was implemented under the authority of the legal profession itself who claimed that the incremental adaptions that had been made showed sufficient compliance with the EU guidelines. Eventually, and despite the EU's pressures to liberalize professional regulation, the Italian legal profession was able to maintain their conservative orientation, including fixed fees and a restrictive advertising policy for legal services.

Overall, Micelotta and Washington's (2013) study makes several interesting contributions to the study of professionals' institutional work. In particular, it shows that – against the background of today's omnipresent pressures towards marketization – professionals remain powerful societal actors: While the Italian legal profession was not able to stop reforms from being implemented, they managed to re-establish their power through what the authors call "repair work".

At the same time, their study shows that professionals' power rests upon the social acceptance of their authority. Specifically, the strategy of "re-asserting the norms of institutional interaction" uncovers that professionals were well-aware of the contingent nature of their power. While their protests and strikes critically affected Italy's legal system, the NFC attempted to reopen negotiations with the government rather than to simply defy regulatory change. As the authors note, this dual strategy of protesting against the changes while trying to open an arena for formal discussion and negotiation stemmed from the NFC's anticipation that they could not push their resistance much further without risking coercive action from the government and thereby jeopardizing their chance to influence the inevitable reforms (ibd.: 1149). Being obviously aware that a profession's authority is of normative nature while the state holds the monopoly over the exertion of coercive power, the Italian legal profession relied more on their ability to dominate negotiations than trying to exert force and risking retribution by the government. Accordingly, professionals leveraged their important role as a pillar of society to defend their right to be 'heard' within the political debates that shape a field. In line with this argument, the authors propose that once the negotiations had been opened, lawyers could draw on their "favorite weapon – rhetoric – to disarm the government's arguments" (ibd.: 1152). Thus, while Micelotta and Washington (2013) illustrate well that professionals' tight embeddedness in fields and their role as pillar of society enables them to force their will upon a field even after regulatory reforms have been implemented, it also

shows that professionals' main strength lies in the provision of normative arguments as to why they should be granted regulatory monopolies over their work. This use of discursive means to promote or resist field-level change is typical for professionals as I will further elaborate in the following paragraphs.

As social scientists have noted, processes of social construction are based upon language (Berger & Luckmann, 2007). Consequently, discursive strategies play a central role in professionals' institutional work on the field-level, starting with the construction of the profession itself as professionals' regulatory monopolies over their work do not emerge from 'thin air' but have to be legitimized (e.g. Martin et al., 2009). While early sociological work from the functionalist tradition suggested that the existence of professions and their associated privileges are a 'natural' function of their socially important services and their inherent morality (Carr-Saunders & Wilson, 1964; Durkheim, 2013), more current research emphasizes the importance of discursively created categories that allow professionals to demarcate themselves from laypeople and members of adjacent professions (Denis et al., 1999; Lamont & Molnar, 2002). In his well-cited study on the discursive construction of the scientific profession, Gieryn (1983) finds that the demarcation of science from non-science rests upon a rhetorical boundary that allows the identification of 'real' science (Gieryn, 1983: 781; see also: Lamont & Molnar, 2002: 178). Similarly, Alvesson (1993: 998) points out that – in the absence of clear-cut criteria for how a profession is to be defined – professionals' status is mainly dependent on the effectiveness of their discursive categorization of themselves as legitimate 'professionals'. As he puts it (Alvesson, 1993: 999):

"Professionals' statements about themselves and, to some extent, researchers' reproductions of such statements, can be understood as elements in their strategies for achieving and maintaining the status of a profession. In line with modern sociology of professions, it is rather claims about having these particular traits that motivate a specific social position and certain privileges, including monopoly of segments of the labour market that are of interest [...].The myths of technocracy, certain knowledge, altruism, rationality and neutrality are seen as ideologies for justificatory purposes [...]."

While becoming a profession is critically dependent on discursively constructing the profession as an institution within a field, professional collectives are also particularly skillful in employing language as a tool to moderate field-level change. As having reached the status of a profession is a particularly valuable symbolic resource for professional collectives (see section 3.4.1), the discursive presentation of institutional change as 'in line' or 'at cross' with their professional logic is central to promoting or preventing change. Ironically, as the studies to be presented in the following will illustrate, professionals may even utilize the symbolic power of pro-

fessionalism to legitimate changes that weaken the impact of their professional logic in the field.

In their case study on the role of professional accounting bodies in the institutionalization of the multidisciplinary practice as new organizational form in the field of professional business services in Alberta, Greenwood et al. (2002) find that professional associations endorsed change by providing discursive theorizations of new organizational templates. Contrary to the popular idea that professionals are conservative forces, Greenwood et al. (2002) show that professionals may promote change even if this change is perceived as a threat to the profession itself. Change in the field of professional business services began as the 'Big Five' accounting firms engaged in multidisciplinary practices that included legal, accounting, management consulting, and other advisory services. As these firms had considerable power within the field, employing over two thirds of public practice professionals (ibd: 63) and 20 percent of all registered accountants (ibd: 70), the accounting profession had little handle on the services these firms planned to offer. Yet, changing accountants' professional role to business advisors and endorsing the new multidisciplinary practice required legitimization within the profession. In professionalized fields, normative legitimization plays a key role to change institutions as institutionalization in these fields depends on whether new practices – often regardless of their technical superiority – are viewed as appropriate against professional values. Accordingly, Greenwood et al. (2002) find that accounting bodies effectively theorized accountants' new role as business advisors in multidisciplinary practices as legitimate by framing changes in the profession as inevitable and by justifying these changes as compatible with professional values. While accounting bodies acknowledged that increasing market pressures would pose a threat to the profession if it did not change, change was presented as an inherent, natural component of the profession. Further, engaging in business consulting was constructed as strongly in line with the characteristically high service orientation and the professional ethos of accounting. Here, accounting bodies clearly drew on professionalism as overarching, societal logic and as general principle on *how* to provide services rather than emphasizing the working *content* of the accounting profession. Interestingly, they enriched their profession with elements of the market logic – in the form of adapting to changed consumer preferences and to the strategic reconfiguration of large firms – by appealing to the key characteristics of professionalism. As the authors point out, the discourse "was conducted in the language of the professional, not that of the businessperson" (Greenwood et al., 2002: 70), implying that accounting bodies utilized appeals to accountants' objectivity and expert status to construct convincing arguments as to why business consulting should be carried out by accountants. Overall, Greenwood el al.'s (2002) work provides an interesting insight into how professionals utilize discursive means to endorse rather than resist field-level

change as it illustrates that professionals' may use language to wrap change into a 'cloak of professionalism', thereby subtly integrating potentially conflicting logic elements into their profession.

In contrast to Greenwood et al. (2002), whose case study showed how professionals engaged in theorization to endorse change within their profession, Suddaby and Greenwood (2005) provide a more comprehensive study on how professionals employ discursive means to control field-level change, including how they build rhetorical strategies to openly oppose change. Specifically, they investigate the discursive struggles between the legal and the accounting profession about the multidisciplinary practice as new organizational form in the field of professional business services. Expanding Greenwood et al.'s (2002) focus on theorization by providing a more detailed analysis on how language is used as a tool to promote and resist change in professional fields, they identify five rhetorical strategies of legitimacy (ontological, historical, teleological, cosmological, value-based), each of which comprises theorization and vocabulary construction. While lawyers sought to delegitimize the multi-professional partnership as it entailed an "expertise model" of professionalism (Suddaby & Greenwood, 2005: 44) that favored elements of the market logic over traditional professional values, accounting associations and large accounting firms promoted the new organizational form by appealing to the consumer benefits that would result from a re-organization of professional work. Both opponents and proponents of change employed institutional vocabularies that uncovered conflicts between their conceptualizations of professionalism. These different stances towards what characterizes – or rather *should* characterize – professional work were then used to (de-) legitimize the new organizational form within theorizations that relied on e.g. appeals to moral values (value-based), a natural order of things (ontological), or greater goals (teleological). While the proponents of change strongly relied on teleological arguments, legitimating the new organizational form primarily with appeals to its effect on service outcomes, opponents drew on ontological theorization in combination with moral vocabularies, emphasizing that laywers' distinct professional ethics are incommensurable with the goal-oriented processes of the multi-professional firm. Lawyers put particular emphasis on their special client-relations that supposedly necessitated 'pure' organizational forms and connected their working ethos to the higher societal purpose of their profession which must not be corrupted by commercial principles like the "one-stop-shopping" (ibd.: 47) promoted in multiprofessional firms. Laywers' appeals to their professionalism as morally superior logic "drew on traditional cultural 'myths' of 'professional identity as a 'higher calling'" (Suddaby & Greenwood, 2005: 49) and is thus in line with what other researchers have identified as popular strategy among professionals to defend their monopoly against external threats (Doolin, 2002; Pieterse et al., 2012; Thomas & Hewitt, 2011). Interestingly, accountants and the

'Big Five' as proponents of institutional change did not dismiss the logic of professionalism as organizing principle but rather sought to redefine professionalism through what Suddaby & Greenwood (2005: 50) describe as effort to "blur the cognitive boundary between profession and market". This finding underlines the general persuasive appeal of professionalism as overarching logic (see section 3.3.2) as well as its power as discursive figure in professional fields: Proponents of change, who clearly promoted a stronger inclusion of market elements into the field, relied on redefining 'good professionalism' instead of openly proposing a market-oriented approach of providing professional services. How proponents and opponents of institutional change in the organization of professional services combined vocabulary construction and theorization further illustrates that legitimization in professional fields rests on the subtle manipulation of social reality and the more visible proposition of how change should (not) be exerted. As Suddaby & Greenwood (2005) point out, the "rationale for change must be connected to the identity of the core actors" who, in this case, were professionals. Accordingly, neither proponents nor opponents questioned *whether* the field should be designed according to professional principles of organizing but rather subtly provided different ideas on *what* professionalism is.

Integrating the findings of the studies presented above, I propose two main reasons why professionals' institutional work is often critically dependent on discursive strategies. First, change within a profession is only achieved when new structures and practices are presented as legitimate against professional ethics as these endow a collective of actors with a distinct identity. As the study of Greenwood et al. (2002) illustrates, this can be achieved by 'wrapping' change into the language of the profession, thereby discursively aligning planned institutional change with the norms and values on which a profession rests. This importance of 'professional language' for the legitimization of changes within a profession is further emphasized by Covaleski et al. (2003). In their study on changes in the U.S. auditing field, they note that large accounting firms effectively utilized a "rhetorical velvet glove" (ibd.: 349) to redefine professional jurisdiction according to financial and political pressures.

Second, the concept of professionalism can be leveraged as powerful discursive figure, either to de-legitimize field-level change as incompatible with professional values or to legitimize change as natural occurrence, in line with the inherent dynamics of professionalism, or even necessary to secure the prosperity of a distinct professional logic within a field. As Suddaby and Greenwood (2005) show, appeals to professionalism may be used to legitimize and de-legitimize the same instance of institutional change at the same time when different actors propose different interpretations of professionalism. The attractiveness and effectiveness of professionalism as discursive figure is rooted in both its high institutionalization in society and

its abstract nature that makes it adaptable to different contexts and applicable to multiple kinds of knowledge-intensive labor (Neal & Morgan, 2000; Wilensky, 1964). As an overarching logic that conveys societal core values like rationality, independence, and social integrity to organizational settings, professionalism as such is widely accepted as a guiding principle in many organizational fields (Hwang & Powell, 2009). Collective professional actors – being representatives of a profession – can easily leverage the discursive power inherent to the general acceptance of professionalism as organizing principle by presenting changes as '(non-)professional' (Fournier, 1999; Jones & Livne-Tarandach, 2008; Turkoski, 1995). However, the details of professionalism in specific contexts are open to interpretation and selective mutation that may foster or restrict the integration of new logics into a professional field. As elaborated above, vocabulary construction is a central mechanism through which professionalism is infused with (new) meanings and hence a particularly relevant aspect to professionals' discursive institutional work (Suddaby & Greenwood, 2005).

Yet, the relevance of vocabulary construction in professionals' institutional work on the field-level is not restricted to the skillful (re-)interpretation and adaptation of what it means to be a 'professional'. Rather, vocabularies have been found to play a central role in the creation of the professions since the construction of distinct vocabularies helps to demarcate professionals form non-professional groups and entities (Gieryn, 1983). Further, vocabularies both reflect and constitute institutional logics (Ocasio, Jeffrey, & Nigam, 2015; Ocasio & Joseph, 2005). Thus, logic constellations within a field can be manipulated by redefining centrals words and phrases, by enriching existent vocabulary structures with new words, and by rearranging words to represent new meaning systems (Loewenstein, Ocasio, & Jones, 2012). Against the background that professionals are endowed with the right to construct specialist vocabularies and to provide laypeople with meaning systems within assigned "spaces of reason" (Schildt et al., 2011: 84), such as health care (for a more detailed description see section 3.3.2), the manipulation of institutional arrangements through vocabulary construction can safely be assumed to be an inherent component of professionals' political skillset.

However, and somewhat surprisingly, there are only few studies that explicitly investigate how professionals construct vocabularies to promote or prevent field-level change (for exceptions see: Lefsrud & Meyer, 2012; Meyer & Hammerschmid, 2006). Vocabularies, when acknowledged as discursive means in institutional work, are mostly viewed as only parts of 'full' legitimization strategies that comprise an explicit argument structure (Jones & Livne-Tarandach, 2008; Suddaby & Greenwood, 2005). Thus research is often overlooking the subtle, yet powerful influence of vocabulary construction on the logic constellations that guide a field (Ocasio & Joseph, 2005). Further, while the "linguistic turn" in the social sciences

(Alvesson & Karreman, 2000) has produced a plethora of studies on how field-level actors like professional collectives use language to (de-)legitimize change (Ahearn, 2001; Astley & Zammuto, 1992; Hardy & Maguire, 2010; Hardy, Palmer, & Phillips, 2000; Lawrence & Phillips, 2004; Maguire & Hardy, 2009; Oakes, Townley, & Cooper, 1998), language is mostly viewed as a strategic tool which political actors skillfully employ to manipulate the legitimacy of existing or new institutional arrangements (Ackroyd, 1996; Erkama & Vaara, 2010; Golant & Sillince, 2007; Green, 2004; Hardy & Phillips, 2004) with only few authors paying explicit attention to the constraining effects of language on institutional agency (Green, Li, & Nohria, 2009; Hardy & Phillips, 1999).

The lack of studies on how professional construct vocabularies to manipulate logic constellations in a field and institutionalists' particular emphasis on language as an *enabler* of agency creates a gap in the literature on professionals' role in field-level change. Specifically, the question on how professionals' institutional work is both enabled *and* constrained by language – vocabularies in particular – remains under-researched. This shortcoming is certainly also owed to the underlying notion that professions are equal regarding their access to discursive strategies of institutional work. While researchers acknowledge that professionals – when compared to non-professionals – are particularly skilled in using discursive strategies (Suddaby & Viale, 2011: 435), interprofessional hierarchies within a field have yet to be included as contextual condition that may shape how different professionals' construct vocabularies to promote or prevent institutional change. Accordingly, the study presented in the following chapter provides a critical discourse analysis investigating how actors of different status in the field of German health care employed vocabulary construction as a discursive strategy to disrupt or maintain medical dominance.

4.3 Empirical Study 1: Vocabularies as Enablers and Constraints in Institutional Work - Establishing New Modes of Task Division in German Health Care

The following study seeks to expand our perspective on professionals' discursive institutional work by drawing attention to the strategic construction of vocabularies[22]. Focusing on the professional project of nurses in German health care, this study provides a typical case of professionals' institutional work insofar as it illustrates political struggles between high-status and low-status professionals that were induced by wider field-level developments like increasing cost pressures and demographic challenges. For nurses, as low-status professionals in German health

[22] Earlier versions of this study have been presented at the EGOS Colloquium 2013 in Montreal, Canada and the 1st First Austrian Young Scholars Workshop in Management 2013 in Linz, Austria.

care, this situation provided an opportunity to promote their professional project as the dominance of the medical logic began to erode. For physicians, who already lost some of their privileges due to the expansion of market and state logics, nurses' attempt to further professionalize by claiming medical tasks posed an additional threat to their professional status and thus evoked strong resistance. Moderated by state actors who endorsed new modes of task division as means to secure efficiency in public health care, nurses and physicians engaged in a fierce struggle about the boundaries of their task spheres (see also section 4.1).

Focusing on how the institutional work efforts of each of the involved field-level actors was enabled and constrained by language, this study identifies three strategic patterns of vocabulary construction: (1) spanning vocabulary spaces, (2) analyzing vocabulary spaces and (3) neutralizing vocabulary spaces. The findings suggest that actors' relative field status determines the choice of the strategic mode of vocabulary (de-)construction. A tentative interpretation of these findings further suggests that low-status actors engage in 'bounded boundary work' as they try to promote new logic constellations within given vocabulary structures. Overall, this study expands extant literature on professionals' institutional work on the field-level by drawing attention to vocabulary construction as a subtle discursive strategy while acknowledging that not all actors are equally enabled and constrained by language when engaging in institutional work.

4.3.1 Introduction

How do political actors in professional fields make use of vocabulary structures to promote or inhibit institutional change? This study seeks to answer this question by examining the discursive struggles on the redivision of medical tasks in German health care. While the notion that processes of social construction are based upon language is not new (Berger & Luckmann, 2007) and the strategic use of language in institutional work efforts has increasingly received scholarly attention over the past years (Erkama & Vaara, 2010; Goodrick & Reay, 2010; Hardy & Phillips, 2004; Maguire & Hardy, 2009; Maguire et al., 2004; Phillips, Lawrence, & Hardy, 2004), the majority of research focuses on the enabling effects of coherent narratives (e.g. Zilber, 2007) and explicit means of persuasion (e.g. Suddaby & Greenwood, 2005). Vocabulary construction as means of institutional work has so far received less attention. This is surprising insofar as the study of vocabulary construction holds significant potential to help "examine the puzzle of institutionally embedded agency" (Green & Li, 2011: 1690). On the one hand, vocabulary structures are constitutive elements of institutions (Loewenstein et al., 2012; Ocasio et al., 2015; Phillips et al., 2004) and hence provide constraints to agency. On the other hand, vocabularies are carriers of meaning, thus making their skillful restructuration a powerful source of agency (Jones & Livne-Tarandach, 2008;

Loewenstein, 2014; Suddaby & Greenwood, 2005). Further, agents may specifically draw on the constraining effects of vocabularies to dominate discursive struggles, as the case study on the redivision of medical tasks in German health care will illustrate. The extent to which actors are enabled and constrained by vocabularies is likely to depend on their relative field status. As Maguire et al. (2004) observe in their study on the emergence of HIV/AIDS treatment advocacy, the particular subject position that actors obtain within a field determines the discursive means available to them and hence their potential of agency. The insight that actors' relative field position affects their access to vocabulary construction as means of institutional work is particularly relevant for professional fields like health care. While researchers have pointed out that professionals are particularly skillful in using discursive strategies as the construction of specific vocabularies is an inherent part of achieving and maintaining the status of a profession (Loewenstein, 2014; Schildt et al., 2011), they rarely account for the fact that not all professional groups enjoy the same status within a field (Battilana, 2011; Kirkpatrick et al., 2011). Accordingly, professionals may not only provide specific vocabularies to shape the meaning systems of a field but may also be constrained by given vocabulary structures.

The goal of this study is hence to (i) explore the enabling and constraining effects of vocabulary structures in the discursive struggles of institutional change episodes and to (ii) examine to which extent the relative field status of an actor is associated with the availability of certain kinds of vocabulary construction in order to answer the question on how different actors make use of vocabularies to promote or inhibit institutional change in a professional field. My study makes two contributions to extant literature. First, it provides a new perspective on discursive institutional work by drawing attention to the construction of vocabularies as strategic means of dominating a discourse beyond the provision of coherent legitimization accounts. In doing so, it addresses explicit calls to study the complex processes of institutional change and maintenance from the perspective of meaning systems that are constructed through vocabularies (Zilber, 2008: 164). Second, I identify three distinct strategic patterns of vocabulary construction which actors employ in the political struggle about changes in the regulatory boundaries between health care professions, thus illuminating how the relations between different professions in a field are shaped by their use of vocabularies. The strategic pattern of 'spanning vocabulary spaces' is mainly employed by federal actors and physicians, both high status actors in the field of health care. By 'spanning vocabulary spaces' actors are able to determine the object – or the 'what' – of the debate apart from and beyond explicit reasoning about the legitimacy of this object. As the findings indicate, high-status actors are only successful in providing the vocabulary structure to the field-level discourse when their vocabularies are sufficiently specific with regard to the object of the debate. The strategic pattern of 'analyzing vocabulary spaces' is mostly used

by nurses as low status actors of the field. By analyzing the vocabulary structure provided by physicians, nurses sought to de-legitimize these actors by uncovering the 'true' motives behind physicians' use of particularly distinct vocabulary structures. The findings suggest that, while analyzing opponents' vocabulary structure may enable actors in creating specific counter-arguments, low status actors risk to get 'caught up' in the vocabulary structures provided by other actors. Finally, the strategic pattern of 'neutralizing vocabulary spaces' was used by federal actors after the debate on the redivision of medical tasks reached a deadlock. Neutralizing the existing vocabulary spaces included the provision of new categories to describe task-redivision that were able to integrate previous categories while being sufficiently precise to redefine the object of the debate with a less value-laden term. Overall, my study underlines that, while the development of arguments and counterarguments is an important means to (de-)legitimize new institutional arrangements, the provision of vocabulary spaces might be an equally powerful instrument to dominate a debate as these help define the *objects* of (de-)legitimization efforts. As vocabulary structures reflect and constitute power relations in a field, the provision of vocabularies is a source of power while the usage of an actor's vocabulary structures acknowledges and reinforces his right to provide the meaning system of a field. This insight provides a new perspective to the study of professionals' institutional work: While profession sociologists have emphasized that professionals have to constantly defend their jurisdictional and workspace boundaries against representatives of adjacent professions (Abbott, 1988), this study highlights that boundary work is not necessarily a struggle among equals as low-status professions may draw on and thereby reinforce high-status professions' definitional power in the field. Their attempt in expanding their (regulatory) boundaries may thus be 'bounded' due to their inability to provide meaning systems of their own.

4.3.2 Theoretical Background

Discursive Institutional Work: Vocabularies as Enablers and Constraints of Agency

Institutional work comprises actors' more or less purposeful attempts of "creating, maintaining and disrupting institutions" (Lawrence & Suddaby, 2006: 125). While several scholars have explored a substantial number of conditions enabling institutional agents (specifically 'institutional entrepreneurs') to challenge the institutional status-quo and illustrated a broad spectrum of strategies these actors employ to shape institutions according to their interest (Battilana et al., 2009; Lawrence et al., 2009a), it has often been criticized for depicting these actors as overly reflective "heroes" (Battilana et al., 2009: 67). As a special kind of powerful agents, able to challenge the very institutions that constitute their norms and beliefs, they represented the polar opposite of the highly embedded and passive "cultural dope" proposed by structural institutionalism (Leca & Naccache, 2006: 633). Institutional

work scholars promote a more balanced view on the dichotomy between structure and agency (Lawrence et al., 2011), often conceptualizing institutional change as outcome of multiple actors' dispersed efforts (Lounsbury & Crumley, 2007). In this view, institutional change episodes are usually characterized by emergent processes of negotiation, bargaining, and conflict between change agents and their opponents rather than the result of a linear change process implemented by a single or few powerful agents. These processes of "interpretive struggles" (Hardy & Maguire, 2008) come into existence through disruptive and creative institutional work on the one side and maintaining or otherwise creative institutional work on the other and are majorly influenced by the purposive use of discursive practices (e.g. Zilber, 2002). Actors employ rhetorical means of persuasion (Greenwood & Suddaby, 2005; Goodrick & Reay 2010), coherent narratives (Hardy & Maguire, 2010) and specific frames to give sense to actions and alter meaning systems (Benford & Snow, 2000). Yet, opponents may use discursive tactics equally skillful to maintain the institutional status-quo or argue for a different kind of institutional change, making discursive struggles neither "predictable [n]or controllable" (Hardy & Maguire, 2008: 205). While language can be considered to be one of the key resources to any kind of institutional work and politically skilled actors often appear to be masters in exploiting discursive practices (Oakes et al., 1998), language – as a constitutive element of institutions – also puts considerable constraints on human agency (Green et al., 2009). Green and Li (2011) recently coalesced this dual function of language into a promising new research stream in institutional theory. "Rhetorical institutionalism" provides a new perspective on embedded agency by integrating old and new rhetoric. For Green & Li (2011:1678) actors are embedded in systems of meaning created by "historical symbolic action" which provide structural constraints to rhetorical acts of persuasion. In this understanding, structure is not exclusively defined by material practices and 'real' entities of social life. Rather, it is also language that drives actors' unconscious perceptions of "social structure, relations and reality" (Green & Li, 2011: 1674). Hence, language itself is a powerful form of practice that defines institutional boundaries and thereby imposes structural constraints on agency. Agency, in turn, exists whenever actors become aware of the symbolic networks of meanings that constitute institutional logics and try to purposefully maintain or manipulate them.

Extant research in discursive institutional work mostly focuses on the use of coherent argument structures that are aimed at legitimizing or de-legitimizing institutional change (e.g. Goodrick & Reay, 2010; Hardy & Maguire, 2010; Zilber, 2007). Often, these argument structures are distinguished by the explicit rhetorical means of persuasion they employ (e.g. Brown, Ainsworth, & Grant, 2012; Erkama & Vaara, 2010; Green, 2004). However, episodes of institutional change are also shaped by the subtle networks of meaning that come into existence through the cre-

ation and manipulation of vocabularies which are not necessarily embedded in complete legitimization accounts (Loewenstein et al., 2012).

Vocabulary structures are constitutive elements of institutions (Phillips et al., 2004). They are the building blocks of collective social rules (Loewenstein et al., 2012) as they describe the motives which are considered "desirable, proper, and appropriate" (Suchman, 1995: 574) within the boundaries of an organizational field. It is vocabularies that define meaning systems, render institutional logics visible and, as integral part of organizational fields, become institutions themselves (cf. Ocasio & Joseph, 2005). Loewenstein (2014) defines vocabulary structure as a combination of word frequency, word-to-word and word-to-example relations. Word-to-word relations describe how words are typically linked to each other within discursive acts like speeches or written statements. Word-to-example relations specify how words are to be interpreted and used as general classifications for a larger range of theoretical or empirical phenomena. Together with the frequency of specific key words these vocabulary networks "[demarcate] a system of cultural categories" (ibd.: 42).

The constraints that vocabularies exert on institutional agency are both cognitive and strategic. First, as a field's vocabularies become institutionalized through a field's ongoing discourses, words and meanings are increasingly taken for granted and unconsciously reproduced by a field's actors (Phillips et al., 2004). For example, in their study on the institutionalization of Total Quality Management among 56 of the largest U.S. industrial companies, Green et al. (2009: 23) observe "that the words 'cost' and 'waste' were virtually used interchangeably" by managers as the existence of a direct link between waste reduction and a decrease in production costs has become unquestioned. Schildt et al. (2011: 82) summarize the process through which vocabularies exert cognitive constraints on actors and hence impede agency as follows: "[I]ndividuals use institutionalized vocabularies to reason about their choices and understand their context with limited understanding of how and why these structures have become what they are."

Second, even if actors become aware of the meaning systems provided by vocabulary structures – this may result from environmental jolts or inherent contradictions in the often multiple logics of a field (Seo & Creed, 2002) – the use of a field's vocabularies represents a crucial strategic precondition for effective institutional work. New institutional arrangements can only acquire legitimacy if they connect to a wider set "taken-for-granted beliefs and values" (Zilber, 2007: 1050), i.e. institutional logics. Institutional logics "encode the criteria of legitimacy by which role identities, strategic behaviors, organizational forms, and relationships between organizations are constructed and sustained" (Suddaby & Greenwood, 2005: 38). Actors need to draw on existing "standard vocabularies and legitimate accounts"

(Meyer & Hammerschmid, 2006: 1005) to establish the indispensable connection between new organizational forms, professional roles or practices and the overarching institutional logics of a field (Loewenstein, 2014; Loewenstein et al., 2012). Put more simply, the acquisition of legitimacy presupposes comprehensibility and appropriateness against the background of a field's meaning systems. While cognitive and strategic constraints limit actors' potential to diverge from a field's vocabularies, the skillful re-structuration and enrichment of existing vocabularies may enable actors' institutional work efforts considerably. As "[s]hifts in meaning are both reflective of changing environments and contributors to institutional change" (Loewenstein et al., 2012: 53), iterative change in vocabularies may not only reflect a change in underlying logics but also bring about this change. Further, and perhaps more importantly, agents who succeed in controlling the meanings of contested practices through vocabulary construction constrain opponents within the discursive struggles of institutional change episodes (cf. Zilber, 2007). By finding new examples for categories and connecting words to new idioms, agents "infuse structures and practices with meaning" (Zilber, 2007: 1050). Opponents must reflect upon these meanings and redefine corresponding words to be able to purposefully deploy these words in their arguments. Hence, the extent to which actors are enabled by vocabularies depends on their skills in anticipating key words in field-level debates as well as their ability to expeditiously arrange meaningful vocabulary structures around them.

Discursive Institutional Work in Professional Settings: Creating Boundaries

As elaborated above, the legitimization and de-legitimization of new institutional arrangements generally relies on the use of language as it is language which infuses structures with meaning (Loewenstein et al., 2012; Ocasio et al., 2015; Ocasio & Joseph, 2005). In professional settings, discursive means of institutional work are of particular importance and professionals have been found to be "skilled rhetoricians" (Suddaby and Viale, 2011: 435). This is the case because the creation and maintenance of professions relies strongly on the construction of discursive boundaries between different categories, particularly the distinction of expert versus laymen work (Fournier, 2000). To be able to claim regulatory power over specific areas of expertise, professionals need to convince the state that their work is special and important to society and thus eligible for formal mechanisms of protection (Larson, 1979). They do so by constructing a meaning system around their profession that differentiates them from non-professional actors with regard to their knowledge and their moral integrity (Fournier, 1999; Suddaby & Greenwood, 2005; Thomas & Hewitt, 2011; Turkoski, 1995). This kind of boundary work is inherently reliant on processes of discursive construction, as, for example, Gieryn's works (1983, 1999) on the scientific profession illustrate. He concludes that the "cultural authority" that the scientific profession enjoys is the result of the successful "discursive attribution

of selected qualities to scientists, scientific methods, and scientific claims for the purpose of drawing a rhetorical boundary between science and some less authoritative residual non-science" (Gieryn, 1999: 4-5).

This cultural authority of professionals is, however, not only the result of successful persuasion but also relies on the creation and maintenance of specific vocabularies. Such professional vocabularies constitute and demarcate "spaces of reason" (Schildt el al., 2011: 84), that is, domains of knowledge in which professionals are granted definitional authority. Loewenstein (2014: 3) points out that vocabularies are "accounts of professions' specialized knowledge". As such, they foster the development of professional identity through a common language that facilitates the enactment of professional practices (ibd.: 4-5). At the same time, using specialized vocabularies and having the authority to define meaning systems by the development of specific vocabularies helps professionals to differentiate themselves from other professional and non-professional occupations. Being able to define specific words (e.g. "heart attack", "criminal", or "care") adds to professionals' "'ownership' of a social problem" (Åkerström, 2002: 531) that eventually translates into a regulatory monopoly and endows professionals with the capacity to exclude non-professionals from engaging in their areas of expertise. While professionals may lend those vocabularies to non-professional actors, they remain in charge of defining the respective words and building meaningful relations between them (Loewenstein, 2014: 6). This division of discursive labor (Loewenstein, 2014; Putnam, 1975; Schildt et al., 2011) enables professionals to exert influence in their organizational fields and makes them skillful in the construction of vocabularies.

However, while any profession is endowed with a specific area of expertise around which they are expected to construct specific vocabularies that embody their expert knowledge, not all professions are equally able to provide vocabularies to structure the general discourses of their field. This, as I will show in the course of this study, is especially true for the low-status, or 'semi'-professionals (Etzioni, 1969) of a field who still struggle to acquire full professional status. Accordingly, in the next section I will first elaborate on how the relative position of political actors in a field may affect how their institutional work efforts are enabled and constrained by the use of vocabulary structures.

Field position and Discursive Institutional Work

How actors use language and how they are used by language (Green & Li, 2011) is likely to depend on their relative position within a field. Generally, "different actors have differential capabilities and resources to exercise power based on their subject position in the relevant field" (Zilber, 2007:1037). Specifically, actors' position in a field determines to which extent they are able to exert discursive power. By processes of social construction, actors acquire the right to legitimately participate in a

discourse, i.e. the right to 'be heard' within a field (Hardy & Phillips, 2004). As the high status of central actors in a field is conducive to the "acknowledgment and 'consumption' of their discourse by other actors" (Battilana et al., 2009: 84), these actors are endowed with the power to determine the frames through which material reality is infused with specific meanings (Hardy & Phillips, 2004). However, as noted above, the discourses through which actors exert institutional work are notorious struggles and field positions may change as discourses evolve. Also, subject positions that grant actors legitimacy in the eyes of several stakeholders may supersede hierarchical status and endow actors with specific discursive resources that are unavailable to other actors (Maguire et al., 2004). Furthermore, having "a louder voice" (Hardy & Phillips, 2004: 4) within a field's discourse does not imply that these actors are immune to the constraining effects of institutionalized vocabularies. Institutional scholars have repeatedly emphasized that any agency is embedded (Holm, 1995), agents are not "hypermuscular" (Suddaby, 2010: 15), and discourses are "not infinitely pliable" (Hardy et al., 2000: 1228). As Battilana et al. (2009: 76) note, actors' social position within a field does not only determine their access to resources and hence their relative power to establish new institutional practices but also their perception of a field. High status actors obtain their status through their central position in a field. This centrality implies a high degree of embeddedness in a field's taken-for-granted meaning systems. As elaborated above, these systems of meaning are constituted by vocabularies. Hence, while high status actors are supposedly skilled in deploying discursive means and are – due to their high legitimacy within a field – more likely to inform the overall discourse, they are also more likely to draw on institutionalized vocabulary structures due to cognitive constraints resulting from their embeddedness in the field. Low status actors, on the other side, are "less privileged by the prevailing institutions" (Battilana, 2011: 817) and hence more likely to envision and pursue a redefinition of the prevalent meaning systems within a field by manipulating the vocabulary structures of a field's discourse. However, as low status actors are endowed with considerably less legitimacy than high status actors they will have to put considerable effort into 'being heard' in a field's discourse. Accordingly, low status actors are more reliant on connecting their ideas to the overarching institutional logics of a field by strategically drawing on a field's dominant vocabularies. So, while high status actors are likely to face the cognitive constraints arising from institutionalized vocabularies, low status actors may be more able to envision and create innovative word-to-word and word-to-example relations. Yet, to strategically enhance their legitimacy and obtain the 'right to speak' in a field's discourse, low status actors will need to build their arguments on vocabularies that noticeably reflect a field's central logics. In conclusion, how actors' relative field status relates to their deployment of vocabulary structures as means of institutional work is ambiguous and depends on the interac-

tion of cognitive and strategic constraints with actors' chance to 'be heard' in a field's discourse. How the relative status of federal and professional actors affected their use of vocabulary structures to promote or prevent institutional change in the field of German health care will be examined in the following section.

4.3.3 The Redivision of Tasks in German Health Care

The health care sector is a particularly suitable setting for studying the construction of vocabularies as means of discursive institutional work against the background of different actors' field positions for several reasons. First, the health care sector is an organizational field that is not only strongly shaped by professions (Currie et al., 2012; Freidson, 1970b, 1970a, 1988b; Kitchener & Mertz, 2012; Relman, 2007; Saks, 2014; Scott et al., 2000) but is also characterized by high status differences. Specifically, most Western health care systems – despite increasing state involvement and marketization – are still shaped by the dominance of the medical profession (Currie et al., 2012; Di Luzio, 2008; Thorne, 2002). The status differences between physicians and nurses are a good example for the professional hierarchies that characterize health care (Salhani & Coulter, 2009). In Germany, where nursing training does not regularly include an academic degree, these status differences are particularly high (Dent, 2002). Further, the creation of special vocabularies as a means to develop and defend areas of expertise, which are the foundation to a professions' regulatory boundaries and status, has been found to be particularly relevant in the field of health care (McIntyre, Francis, & Chapman, 2012). Explicit calls for health care professions to develop and enact common vocabularies bear witness of the importance of language as a means of institutional agency in this field (Dixon, 1983). Accordingly, political actors in this field – professions in particular - can be assumed to be skilled in employing discursive strategies (Suddaby & Viale, 2011). This makes the field of health care highly suitable for linguistic analyses as even subtle patterns of vocabularies are unlikely to be incidental. Lastly, drawing on the context of German health care for the study of the enabling and constraining effects of vocabularies on institutional agency also has pragmatic appeal. Due to high levels of legal regulation and the highly institutionalized practice of joint self-government in German health care, discursive struggles between professional actors often take place in public, are usually well documented, and thus readily accessible to research.

Setting

In Germany, the delegation of low-risk medical tasks to nurses has always been a usual approach to secure prompt and continuous patient care in clinical practice. Within this task division, nurses were so far mostly perceived as ad-hoc assistants to physicians rather than health care professionals of their own. Accordingly, legal

plans to grant nurses the right to autonomously provide medical care, which, in legal terms, depicts a 'substitution' of medical tasks (as opposed to a 'delegation' that leaves decision rights with physicians) represented a major shift in the German health care sector that had long been dominated by the medical logic. Table 4.1 gives a brief overview over the key events in this episode of institutional change.

Table 4.1: Key Events in the Negotiations on the Redivision of Medical Tasks in Germany

Date	Event
07/2007	Publication of the report "Cooperation and Responsibility - Prerequisites for Target-Oriented Health Care" by the Advisory Council on the Assessment of Developments in the Health Care System (SVR), arguing for a redivision of medical tasks between physicians and other health care occupations such as nurses
07/2008	Passing of the Long-Term Care Further Development Act which generally allowed the autonomous provision of medical treatment by nurses and other non-medical occupations within pilot programs
10/2011	Proposal for a directive on the design of pilot programs by the Federal Joint Committee (G-BA), the highest institution of the German joint self-government of physicians, hospitals, and health insurances
03/2012	Commencement of the proposed directive on the re-allocation of medical tasks within pilot programs

4.3.4 Data and Methodological Approach

Sources of Data

The case study is based on several types of archival data. The data used in the analysis mainly consist of official documents such as reports and public statements. These were supplemented by conference protocols, comments, and articles of the respective professional or federal organization and their representatives. All archival data were collected searching the websites of the central federal, physician and nursing (umbrella) associations for documents including articles, statements, summaries, and comments on the topic of rearranging professional responsibilities. Specifically, I included publications of the Federal Joint Committee (G-BA) and the Advisory Council on the Assessment of Developments in the Health Care System (SVR), publications of the German Medical Association (BÄK), and publications of the German Nursing Council (DPR).

The G-BA is the highest institution of the German joint self-government of physicians, hospitals, and health insurances and hence obtains a high status within the field of German health care. While the G-BA includes physician representatives it is subordinated directly to the Federal Ministry of Health and strictly obliged to make neutral decisions. The SVR, as second federal association included in the analysis, is responsible for the preparation of reports on current challenges and options for the further development of German health care. While the SVR itself does not possess any decision rights of its own, it is considered a central association within the German health care sector and its reports are usually much-quoted. Accordingly, the SVR obtains a high status within German health care. Both the G-BA and the SVR are representing federal interests. The BÄK is the umbrella associa-

tion of medical self-government and represents the professional interests of German physicians. Within the (still) physician-centered German health care system, the BÄK obtains a particularly high status which is derived from the profession they represent. Kuhlmann (2006: 69), in her comprehensive study on recent changes in German health care points out: *"Physicians have overwhelmingly high social status and belong to the peak earners among academics [...]. They face the advantages of state-regulated and limited access to medical schools and markets, in particulars SHI care"*.

As umbrella association of German nurses and midwifes, the DPR represents a group of low status actors in the field of German health care. While in Germany, nurses strive for an increased academization of their occupation and their recognition as a full 'profession', their status is still lower than in most European countries (Dent, 2002).

The search of the respective websites was conducted using the German translations to the search terms "delegation", "substitution", "rearrangement", "reallocation", and "transfer" as these were the main labels under which a redivision of medical tasks was discussed. Duplicates and information irrelevant to the redivision of tasks between physicians and nurses (e.g. evaluations on the usefulness of "methadon *substitution*") were removed. Overall, 112 documents could eventually be included in the analysis. To gain additional insights into the overall discourse in which the respective statements were embedded, I conducted a supplementary literature review focusing on articles and reader comments in practitioner journals.[23] Often, texts become meaningful only in their relation to other textual material (Phillips et al., 2004). Hence, locating specific texts in a wider discourse is of particular importance when studying practices of institutional work as social reality is constructed through collections of texts and the linkages between them (Leitch & Palmer, 2010; Phillips & Hardy, 2002). Table 4.2 provides an overview of the actors and publications included in the analysis.

Table 4.2: Actors and Data

Field-level actor	**Representing organization**	**Position within the field of health care**	**Number of publications included in analysis**
Federal Actors	Federal Joint Committee (G-BA)	High status actor	**12**
	Advisory Council on the Assessment of Developments in the Health Care System (SVR)	High status actor	**6**
Physicians	German Medical Association (BÄK)	High status actor	**58**
Nurses	German Nursing Council (DPR)	Low status Actor	**36**

[23] For pragmatic reasons I only included the search terms „delegation" and "substitution" combined with several synonyms for "medical tasks" in a google scholar search. Overall, 79 additional articles in practitioner journals and other publications (e.g. press releases) were read in detail.

Valuable background information was provided by 17 semi-structured interviews with nursing directors and executive nursing specialists conducted as part of a larger research project on the redivision of medical tasks within university hospitals. All of the interviewees were members of a central nursing association and hence familiar with current field-level discourses. The additional information gained from these interviews facilitated the interpretation of official texts and the unavoidable "reading between the lines" when studying the strategic use of language (Erkama & Vaara, 2010: 822).

Method

The methodological approach taken here is based on a critical discourse analysis that is supplemented with content analytical methods. Generally, critical discourse analysis (CDA) is particularly suitable for the study of language-based institutional work as its main focus lies on the study of social phenomena like the exertion of power rather than the textual units per se. Furthermore, most CDA scholars agree that discourse is "determined by social structure and contributes to stabilizing and changing that structure simultaneously" (Wodak & Meyer, 2009: 7). Putting a stronger focus on human agency and power relations, CDA better lends itself to the study of institutionally embedded agency than classical discourse analysis (Green & Li, 2011; Phillips & Oswick, 2012). Vaara, Sorsa, and Pälli (2010: 688) summarize CDA as "specific discourse analytic methodology that examines the role played by language in the construction of power relationships and reproduction of domination". However, critical discourse analysis does not offer a systematic framework for analyzing smaller parts of a discourse like vocabularies. Content analysis, on the other side, provides specific tools for text analysis but is criticized for decontextualization (Duriau, Reger, & Pfarrer, 2007). Combining both analytical approaches allows for an in-depth analysis of vocabulary construction as instrument of institutional work while accounting for the context, specifically actors' field position, in which the discursive strategy is embedded. In preparation of the in-depth analysis of text material published by the organizational actors involved in the renegotiation of task responsibilities in German health care, I conducted a screening of the overall material collected to gain a coarse overview of major themes and critical events shaping the discourse. The actual coding of the text material was carried out using the content analysis software MaxQDA (Kuckartz, 2011). Coding included several stages, the most important of which are discussed below. First, I divided the material according to institutional actor and year of publication. In fact, some documents published on the website of a federal, physician or nursing organization had to be assigned to another organizational actor as they were part of a larger collection of official statements or used in reference to statements by other actors. Further organizing of the material by year was of particular importance as it allowed tracing the development of vocabularies structures with regard to their enabling and constrain-

ing effects on the overall discursive struggle. The second step of the coding involved the inductive characterization of vocabulary structures. In line with Loewenstein et al.'s (2012) framework, characterizing vocabulary structure included the identification of central words used by the respective actors as well as the uncovering of linkages between these words and the word-to-examples relations. The coding approach taken here was very iterative, and included constant going back and forth between word categories and textual material. The final coding comprised 32 word categories such as 'substitution', 'qualification' or 'non-medical' that were later summarized to the three broader categories 'modes of task redivision', 'reasons and effects of task redivision' and 'change in the professions'.

Text excerpts were assigned to a code according to the central vocabularies used within the paragraph. Yet, as a key feature of vocabulary construction is the creation of word-to-word and word-to-examples relations, paragraphs were often assigned to two or more categories. The findings of the analysis are presented below.

4.3.5 Findings[24]

The discursive struggle about the redivision of tasks in the German health care sector is characterized by two major themes around which the involved parties arranged specific vocabulary structures. Namely, these themes were 'current challenges in health care' and 'modes of task redivision'. All actors agreed that the provision of high-quality health care to patients in the face of an aging society was one of the major challenges in German health care. This consensus manifested in the frequent use of idioms that included the word 'provision (of health care)' and 'patient'. The word 'provision (of health care)' can be found at least once in 76 percent, the word 'patient' in 71 percent of all documents in the analysis[25] with no obvious differences in the frequency of use between physician, nursing or federal associations. This focus on the 'provision (of health care)' and the 'patient' is not surprising as it reflects the dominant goal of the organizational field: the provision of health care to patients as overarching task (cf. Reay & Hinings, 2009: 633). A lack of concern about the provision of health care to society would have disconnected actors from the field's discourse. In Germany, the discourse in the field of health care is primarily shaped by its tradition of universal health care that promotes equal access of all citizens to high-quality health care (Bode, 2015). Hence, the inclusion of these words and their underlying meanings can be interpreted as necessary precondition to identify as a legitimate member of the field and, as such, a dis-

[24] Text excerpts presented in the following have been translated from German by the author.

[25] As the publications of the different institutional actors differ considerably in length and quality (ranging from conference protocols to official recommendations), I refrained from counting absolute word frequency. Reporting absolute word frequencies might have led to the misimpression that specific words and idioms that were used repeatedly within single or few publications were central to the discourse.

cursive constraint by which all actors were equally affected. Yet, how the challenge of securing the provision of health care is to be addressed with regard to the allocation of medical tasks became the topic of a heated discussion. A central point of contention was the allocation of responsibilities in the context of a redivision of medical tasks. A redivision of task responsibilities can be distinguished into the modes of task 'delegation' and task 'substitution'. In the legal sense, a substitution of medical tasks equals a re-allocation of medical responsibilities to nursing and other non-medical health care professions. Delegation, in turn, leaves decision rights with physicians. Divergences in the institutional (sub-)logics proposed by the involved actors caused different stances towards the mode of task redivision which fuelled the debate. Physicians, who traditionally enjoy the highest status among health care professionals, generally argued for the maintenance of their central position as sole provider of medical treatment in the narrow sense. In this role, physicians function as coordinators and decision-makers while secondary health care professions such as nurses may perform therapeutic measures only by the order of a physician. In contrast to the paradigm of 'physician centrality', nurses, who still obtain a low status position within German health care, depicted effective health care as the outcome of a combined effort of equally specialized and autonomous professionals. This paradigm of 'professional equality' that promoted the importance of nurses' professional logic in the provision of health care was supported by efforts to establish nursing as autonomous profession, including the increased academization of nursing training. Federal health care organizations, following their purpose of securing long-term public health, promoted a logic of 'efficiency' that transcended professional interests (cf. Scott, 2004). As will be elaborated below, the resulting discursive struggle illustrates how actors construct distinct vocabulary spaces to promote a specific institutional (sub-)logic and how these vocabulary spaces enable some actors while constraining others.

2007-2008: Opening the debate

Federal actors

The publication of a report titled *"Cooperation and Responsibility - Prerequisites for Target-Oriented Health Care"* by the Advisory Council on the Assessment of Developments in the Health Care System (SVR) in 2007 marks the central starting point of an intense debate between federal, nursing and physician representatives about the appropriateness of an altered allocation of medical tasks between the different health care occupations. The report itself argues for an increase in cooperation between health care occupations while not explicitly preferring a delegation over a substitution of medical tasks or vice versa. Rather, it argued for an efficient task redivision in the sense of a combination of both. With only three publications in 2007 and none in 2008, federal associations only selectively took part in the pub-

lic debate. Nevertheless, especially the 2007 report of the SVR which specifically included a 60-page chapter on the redivision of medical tasks informed the public debate notably and – in the context of the overall discursive struggle – exposes several interesting discursive features.

Vocabulary construction: The vocabulary structure of the SVR report generally expresses an ostensibly neutral and conciliatory stance towards a redivision of tasks. While a widely presumed "inherent conservatism" (Brown et al., 2012: 301) of governmental publications might explain such distinctly uncontroversial vocabulary structures, current research draws attention to the subtle, yet skillful deployment of discursive practices by governmental actors (Brown et al., 2012). The term 'provision (of health care)' was typically combined with concerns about 'efficiency and effectiveness', reflecting federal actors' responsibility for the long-term financing of health care. Considering that the theme 'modes of task redivision' was most highly contested within the debate between physicians and nurses, federal actors' particular emphasis of the term 'cooperation' – as opposed to a focus on the redivision of tasks as such – marks an interesting feature of federal actors' vocabulary structure. Within its 2007 report, the SVR portrayed the terms 'delegation' and 'substitution' as exemplary modes of intensified 'cooperation' and 'collaboration' between health care professions. Supporting the notion that delegation and substitution are merely different practical modes of an efficient allocation of medical tasks, federal actors framed 'delegation' and 'substitution' as legally different concepts, yet similar in their positive effects on 'quality and efficiency' or 'quality and patient-safety'. Common word-to-word relations were 'delegation and substitution' or 'delegation or substitution' that further mitigated differences between these concepts. Notably, federal actors rarely embedded the highly contested task-redivision modes 'delegation' and 'substitution' in complete legitimization accounts but rather framed them as potential examples of the presumably inevitable increase in *"efficient [and] effective division of tasks in health care" (Question catalogue for official responses following the publication of the SVR report, 2007).* As federal actors had anticipated that *"the medical profession reacts alarmed when the very foundations of their authority [...] are being shaken" (Member of the G-BA, 2011),* the discursive reduction of contrasts between a delegation and substitution of tasks can be viewed as an attempt to appease opponents of institutional change. This interpretation is supported by the SVR's explicit acknowledgement of the importance of vocabularies within the debate. Recognizing the power of vocabulary creation, the SVR urged field actors to refrain from using hierarchical categories such as *"medical profession and medical assistant profession"* as they would stand in the way of a *"modern, cooperation based understanding of collaboration between health-care occupations" (SVR report, 2007).*

The discursive reduction of contrasts between a delegation and substitution of tasks can be viewed as attempt to create a fit between the 'physician centrality', encoded in the medical logic that was promoted by the most powerful opponents of federal actors' plans to grant nurses increased autonomy. Although the SVR noted that the task division in German health care is characterized by a *"not always efficient physician-centeredness" (SVR report, 2007),* it remained mostly ambiguous about its preferred mode of task-division between health care professionals, hence leaving the future role of physicians in health care open to debate. Such discursive ambiguity has been found to enable collective action in intra-organizational contexts (Jarzabkowski, Sillince, & Shaw, 2010). Yet, as the further course of the debate will illustrate, within episodes of institutional change, a lack of discursive specificity is likely to invite opponents to dominate discursive struggles through the exploitation of these ambiguities.

Physicians

While the BÄK expressed its appreciation of an increased cooperation between health care occupations, it also insisted on the indivisibility of medical responsibility and the importance of preserving physicians' central role as a measure to maintain patient safety. Physician associations had a particular interest in maintaining the institutional status-quo as they had to witness several institutional changes that weakened physicians' influence in health care over the last years.[26] Still, physicians are well-organized and highly visible actors in political decision making in Germany. As high-status actors within the field, physicians are experienced in political activities and deploy discursive strategies with great skill. This was also the case with regard to federal plans to re-allocate medical tasks to other health care professions. As the conference protocols and petitions from the 111th German Medical Assembly in 2008 underline, vocabulary structures were created with great care and accuracy: One delegate even requested to delete any phrases in a resolution proposal that *"may lead to the misimpression that the medical profession would [...] agree to a substitution of medical tasks"*. Another delegate noted that a proposal should be rejected as its *"text lacks specificity to an extent that it is dangerous" (Speech at the 111th German Medical Assembly in 2008).*

Vocabulary construction: The BÄK noticeably relied on the creation of dichotomies within their construction of vocabularies. Their vocabulary structure is built around 'insiders' and 'outsiders' of the medical profession and pairs of 'right practices' versus 'wrong practices'. In the center of their vocabulary creation efforts lies the distinction between 'delegation' and 'substitution'. The term 'delegation' was

[26] The most drastic among these changes was certainly the introduction of case-based reimbursement rates for medical treatment in 2003 ("G-DRG-System") which curtailed medical autonomy in favor of treatment standardization and cost reduction.

often further specified as being 'physician-relieving' and contrasted to a 'physician-replacing substitution'. This explicit discursive distinction was introduced as early as 2008, when the passing of the Long-Term Care Further Development Act laid the legal foundations to an autonomous provision of medical treatment by non-medical occupations. Most prominently in the context of the 111th annual German Medical Assembly in May 2008, physicians reinforced the contrast between delegation and substitution, e.g. by adopting a resolution titled *"delegation yes – substitution no"* that indicated a considerable qualitative gap between these two modes of task-redivision. How intensely physicians attempted to construct a negative, even hazardous image of 'substitution' becomes obvious in the usage of this term by the president of the Westphalian state chambers of physicians who, at the annual German Medical Assembly in 2008, indignantly asserted that federal plans to transfer medical tasks to nursing professionals equal a *"conscious and politically volitional substitution of medical tasks"*. In fact, federal actors had at no point of the debate denied that 'substitution' was one mode in which a redivision of medical tasks was supposed to be implemented. Using the term 'substitution' in a way that connotes inherent danger was only possible by defining it as 'physician-replacing'. When constructing this very prominent vocabulary structure, physicians relied on their hitherto central position in health care. Most notably, medical representatives did not refer to 'substitution' as a re-allocation of medical tasks to other health care professionals but rather as generally 'physician-replacing' or 'physician-replacement'. As, of course, the health care system is reliant on the provision of medical services by physicians, it is hardly challengeable that physicians as a profession cannot be substituted. Another dichotomy that became characteristic for physicians' vocabulary structure within the debate was the discursive distinction between physicians and other health care professionals. While 'non-medical' is not an uncommon descriptive adjective when addressing several different groups of health care occupations (excluding physicians), physician associations used this specification more frequently than federal and nursing actors and often in direct contrast to the 'medical' profession, thereby underscoring differences between physicians and other health-care professions.

This contrast was further reinforced by explicitly demarcating physicians from 'non-physicians' as the title of a press release in 2008 suggests: *"The Medical Assembly rejects a transfer of medical tasks to non-physicians"*. This discursive reduction of other health care occupations to their 'non-medical' nature becomes particularly meaningful when taking into consideration that the *"medical specialist standard"* became one of the key phrases around which physicians built their legitimization strategies. While pointing out their general willingness to cooperate, physicians expressed their worries about the substitution of medical tasks as violation of patients' right to be treated according to a *"medical specialist standard":*

"[…] the medical specialist standard in diagnosis and therapy must be strictly obeyed because [it] assures patient protection." (Presentation at the 111th German Medical Assembly, 2008).

The German medical profession rejects concepts and pilot projects that aim at an easing of physician qualification and diagnoses and therapies below medical specialist standard. The medical profession has developed its own approaches to promote physician-supporting and physician-relieving measures in the context of delegation that – in the interest of the patient – stick to the principle of therapeutic responsibility of the physician […]" (Resolution of the BÄK, 2008)

The presumed effects of treatment procedures that lack medical specialist standard were particularly graphically described in the context of the 111th German Medical Assembly in 2008 when the president of the Westphalian state chambers of physicians, one of the key speakers with regard to this topic, provided an example of a patient who was severely harmed while receiving medical treatment from an anesthetic nurse specialists:

"What happens when the medical specialist standard is not being respected? […] On 24 October 2005, just 3 weeks after the practical implementation of the 'medical assistants in anesthesia', the so-called MAFA, a tragic incident at the Helios Clinic Erfurt occurred. During a harmless routine surgery, an 18-year-old patient suffered a cardiovascular arrest. The result: Severe brain damage. Anesthesia was occasionally monitored by a MAFA, the supervising anesthesiologist was simultaneously responsible for two other anesthetics."

By constructing a vocabulary structure which emphasized that other health care professionals are 'non-medical', physicians subtly underlined their proposition that e.g. nurses are not able to meet medical specialist standard. Aside from constructing meaningful dichotomies, physician associations, as experienced political actors, also sought to deconstruct federal actors' vocabularies:

"As one of the central theses in this report we find: 'A not always efficient physician-centeredness becomes apparent in health care'. The term 'physician-centeredness' is used in a context that connotes inefficiency and hierarchy. The opposite is true: Physician-centeredness is a quality characteristic! Who else, if not the physician, bears the burden of responsibility for the treatment of patients? Politics knows this, when it uses the word 'physician-centered' again in the context of 'physician-centered provision of health care', this time with a positive connotation." (Speech at the 111th German Medical Assembly, 2008).

In sum, physicians' discursive efforts between 2007 and 2008 illustrate how vocabularies are used to constrain potential opponents. By creating the *'delegation versus substitution'* dichotomy, the BÄK exploited the discursive ambiguity of the phrase

'cooperation' which the SVR used as a neutral alternative to include both modes of task redivision. In doing so, physicians drew attention to the qualitative differences between a delegation and a substitution of tasks and restricted the debate to the discursive space between these poles of 'good' and 'bad' modes of task-redivision while not rejecting an increased cooperation per se. Particularly, by defining 'substitution' as 'physician-replacing' at an early stage of the debate, physicians constrained federal and nursing associations in neutrally deploying this term as mere description of a task-division mode. Further, physicians' discursive strategy illustrates how the creation of vocabulary structures is a powerful instrument for subtle (de-)legitimatization attempts. Specifically, when arguing that patients have a right to a 'medical specialist standard', physicians drew on their implicit definition of nurses and other health care professions as being merely 'non-medical' and hence strengthened the perception of qualitative differences between the different health care occupations. While e.g. qualified nurses may be well capable of providing health care services according to medical specialist standard, 'non-medical' professionals were discursively separated from a "*medical specialist standard"*.

Nurses

In Germany, nurses are still far less present in health care politics than physicians. The German nursing council (DPR), as umbrella association of German nursing and midwifery, was founded in 1998 while the history of the German Medical Association goes back to 1947. Still, nurses vividly engaged in the discussion on altered task-division modes in health care. For nurses, federal considerations to extend nurses' medical autonomy marked an important step towards evolving from a non-professional occupation to a health care *profession* on par with the medical profession. Hence, nursing representatives exposed a positive stance towards a substitution of medical tasks. However, the discursive strategies employed by the DPR and its representatives between 2007 and 2008 expose that while nurses struggled for their recognition as professionals they arranged their arguments mostly within the vocabulary space proposed by physicians.

Vocabulary construction: Like federal actors, the German Nursing Council focused on the terms 'cooperation' and 'collaboration' and related synonyms when framing changes in the modes of task division between health care occupations. As nurses are still low status actors within the field of health care, this characteristic of their vocabulary structure can be viewed as attempt to discursively ally with more powerful actors of the field (cf. Boxenbaum & Battilana, 2005). Nurses' strategic deployment of vocabularies becomes particularly apparent in their frequent use of the terms *"profession/al"* or *"professionalization"*. Hereby, and in contrast to physicians' attempts of reinforcing nurses' lower status as basically *'non-medical'*, nurs-

ing representatives insisted on representing a nascent health care *profession,* an occupational status that has hitherto been reserved to physicians:

"The medical fraternity […] has to realize that nursing is not a competitor but at partner in patient care. This, of course, implies that the nursing profession will get the right to write prescriptions […]" (DPR Newsletter, 2008).

While nurses' ideas of desirable task-division modes between nurses and physicians differed considerably from those of physicians, nursing representatives frequently referred to statements of physician associations. Specifically, nurses sought to de-legitimize physicians' position within the debate by portraying physicians as 'ideology-driven' actors who obscured their true motives:

"To ensure that patients and those in need of care are provided with medical services in a resource-friendly […] way, an ideology-free discourse between the different professional groups health-care is essential. (Newsletter of the German Nursing Council, 2008).

However, this meta-level strategy of dissecting physicians' arguments put physicians' juxtaposition of the two different task division modes 'delegation' and 'substitution' also in the center of the DPR's vocabulary structure though embedded in a different argument structure. While the term 'substitution' was rarely explicitly used between 2007 and 2008, nurses adopted the distinction between 'delegation' and synonyms for 'substitution' like 'redistribution' or 'transfer' and thereby involuntarily perpetuated the discursive dichotomy proposed by physicians:

„Delegation or substitution?[…] physician representatives still have their difficulties with the call for substitution (Newsletter of the German Nursing Council, 2008).

"A new argument is inevitable: It is about the question: delegation or transfer?" (Newsletter of the German Nursing Council, 2008).

2009-2010: Reinforcing and enriching vocabulary structures

Federal actors

Apart from four short comments in 2009, the G-BA and the SVR mostly withdrew from the public debate on a task redivision in German health care between 2009 and 2010. Yet, their vocabulary construction does not differ notably from that in the period between 2007 and 2008. In particular, the SVR further reinforced the proposed similarity between delegation and substitution of tasks with regard to their effects:

"The increased delegation and substitution of tasks to non-medical occupations leads to a relief and thus more freedom for the respective physicians." (Special report of the SVR, 2009)

Physicians

Similar to federal actors, the BÄK published significantly less statements and comments on the redivision of medical tasks between 2009 and 2010. This is most likely the case as this phase is characterized by the absence of significant legal progress concerning the practical implementation of new task division modes. Within the overall six conference protocols and press releases to be found between 2009 and 2010, physicians mostly relied on their existing strategy of specifying and antagonizing the task-redivision-modes of 'delegation' and 'substitution'.

Vocabulary construction: While the BÄK continued to use of the word pair 'delegation' and 'substitution' excessively within their publications, the direct juxtaposition of these two terms – as it was the case in the years before – decreased between the years 2009 and 2010. However, the BÄK increasingly portrayed the substitution of medical tasks as a violation of the already much-quoted 'medical specialist standard' and hence an infringement of 'patient rights'. Here, physicians repeatedly emphasized the misfit between a substitution of medical tasks and patient-orientation as central element of the overarching field-logic, further defining the term 'substitution' as not only 'physician-replacing' but as an infringement of patient rights:

„[...] [W]e must consider the level of patient protection. [...] Substitution would undermine the patient right of a medical specialist standard."(Presentation at the 113th German Medical Assembly, 2010).

Nurses

In contrast to federal actors and physicians, nurses used the phase between 2008 and 2009 to reinforce and enrich their discursive strategy. Specifically, the DPR continued to dissect the 'true nature' of physicians' reservations against a substitution of tasks and contrasted the political struggle with current developments on the practice level.

Vocabulary construction: As the DPR mainly constructed its arguments as observations and comments on the ongoing debate, the discursive space between the poles 'delegation' and 'substitution' was sustained within the DPR's vocabulary structure. Between 2009 and 2010, the DPR further increased its use of synonyms for the redivision of medical tasks in their vocabulary structure. These were often used as interchangeable alternatives for delegation, substitution or both. For example, in an interview from 2010, the DPR's president noted, that *"there is no way around a reallocation of tasks"*; in a newsletter article from 2009, the redivision of tasks is referred to as *"division of labor"*, *"allocation of tasks"* and *"substitution"*. While this enrichment of vocabulary structure can be interpreted as an attempt to expand the vocabulary space around the value-laden terms 'delegation' and 'substitution' to

support the idea that *„[m]odern medicine and patient care follow the laws of task division among equals" (DPR newsletter, 2009),* it had little impact on the overall discourse.

Here, nurses' discursive strategies illustrate how the use of certain vocabulary structures to promote a specific logic can become a constraint to agency. Physicians' early linking of the word 'substitution' to an illegitimate infringement of patients' rights impeded a neutral use of this formerly descriptive legal term. By employing a discursive strategy that relied on the dissection of the BÄK's arguments, the DPR (involuntarily) reinforced the idea that delegation and substitution are two modes of task division that differ considerably. On the one hand, analyzing physicians 'true motives' enabled the DPR in questioning the legitimacy of physicians' central position in health care. On the other hand, by incorporating physicians' vocabulary structure into its own arguments, the DPR implicitly confirmed physicians' status as central actors of the field who are capable of defining the central object of the debate.

2011-2012: Discursive deadlock and resolution

Federal actors

In October 2011, the Federal Joint Committee (G-BA) proposed a directive on the design of pilot programs to test the redivision of medical tasks, including task substitution. As comments and press releases of the G-BA suggest, the discursive means employed within the directive were carefully arranged to provide a more neutral context for the on-going debate about appropriate modes of task redivision.

Vocabulary construction: As by 2011, the discursive struggle between physicians, nurses and federal actors had obviously reached a deadlock over the polarity between 'delegation' and 'substitution', the G-BA replaced both words by the neutral term *'transfer (of medical tasks)'* within the proposed directive. As federal representatives emphasized, this radical change in vocabulary structure was motivated by an attempt to contain the escalating debate:

"Both parts [of the directive] refrain from using the terms delegation and substitution. Oriented towards consensus, conflict is being bypassed by using the term transfer."(Commentary of a neutral member of the G-BA, 2011.)

"[The compromise] does not rely on the used up conceptual poles but describes respective responsibilities positively [...]"(Commentary of the neutral chairmen of the G-BA, 2011).

As this change in vocabulary underlines, federal actors initial attempts' to define the 'substitution' and 'delegation' of medical tasks as comparable examples of an increased 'cooperation' between health care professionals had been mostly unsuccessful. The creation of this ostensibly neutral and ambiguous vocabulary structure

did not only fail to enable federal actors in their efforts to sponsor a new institutional practice. The inherent lack of clarity within the 2007 report of the SVR also turned out to become a major constraint in effectively promoting altered modes of task-division in health care as it allowed physicians to enrich the formerly merely legal terms 'delegation' and 'substitution' with normative meanings. As a neutral member of the G-BA put it, legislative authorities made a momentous mistake when not resolving the potential for conflict inherent to the terms 'delegation' and 'substitution' in 2007:

"The fuzzy transition [between these modes] cannot hide the conflict potential underlying the antagonistic terms of delegation and substitution. Unfortunately, legislature did not resolve this by a clear statement of intend towards delegation or substitution. Hence, the legal framework provided a welcome template for the involved actors to play out their conflicting positions on the foundation of an imprecisely formulated law."

Physicians

Between 2011 and 2012, the BÄK notably increased its discursive efforts to prevent a transfer of medical tasks to nurses and other health care occupations in the sense of a task substitution. Apart from taking the opportunity to provide an official statement within the course of the development of the directive, the BÄK continued to de-legitimize a substitution of medical tasks even after the directive had been passed by the German Federal Ministry of Health in 2012. While the commencement of the G-BA directive marked a defeat for physician representatives, the practical implementation of a task substitution had only been allowed within pilot projects and was thus still in the ongoing process of institutionalization.

Vocabulary construction: As the BÄK particularly relied on the meanwhile established antagony between the delegation and substitution of tasks within their discursive efforts, it sought to redefine the newly introduced term 'task transfer' as synonym and mere cover-up for a planned substitution:

"A transfer [of tasks], i.e. a substitution of medical practice to other health care occupations is being rejected." (Resolution of the BÄK, 2011)

"The BÄK and the DKG have – at that time – consistently rejected the introduction of § 63 para. 3c SGB V based on the rationale that it would imply a legal manifestation of a transfer of medical practices in the sense of a substitution." (Official response of the BÄK to the G-BA proposal, 2011)

However, the direct contrast between a delegation and a substitution of tasks did not dominate the discursive strategies of physicians as much as it did between 2007 and 2008. Rather, the BÄK put more emphasis on the term 'delegation' as supposedly more appropriate mode of task-redivision. Arguably, this change in vocabulary

structure can be interpreted as recognition of an altered vocabulary space that had been introduced by the G-BA. This interpretation is supported by two further observations. On the one hand, the term 'task transfer' had been – after more than two years of negotiation – adopted as compromise between the 13 members of the G-BA committee, including two physician representatives. On the other hand, the BÄK's publications between 2011 and 2012 display a notable increase in the use of the terms 'transfer' and 'medical science' – two terms that are central to the G-BA directive and thus also define the new vocabulary space. Nevertheless, the BÄK continued to emphasize the importance of the medical specialist standard and enriched its vocabularies with the term *"(medical) responsibility"* that was further specified as a non-divisible characteristic of medical practice exerted by physicians:

"Hence, every form of substituting medical responsibility by non-medical employees needs to be resolutely rejected" (Resolution proposal of the BÄK, 2011).

Overall, the vocabulary structure of the BÄK between 2011 and 2012 was notably informed by the vocabulary space around the term 'transfer (of medical tasks)' that had been proposed by the G-BA. Yet, while the BÄK gradually reduced the creation of a contrast between the delegation and the substitution of tasks as polar opposites, it continued to separate the 'medical specialist standard' as well as 'medical responsibility' from nurses as 'non-medical' occupation. In doing so, physicians sustained a discursive sub-space that allowed them to dismiss the meanwhile legally permitted substitution of tasks as inferior against the background of patient rights and hence normatively illegitimate.

"A transfer of medical services and responsibilities to non-medical health care occupations in the sense of a substitution would, however undermine the patients' right to a medical specialist standard." (Resolution of the BÄK, 2012)

Nurses

The DPR's discursive strategies between 2011 and 2012 show an interesting combination of change and stability. While the DPR continuously questioned physicians' integrity within their rhetorical legitimization strategies, their vocabulary structure reveals a change in the vocabulary space nurses drew on.

Vocabulary construction: The vocabulary structure of the DPR between 2011 and 2012 underwent a significant change after the G-BA directive introduced the term 'transfer' in the second half-year of 2011 as conciliatory alternative to 'delegation' and 'substitution'. While in 2011 the DPR still relied on the discursive space proposed by physicians, the term 'substitution' is no longer used within its publications from the beginning of 2012 onwards. Instead, the DPR heavily drew on the terms 'transfer' and 'medical science' as soon as the G-BA had published the first drafts of its directive proposal. In the context of the DPR's increased usage of the term

'cooperation' between 2007 and 2008, this abrupt adoption of the G-BA's vocabulary strengthens the perception that the DPR sought to establish a discursive alliance with a more powerful actor of the field that, in addition, had already laid the foundations to an institutional change that was likely to enhance nurses' status.

Table 4.3 provides an integrated overview of the vocabularies that each collective actor employed within the course of the debate.

Table 4.3: Patterns of Vocabulary Construction

Actor	2007-2008		2009-2010		2011-2012	
	Vocabulary Construction	**Examples**	**Vocabulary Construction**	**Examples**	**Vocabulary Construction**	**Examples**
Federal Actors	'cooperation' through 'delegation' and 'substitution'	*"Tasks can be transferred from one occupational group to another (delegation/ substitution)."(SVR report, 2007)* *"[…] an extension of cooperation between occupational groups may be more advantageous for all actors involved […]." (SVR report, 2007)* *"We need to discuss new modes of cooperation primarily from […] the patients' perspective." (SVR report, 2007)*	'cooperation' through 'delegation' and 'substitution'	*"Building on its explanations in the report of 2007, the Council welcomed the testing of new forms of cooperation between medical and non-medical occupational groups." (Special report of the SVR, 2009)* *"The increased delegation and substitution of tasks to non-medical occupations leads to a relief and thus more freedom for the respective physicians." (Special report of the SVR, 2009)*	'transfer (of medical tasks)' and 'medical science'	*"The Federal Joint Commitee has…decided upon the definition of medical tasks suitable for a transfer to members of the nursing and geriatric care profession for the autonomous execution of medical science […]." (Announcement of the federal ministry of health, 2012)* *"It will take some more time until the first model project for the transfer of medical tasks to nurses will be implemented." (Short report of the G-BA 2012)*
	'efficiency'	*"The further development of the collaboration between health care occupations as contribution to an efficient and effective provision of health care" (press release of the SVR, 2007)*				
Physicians	'delegation' versus 'substitution'	*"In addition to delegation that we can approve of in single cases, substitution is becoming a threat. We do not really know where the line between delegation and substitution is drawn. We must not leave that to arbitrariness." (Speech at the 111th German Medical Assembly, 2008).* *"I want to protect our family doctors from being replaced by someone who has a lower qualification. The delegation of medical services is reasonable, but there must be no substitution." (Speech at the 111th German Medical Assembly, 2008)*	'delegation' versus 'substitution'	*"Whenever we discuss about the limits of delegation and substitution we must consider the level of patient protection. Delegation equals physician-supporting and physician-relieving measures under medical responsibility. Substitution would undermine patients' right to the medical specialist standard."(Presentation at the 113th German Medical Assembly, 2010)*	'transfer (of medical tasks)' as 'substitution'	*"Model projects[…] that include a transfer (substitution) of tasks[…] have to be rejected." (Resolution of the BÄK, 2011)* *"The German Medical Assembly explicitly rejects a substitution of medical services by non-medical occupations." (Press release of the BÄK, 2012)*

Table 4.3: Patterns of Vocabulary Construction (continued)

Actor	2007-2008		2009-2010		2011-2012	
	Vocabulary Construction	**Examples**	**Vocabulary Construction**	**Examples**	**Vocabulary Construction**	**Examples**
Physicians	'cooperation'	*"The increasing demands by demographics and medical advances, but also the growing economic pressures require a different approach in the cooperation of everyone in the health care sector. The medical profession will not refuse [cooperation]." (Presentation at the 111th German Medical Assembly, 2008).*	'medical specialist standard'	*"The concern for protection inherent to the medical responsibility for medical diagnostics and therapy and the legal right of patients to a medical specialist standard in medical care must not be undermined." (Proceedings of the BÄK, 2010)* *"For the first time in 1993, the federal court has concluded that our patients have an entitlement to be treated according to medical specialist standard. This is […] a patient right by case-law. And it is an important one, […] because it grants the patient the right to high quality care and protects them from a deprofessionalization of the medical profession." (Speech at the 113th German Medical Assembly, 2010)*	'cooperation' by 'delegation'	*"With regard to the cooperation between the health care occupations we have to apply the principle 'delegation instead of substitution'." (Resolution proposal of the BÄK, 2011)*
	'non-medical'	*"Medical responsibility only for medical practice! No transfer of medical core tasks to non-medical health care occupations! […] An alleged need to economize is being used to legitimize an extended transfer of medical tasks to non-medical health care occupations." (Resolution from the 111th German Medical Assembly, 2008)*			'non-medical' versus 'medical responsibility'	*"The Medical Assembly stress-ed that the delegation of medical services to qualified non-medical staff is a useful measure for maintaining patient care. […] The Medical Assembly explicitly rejects a substitution of medical services by non-medical occupations. The medical responsibility for medical diagnosis and therapy is one of the main reasons for the high quality of medical care in Germany." (Press release of the BÄK, 2012)*
	'medical specialist standard'	*"According to jurisdiction, the patient has a right to [medical specialist standard] in hospitals. The medical specialist standard is also the benchmark […]in ambulant care." (Press release of the BÄK, 2008)*				

Table 4.3: Patterns of Vocabulary Construction (continued)

Actor	*2007-2008*		*2009-2010*		*2011-2012*	
	Vocabulary Construction	**Examples**	**Vocabulary Construction**	**Examples**	**Vocabulary Construction**	**Examples**
Nurses	'cooperation and collaboration'	*"The collaboration between health care occupations is no longer in accordance with the numerous changes and new challenges in the provision of health care to an aging society." (DPR Newsletter, 2008)*	'profession'	*"Politics must not ignore that professional nursing is also suffering from severe troubles." (Interview with the president of the DPR, 2010)* *"[...] [N]o proof of an integration of the nursing profession." (Editorial comment of a DPR member, 2009)*	'transfer (of medical tasks)'	*"We consider the planned transfer of medical tasks to member of the nursing professions a very welcome development."(Official response of the DPR to the G-BA proposal, 2011)*
	'profession'	*"In the summer of 2007, comments from the medical fraternity gave the impression that the nursing profession pursues the intention to provide some kind of 'small medicine'." (DPR Newsletter, 2008)* *"Today, we see that different professions are involved in the provision of health care to the population." (DPR Newsletter,2008)*	'delegation' and 'substitution/ re-distribution/ /transfer''	*"[There was] no consensus about a new division of tasks beyond a delegation of medical tasks[...]A substitution of medical tasks by services of non-medical health care occupations is being rejected by the BÄK [...]" (Newsletter of the German Nursing Council, 2008)* *"The pressure is particularly high in hospitals. Here, we have to think about a re-adjustment of tasks because of the shortage of physicians and nurses. This could happen via Delegation or re-allocation, which means substitution." (DPR Newsletter, 2010)*	'profession'	*"We need to prioritize: more transparency of services offers and their quality, a better integration of sectors and actors and a re-orientation of the tasks of the different health care professions." (Vice-president of the DPR, 2011)*
	'delegation' and 'substitution/ re-distribution/ /transfer'	*"Delegation or substitution? [...]physician representatives still have their difficulties with the call for substitution" (DPR Newsletter,2008)* *"A new argument is inevitable: It is about the question: delegation or transfer?" (DPR Newsletter, 2008)*			'delegation' and 'substitution/ re-distribution/ /transfer''	*"One point of contention is [the question about] delegation, i.e. a transfer of medical tasks [...]under the medical and legal responsibility of a physician, or substitution."(DPR Newsletter 2011)* *"Some favor an expanded delegation...Others favor a real transfer of medical tasks in model project to seriously try out a re-distribution of medical tasks in the health care sector." (Editorial comment of a DPR member, 2011)*

After 2012: New regulation and structural changes in the field

Following the intense debate between federal, nursing, and medical representatives between 2007 and 2012, the directive on the re-allocation of medical tasks within pilot programs that had been proposed by the G-BA was eventually passed in March 2012. While this was perceived as a step forward in the professional project of the nursing profession (DBfK, 2011), the regulatory changes did not translate into notable changes at the operational core of health care. By 2013, more than one year after the new directive had been passed, no pilot projects have been initiated (Hibbeler, 2013; Kälble, 2013; Roes, 2013). As the president of the German Nursing Council (DPR) – while welcoming new task spheres for nurses – pointed out, this was because the new directive was highly complicated (explicitly leaving open whether he thought that the directive was intentionally made hard to implement). Additionally, he emphasized that the new directive only applied to pilot projects that had to be jointly initiated by hospitals and SHI-funds, implying that changes in the physician-centered health care system of Germany are not to be expected any time soon (Hommel, 2013). Similarly, in 2014, the G-BA noted that "it will still take some time until there will be the first model projects for the transfer of medical tasks to nursing personnel" (G-BA, 2014d). In a press release from 2014, the DPR even revived the dichotomy between *'delegation'* and *'substitution'*, specifically suggesting that despite the regulatory changes, the medical and the nursing profession were "again going round in circles in the discussion about delegation versus substitution" (DPR, 2014b). In sum, the redivision of medical tasks – while having gained regulatory legitimacy – is still far from being embedded in the normative or cognitive frameworks of German health care. Thus, the dominance of the medical logic may be challenged by economic pressures and increased state intervention but has yet to be replaced by a collaborative, multi-professional health care system that is shaped by *equal* professionals. How this dominance of the medical logic was enacted and reflected within the discursive struggles about the redivision of medical tasks will be discussed in further detail below.

4.3.6 Discussion

Existing research on the use of language in institutional work focuses mostly on the enabling effects of explicit means of persuasion (e.g. Suddaby & Greenwood 2005) and coherent argument structures (e.g. Zilber, 2007). More subtle strategies of vocabulary construction have, however, received less scholarly attention. As the present study suggests, a stronger emphasis on the construction and deconstruction of vocabularies can enhance our perspective on discursive institutional work in professional settings.

The analysis shows that institutionalized vocabularies which reflect the dominant institutional logics of an organizational field constrain agency regardless of an actors' relative status within the field. In the present case, the focus on the "provision (of health care)" and the "patient" reflected the community logic that is a central pillar of German health care as a universalist health care system (Bode, 2014). This further strengthens the prevailing assumption that vocabularies reflect dominant institutional logics in which actors are embedded (e.g. Ocasio & Joseph, 2005) and which actors have to draw on to demonstrate their familiarity with the legitimate motives and frames of a field and thus their affiliation and legitimacy as participants in the respective field's discourse. However, actors are not only embedded in and constrained by meaning systems that result from accumulations of historical symbolic action (Green & Li, 2011) but are also confronted with the limits of agency caused by 'vocabulary spaces' that come into existence when other actors actively make use of the constraining effects of vocabulary structures. Hence, vocabulary structures hold in them constraining and enabling effects that shape discursive struggles apart from and beyond explicit means of persuasion. In the present case study on the redivision of medical tasks in Germany, three distinct patterns of vocabulary construction are observable. These can be described as 'spanning of vocabulary spaces', 'analyzing vocabulary spaces' and 'neutralizing vocabulary spaces'.

Patterns of Vocabulary Construction

Spanning vocabulary spaces

The strategic pattern of 'spanning vocabulary spaces' can be observed for physicians and federal actors who both represent high status actors in the field of German health care. In its 2007 report, the SVR proposed a vocabulary space that focused on the term 'cooperation' as neutral and positively connoted description for an altered task division between health care professionals. While the general necessity for increased cooperation as such was acknowledged by both professional groups, physicians provided an alternative vocabulary space by introducing the prominent distinction between 'physician-relieving delegation' and 'physician-replacing substitution' of tasks as polar opposites rather than comparable modes of task redivision. In doing so, physician representatives exploited the neutral, yet ambiguous vocabulary structure around the term 'cooperation'. As Suddaby and Viale (2011: 435) note, it is not uncommon that "professionals legitimate new categories […] simply by interpreting vague dictates of government or other dominant players within a field". Yet, the case study illustrates that physicians did not only attempt to de-legitimate a substitution of tasks but dominated the debate by a vocabulary space that specified the object of the ongoing discourse. While the term 'cooperation' was continuously used by federal actors, it only provided the general background

against which actors discussed the appropriateness of specific modes task-redivision. The answer to the question on what the debate was actually about was provided by physicians who specified the objects of the debate as task delegation and task substitution (and specifically not as a new mode of 'cooperation' or 'task-division'). As this result suggests, the success of 'spanning a vocabulary space' is not only contingent upon an actors' status in the field but also on the distinctiveness of the vocabulary structure employed. While 'cooperation' was used to include a delegation and a substitution of tasks it was not specifically linked to a redivision of tasks. In fact, actors were unable to draw on this term to argue for or against a certain mode of task-redivision, as any kind of medical treatment involves cooperation. Delegation and substitution, on the other side, provided a sufficiently precise description of distinct task-division-modes.

Analyzing vocabulary spaces

The strategic pattern of "analyzing vocabulary spaces" is employed by federal, physician and nursing representatives. However, federal actors merely urged other actors to refrain from using hierarchical categories such as *"medical profession and medical assistant profession" (SVR report, 2007)* and physicians only once referred to federal actors' ambiguous use of the term "*physician-centeredness"* (*Speech at the 111th German Medical Assembly, 2008)*. In contrast to federal actors and physicians, nurses, as low status actors within German health care, employed this strategic pattern to a great extent. While embedding nursing in a vocabulary structure that emphasized its status as a 'profession' and nurses as 'professionals', the DPR also strongly relied on the dissection of physicians' arguments when attempting to legitimate a new mode of task redivision. In particular, nurses noted that the *"discussion 'delegation versus substitution' has to be ended" (Interview with the president of the DPR, 2010)* and that the "*much-quoted 'medical specialist standard' […]is merely about defending a monopoly and privileges that have become obsolete a long time ago." (President of the DPR 2012).* Hence, 'analyzing vocabulary spaces' is a strategy of vocabulary deconstruction rather than vocabulary construction. As such, this strategic pattern puts actors at the junction of enabling and constraining effects of vocabulary structures. On the one hand, analyzing opponents' vocabulary structures enables actors in questioning the legitimacy of opponents' claims by drawing attention to underlying motives. On the other hand, the deconstruction of opponents' vocabularies necessarily includes a perpetuation of these. As the results of the debate on task redivision in German health care suggest, low status actors – who are less likely to 'be heard' in the field – risk to confirm central actors' status by drawing on their vocabulary spaces rather than being able to delegitimate their position by dissecting their vocabulary structure.

Neutralizing vocabulary spaces

The strategic pattern of 'neutralizing vocabulary spaces' is primarily employed by the G-BA from 2011 onwards. The G-BA explicitly refrained from using the terms 'delegation' and 'substitution' and integrated both modes of task-redivision into the neutral term 'transfer (of medical tasks)'. The strategy of neutralizing vocabulary spaces differs from 'spanning vocabulary spaces' insofar as it presupposes the existence of vocabulary structures that define the objects of a debate. When actors, in this case the G-BA, become aware of the effects of these vocabulary spaces on the course of the debate, they can construct alternative and overarching vocabulary structures that include and neutralize contested terms. The introduction of the term 'task transfer', as neutral alternative to describe both modes of task-redivision, opened an alternative and integrative discursive space that provided nurses – as low-status actors of the field – with a new vocabulary structure on which to build their legitimization strategies without perpetuating and thereby reinforcing the antagonism between 'task delegation' and 'task substitution'. That this new term marked the center of a powerful new vocabulary structure becomes particularly apparent in physicians' struggle to redefine the 'transfer (of medical tasks)' as rhetorical cover-up for a substitution of medical tasks. Similar to the spanning of vocabulary spaces, the successful neutralizing of vocabulary spaces necessitates a sufficient specificity of the central terms employed. While the initial attempt to span a vocabulary space around the term 'cooperation' failed, the discursive poles 'delegation' and 'substitution' could successfully be replaced by the term 'transfer (of medical tasks)' as it is general enough to include both modes of task-redivision and sufficiently precise to clearly relate to altered modes of task division in health care. Yet, as illustrated above, while nursing representatives did increasingly draw on the new vocabulary space that had been provided by federal actors, they never fully distanced themselves from the dichotomy between 'delegation' and 'substitution', further underlining physicians' power in defining the object of the debate.

Vocabulary Construction as Discursive Boundary Work

As elaborated in the theory section, the discursive demarcation of professionals from non-professionals and the construction of boundaries between professions relies on the development and maintenance of specific vocabularies that constitute and reflect a professions' "space of reason" (Schildt et al., 2011). As the case study has shown, however, the creation of vocabularies does not only enable professionals to gain status by defining and defending their areas of expertise. Rather, professionals may utilize their distinctive access to certain words and the meanings they convey to control the discourses of a field and thereby defend their dominant position. This was the case for physicians who repeatedly subsumed other health care professions under the term 'non-medical', deliberately ignoring the technical and

hierarchical differences between e.g. nurses and physiotherapists and implying that the only relevant distinction in the professional hierarchies of the field was between medicine and non-medicine. This construction of vocabularies is a particularly illustrative example of Abbott and Meerabeau's (1998: 16) observation that the "power of the discourse is used to control the behavior of the aspiring profession".

More interesting, however, is the discursive boundary work of nurses as it illustrates well how discursive and thus political power is not only actively acquired but also passively granted as participants in a debate acknowledge each other's vocabularies.

In the present case study, the emerging pattern of vocabulary (de-)construction represents a paradox insofar as nurses contributed to physicians' discursive power while explicitly trying to reduce the dominance of the medical logic (which promoted the physician as sole decision-maker in clinical practice) within the field of German health care. While the constant usage of physicians' prominent distinction between '(physician-relieving) delegation' and '(physician-replacing) substitution' may have been a tactical move to demonstrate awareness of the field-level discourse, it also constrained nurses' ability to emancipate from being subordinate to the medical profession. Specifically, within their discursive attacks on physicians' jurisdictional monopoly over specific tasks in health care (such as writing prescriptions), nurses' granted them a discursive monopoly. Their attempt to expand their jurisdictional boundaries at the cost of the medical profession took place within the vocabulary spaces provided by these high-status actors, thus making nurses' professional project an example of what could be called 'bounded boundary work'.

Whether such discursively 'bounded boundary work' contributes to the maintenance of institutional structures within professional fields remains open to further research. Yet, it raises the question whether low-status actors can successfully attack the hierarchies of a field by allowing high-status actors to discursively delineate the central objects of the debate (in this case 'delegation' and 'substitution'). As the creation of vocabularies is an essential part of defining and interpreting (i.e. making sense of) reality, it appears unlikely that the reproduction of high-status professionals' vocabularies will add to the decline of their dominance. A tentative interpretation of the outcome in this case also suggests that nurses' attempts to expand their task spheres were of limited success as even over a year after the respective directive had been passed, no pilot projects have been initiated.

This kind of bounded boundary work has interesting implications for the study of institutional work in general as it gives a more nuanced understanding on the different kinds of embeddedness with which institutional workers – in this case, professionals – may be confronted (cf. Garud et al., 2007). While nurses were well able to imagine alternative institutional arrangements, they were obviously either not able

or not willing to provide alternative vocabulary spaces to proactively shape the discussion about altered task divisions between nurses and physicians. Accordingly, institutionalists' notion that low-status actors' institutional creativity – which make them more likely to imagine and pursue alternative institutional arrangements (Battilana et al., 2009) – is not necessarily reflected in the means they use to promote institutional change.

4.3.7 Limitations and Conclusion

This study raised the question on how actors make use of vocabulary structures to promote or inhibit institutional change in professional fields. As exploratory single case study in a specific context, the findings of my study are, of course, of limited generalizability. Further, while this study could show that nurses, as the low-status actors within the discourse on task-redivision in German health care, relied much on the vocabulary structures provided by the high-status of the field, their motives remain ambiguous. Further research should thus focus more on when and why low-status actors draw on the vocabulary spaces provided by high-status actors. Specifically, while this study provided first insights on how low-status professionals may reinforce given power structures by reflecting these in their 'bounded' use of discursive means, future research should examine in more detail whether low-status actors intentionally restrict their use of novel vocabularies and try to 'borrow' legitimacy by drawing on high-status actors' vocabulary structures or whether such discursive constraints result from a lack of reflectiveness. In the case examined here, both of these mechanisms may have been present: Nurses may have unintentionally reinforced physicians' power in defining the discourses and meaning systems in German health care when dissecting their arguments. Yet, they may have strategically aligned their vocabularies with the vocabulary spaces provided by federal actors who – just as nurses – were interested in a less physician-centered health care system. However, as these interpretations have to remain tentative for now, more research on actors' motives behind the (de-)construction of specific vocabularies is needed. Similarly, more comparative research is needed to uncover the effects of using other actors' vocabulary structures on the successful promotion (or prevention) of institutional change. Other research on intra-organizational institutional changes in health care has already pointed out that a professions' use of the "tools and techniques of its oppressors" (Thorne, 2002: 23) may be a promising strategy to gain or defend their status. However, it remains open whether this finding also pertains to the use of vocabularies as subtle, but powerful building blocks of social reality.

Despite the aforementioned limitations, this study draws attention to the enabling and constraining effects of vocabularies as an instrument of institutional work. Specifically, the findings suggest that the strategy of actively creating vocabulary struc-

tures to manipulate institutionalized meaning systems is not equally accessible to all actors of a field. This may lead to the paradox situation of institutional agents who challenge the structural hierarchy of a field while perpetuating the discursive hierarchy.

Overall, the results of the case study expose three distinct strategic modes of vocabulary construction with the creative and original strategies of vocabulary construction being mostly associated with high-status actors. While the strategies of spanning and neutralizing vocabulary spaces were primarily employed by federal actors and physicians both of whom obtain a high field-level status, nurses as low status actors of the field mostly relied on the strategy of analyzing the vocabulary spaces provided by physicians. By drawing on these vocabulary spaces, nurses, although strongly disagreeing with physicians on the content level, confirmed existing power relations in the field. In sum, this study provides a new perspective on the discursive struggles that entail institutional change by drawing attention to the importance of vocabulary construction in political struggles. Whenever actors acquire interpretive control over a debate's key words, they constrain opponents by providing the object (i.e. the 'what') of a debate. Hence, by spanning or neutralizing vocabulary spaces, actors can dominate discursive struggles regardless of whether their explicit legitimization accounts are being considered appropriate.

5 Professionals and Organization-Level Change

Early neo-institutional theory has largely limited professionals' role in institutional change on the organization-level to being enablers of convergent change. Professionals were conceptualized as little more than vehicles through which norms and values diffused into organizational structures (DiMaggio & Powell, 1983). Institutional dynamics that occurred within the realm of organizations appeared to be of little interest to institutional researchers for a long time. Yet, as elaborated above, organizations provide important arenas in which professionals *actively* promote or prevent institutional change while they enact their professional and organizational roles (see section 3.4.2). Given that the autonomous professional practice is on the decline and employment in large organizations has become the rule rather than the exception within professional work (Leicht & Fennell, 1997; Suddaby et al., 2009; von Nordenflycht, 2010), much attention has been given to how professional core values are affected by professionals' increasing organizational embeddedness (Sorensen & Sorensen, 1974; Toren, 1975; Wallace, 1995), how professionals are to be managed (Conrad et al., 1996; Parkin, 2009; Raelin, 1986, 1989; Sorensen & Iedema, 2008), and how professionals resist managerial control (Armstrong, 2002; Pieterse et al., 2012). This focus on the dichotomy between professionalism and managerialism has reinforced the notion that professionals' institutional work on the organizational level is often owed to their attempts to restrict managerial influence on their practice. Also, much research has focused on the interprofessional dynamics that result from the close collaboration and collocation of different professional groups within organizations (Chreim, 2012; Currie & White, 2012; Dent, 2002; Mitchell et al., 2011). Similarly to the control-resistance-paradigm that has informed the study of managerial influence in professional organizations, the dynamics between professional groups in organizations are often studied with a focus on inter-professional competition and conflict (Apesoa-Varano, 2013; Hall, 2005; Kirkpatrick et al., 2011). Research on professionals' institutional work within organizations has thus been occupied with the defense of privileged roles against the influence of managers and other professionals, often reducing institutional dynamics within an organization to struggles between two antagonistic groups.

Accordingly, this chapter sets out to give a more nuanced understanding on when, why, and how professionals exert institutional work within their organizational context. Specifically, this chapter seeks to move away from the 'resistance'-centered perspective of professionals' institutional work that is rooted in the assumption that professionals constantly struggle to defend their professional role against usurpation in the hierarchical systems of organizations. While acknowledging the critical in-

fluence of their professional role on professionals' agency in organizations, I want to provide a more balanced view on how organizational context – as a sphere in which the political and the practical meet – shapes professionals' involvement in institutional change.

As in the previous chapter, I will first provide further insights on current developments in German health care before expanding on the theoretical background and providing an original study to address selected gaps in literature. Hence, in the first section, I will elaborate on typical changes in German health care organizations, specifically hospitals, that occurred against the background of marketization and increasing state-involvement in the field (see section 4.1). Here, I will give some short insights on how these changes affected professionals' roles in their organization and how they fostered professionals' institutional agency within their organization. This concise overview on the general changes that characterized German hospitals over the last decade will provide empirical background information to the study presented in the last section of this chapter. In the second section, I will discuss and integrate findings from extant empirical studies to show that professionals' institutional work on the organizational level is more contextual and pragmatic than their abstract, political work on the field-level. Here, I will focus on when and why professionals work towards or against institutional change in their organizational roles, structures, and practices. In particular, I will elaborate on how professional and organizational roles may interact to induce reactive and prospective agency. Further, I will discuss how professionals leverage the resources available in their organizational context (e.g. social relationships with potential allies) to promote or resist institutional change before identifying major gaps in the literature on professionals' intraorganizational institutional work. The final and main part of this chapter comprises a fuzzy-set qualitative comparative study on change projects that promoted new task spheres for nursing professionals in the internal medical departments of German university hospitals. This study will add to current literature by focusing on when and why professionals are open rather than resistant towards institutional change, identifying three distinct constellations of organizational boundary conditions that led nursing professionals' to react openly towards changes in institutionalized role divisions.

5.1 Setting: Increased Managerial Control and Blurred Professional Boundaries in German Hospitals

With increasing economic pressures and new regulatory developments, German health care organizations – specifically inpatient facilities like hospitals – had to re-evaluate their goals, structures, and practices to ensure organizational survival.

One of the most striking changes in German hospitals is the proliferation of managerialism as an intraorganizational answer to the cost pressures that had been brought about by the new, prospective reimbursement system. While this change is probably best illustrated by the relative increase in privately-owned hospitals (including ownership changes even in large university hospitals)[27], that spread the idea of hospitals as revenue-generating firms, managerial techniques became more and more influential throughout the hospital sector and regardless of ownership structure (Bär, 2011; Schrappe, 2009). As Dent, Howorth, Mueller, and Preuschoft (2004: 733) find in their study on the modernization of a German hospital network, German hospital archetypes changed from the archetype of the "Public Sector Hospital" to the "Public Sector Corporation". This shift implied changes in the (i) interpretive schemes, (ii) systems, processes and practices and (iii) structures of hospitals (ibd: 733). In short, the logic constellations that guide hospitals have changed, translating the rise of the market and state logic on the field-level into a rise in managerialism on the hospital-level.

In contrast to other Western countries in which health care organizations commonly adopted more radical restructuration approaches, German hospitals are still reflecting the long tradition of medical dominance that becomes increasingly questioned but is still notably informing hospital structures. In particular, physicians often remain in central positions within the hospital hierarchy as German law defines hospitals as organizations which are under constant medical direction (§ 107 Abs. 1, No. 2 SGB V). Chief physicians, for example, have remained the sole directors of medical departments and still enjoy considerable decision autonomy over their departments' structures and processes (Jacobs, Marcon, & Witt, 2004). Accordingly, Kuhlmann et al. (2013: 1) describe the new modes of governance that characterize German hospitals as "partly integrated control", meaning that managerial and professional governance are being combined. While the medical professional logic informs the structures and practices for quality and safety control on the operational level, physicians' influence on the top management level is constrained as German hospitals typically exhibit a collegial top management structure that is shared between the medical director, the nursing director, and the administrative director

[27] Between 1991 and 2013 the share of privately-owned hospitals increased from 14,8 percent to 34,8 percent (Destatis, 2013). In 2005, the university hospitals of Gießen and Marburg were merged and sold to the 'Rhön-Klinikum' corporation (Hanschur & Böhlke, 2009).

(Jacobs et al., 2004: 340). Additionally, cost control and accountability measures now mostly lie within the responsibilities of non-medical managers (Kuhlmann et al., 2013: 8). As medical work is increasingly scrutinized by non-physicians with regard to its quality and cost-effectiveness, the dichotomy between medical autonomy and managerial control has become a common source of conflict (Dent et al., 2004: 738) and research shows that bureaucratic structures and perceived lack of autonomy are major causes for lower levels of work satisfaction among German clinicians when compared to their American counterparts (Janus et al., 2009). Yet, the diffusion of managerial techniques in hospitals also evokes tensions between administrative staff and non-medical health care professionals. Nurses, for example, have been reported to perceive the introduction of financial incentives into their salary system to be patronizing as it questions the inherently high quality standards of their professional work (Janning, 2008). Overall, the rise of managerialism in hospitals – both a symptom and the local instantiation of increasing political pressures towards efficiency and accountability – led to an intraorganizational replication of field-level struggles between representatives of the market and the state logic and health care professionals.

However, the duality between managerialism and professionalism in German health care organization can hardly be reduced to struggles between different organizational groups. Professionals also experience intra-individual role tensions and ambiguities as they are increasingly expected to fulfill managerial roles.

The question on how German health care professionals, physicians in particular, are supposed to deal with the increasing relevance of managerial roles has received ambiguous answers. Often, practitioner literature encourages physicians to actively engage in management as the coordination and control of medical work would otherwise be left to non-medical administrative staff, which would further reduce peer-control and medical autonomy in hospitals (Ekkernkamp, 2011). Accordingly, recent practitioner publications are much concerned with the specifics of additional managerial training for medical managers (Tecklenburg, 2011; Tecklenburg & Liebeneiner, 2010) and provide examples for useful managerial techniques to support physicians in their role as both medical professionals and managers (Dick, Krieg, & Schreiber, 2002). While formal managerial education and the tactical acquisition of managerial techniques is evidently most relevant for physicians in the executive ranges of hospitals, the role of the 'medical manager' has also – though to a lesser extent – gained importance in the lower ranges of the organizational hierarchy, reaching down to the operational core of hospitals. Currently, health care professionals are not only required to acquiesce to non-medical managers' prescriptions about the (cost-)efficiency of their work, but are increasingly expected to develop a managerial perspective on their work (von Eiff, 2001). These new role expectations put health care professionals on all levels of the hospital hierarchy in a

situation in which they are 'caught between two stools' as they have to maintain professional integrity while contributing to the economic survival of their organization. Consequently, literature reports mixed reactions among German health care professionals regarding the infusion of their organizational role with typical managerial elements.

Jacobs et al. (2004), for example, find in their study on clinicians' access to and interest in cost and performance information, that German hospital physicians are clearly interested in cost information and consider cost information to be an important factor for their clinical decision-making (e.g. by weighing different treatment options) and their decisions on investments in medical equipment. Further evidence from interview data shows that clinicians have accepted their managerial role as a necessity against the background of field-level pressures and are willing to take on responsibility for their organizations' economic survival. As one medical director stated, "[t]he medical staff think that the new DRG system is very complicated but we must learn it. If we don't learn the system it will be dangerous and our hospital will go broke" (Jacobs et al., 2004: 344). On the other side, the managerial role of health care professionals has been declared the cause of an "identity crisis" among physicians and the proliferation of the managerial perspective in hospitals has been depicted as "Trojan horse [that] carries economics into the daily medical work" (Woopen, 2009: 181)[28].

Overall, health care professionals' reaction towards their double role as professionals and managers within their organization can probably be best summarized as the acceptance of a necessary evil. While professionals still remain skeptical over administrative staff's rising involvement in their work (Encke, 2008; Lesinski-Schiedat, 2007), they seem to acknowledge the inevitability of increasing managerialism in their working context. As Leschke (2013: 315) explains for the professional group of physicians: *"The doctor, naturally, feels impelled to consider the efficiency of his work, which often causes remorse. Still, he gives in. Also in his own interest"*.

Besides being forced to balance professional and managerial roles, German health care professionals are increasingly confronted with new types of organizational arrangements that foster the development of new roles which provide professionals with new opportunities to exert influence in their organizations. The general strive for efficiency, effectiveness, and quality in health care brought forth process-oriented structures that transcended the strict division between ambulatory and inpatient care and integrated several medical subspecialties (Mühlbacher, Nübling, & Niebling, 2003). With the rise of integrated health care centers (Knieps &

[28] This and the following quote have been translated from German by the author.

Amelung, 2010), new administrative roles emerged to secure the coordination of patient- and disease-centered care across organizational and professional boundaries. The proliferation of 'case managers' in German hospitals represents a typical example of these new administrative roles that enabled health care professionals to acquire new sources of authority. The role of a case manager in health care generally comprises the "managing, coordinating, facilitating, and expediting patient care" (Carr, 2009: 333) and puts the involved professionals in a brokerage position between patients, physicians, and other health care professionals. In line with the global spread of advanced nursing practice that promotes more responsible and more managerial nursing roles (Sheer & Wong, 2008), case management in German hospitals is typically exerted by specially trained nurses, increasing their leverage in the coordination of clinical care (Ewers, 1997; Wendt, 2012). Specifically, by acquiring the role of case managers, nurses do not only contribute to the efficiency and effectiveness of service provision in their organization but also gain access to an important position in the organizational hierarchy. Being able to coordinate, schedule, and synchronize medical services partly reverses the traditional power relations between nurses and physicians, and thus resonates well with nurses' professional project on the field-level (see section 4.1). Accordingly, while medical professionals still represent the dominant professional group within German hospitals, the focus on process efficiency induced structural changes that created 'power niches' for non-medical professionals.

Besides creating opportunities for low-status professionals like nurses to gain power through formal authority, the emergence of new administrative roles in hospitals also provided physicians with opportunities to buffer their work against managerial influence and gain strategic power in their organizations. As internal quality management systems became legally mandatory in 2004 (§ 135a SGB V), many hospitals began to introduce formally defined and certifiable quality management systems such as the models provided by the European Foundation for Quality Management (EFQM), the DIN EN ISO 9001:2000 norm, or the Cooperation for Transparency and Quality in Health Care (KTQ). These formal quality management systems include the appointment of quality managers, an organizational role that is commonly fulfilled by clinical professionals who are familiar with the working processes on the operational level as well as capable of defining and controlling appropriate indicators of service quality. Often, it is physicians who work as full-time or part-time quality managers[29] as the role of the quality manager in health care presupposes sufficient clinical experience to be able to mediate between the

[29] While quality managers in health care do are not generally required to have a professional background in medicine, it is not uncommon that this role is filled by physicians (Blumenstock, Streuf, & Selbmann, 2005). Some specific quality managers, such as quality managers for blood transfusion (Kaiser, 2006), do, however, have to be medical doctors with a specific amount of clinical experience.

administrative and the clinical staff of a hospital (Haust-Woggon, 2011). Against the background of the critical importance of service quality in health care – both from a normative as well as from an economic and a regulatory perspective – quality managers occupy a strategically important position in the organizational hierarchy. They ensure compliance with critical quality indicators and regulatory norms, evaluating hospital doctors' performance as peers while reporting to the hospital management as part of the administrative elite. The control of hospital quality management by medical professionals thus provides an illustrative example of how physicians strategically exploited an increase in administrative positions to protect medical dominance within the German hospital sector (cf. Kirkpatrick et al., 2011). While the accountability and efficiency turn in German health care has notably reduced the direct influence of clinical professionals on the structures and practices of their organizations, physicians seem to have adapted well to the increasing importance of managerial roles as new sources of power in hospitals.

However, the rise of managerialism in German hospitals did not only bring about a greater variety of administrative roles but also affected professional role divisions on the operational level. As questions about the most effective and efficient 'skill mix' among the health care workforce arose, more and more hospitals began to re-evaluate the division of labor between medical and non-medical health care professionals in clinical practice (Aiken, Clarke, & Sloane, 2002). Some privately-owned hospitals even went so far as to introduce new occupations to achieve an optimal skill-mix that followed the example of industrial work specialization. As these new job profiles created additional competition for members of established professions, lacked state accreditation, and fostered the fragmentation of medical care, they evoked much criticism from both nursing and physician groups (Dielmann, 2010; Harder et al., 2008) and eventually remained a rather marginal phenomenon in the German hospital sector.

Yet, the strive for an efficient division of labor in health care also led to a re-evaluation of role divisions among the established health care professions. Against the background of doctors shortage and the costliness of medical work, more and more hospitals have started to implement structured models of task delegation from physicians to nurses (Heil, 2014). While health care regulation did not allow medical tasks to be fully transferred to nurses until 2012[30], several pilot projects of task redivision , primarily in university hospitals, bear witness of the practical appeal of

[30] Before the publication of a G-BA guideline for the transfer of medical tasks to non-medical health care professionals (G-BA, 2014b), the redivision of tasks between physicians and nurses was only allowed in the form of a case-based delegation. This included autonomy in the exertion of the respective task while decision-rights officially remained with the doctors. Yet, as will be illustrated in the empirical study in section 5.3, delegation projects in hospitals usually included a general transfer of specific task bundles rather than being a strictly case-based delegation of task execution.

enhancing nurses' roles in the provision of health care services in hospitals (Hänsch et al., 2010; Rausch, Schäper, & Rentmeister, 2008; Schramm, 2007). Study findings underline that a redivision of tasks between physicians, nurses, and other non-medical health care professionals may improve critical quality indicators like patient satisfaction and continuity of therapy (Meyenburg-Altwarg & Tecklenburg, 2010) and holds significant potential to increase the overall efficiency of service provision in health care (Lussi, 2012; Neiheiser & Offermanns, 2008; Offermanns, 2008). However, despite its positive effects on process efficiency and quality of care, the redefinition of health care professionals' task spheres remains a challenging endeavor for hospitals.

While assuming medical tasks resonates well with nurses' professional project on the field-level as it opens opportunities to demonstrate and expand the professional qualification of nurses, the delegation of medical tasks has been found to increase nurses' perceived workload (Meyenburg-Altwarg & Tecklenburg, 2010: 28). In addition, legal and task uncertainty are commonly discussed as main challenges when implementing new modes of task division between nurses and physicians (Achterfeld, 2014). While additional training and formal agreements to restrict nurses' scope of liability are relatively easy to arrange in large hospitals, changing the social relations between different professional groups is rarely without struggle. Hospital physicians were generally open towards transferring routine-tasks to non-medical professionals, however remained cautious about the potential implications of comprehensive task redivision projects for the professional hierarchies between members of the medical and the non-medical health care professions (Heil, 2014; Klakow-Franck, 2010). For nurses, task delegation has been discussed ambiguously as both an opportunity for empowerment and a source of stress due to role insecurity and excessive work strain (cf. Tewes, 2014: 217f.). Given the potential economic benefits of a task redivision between physicians and nurses and its ambiguous implications for nurses' professional role in an actual work context, it seems important to investigate when and why hospital nurses are willing to accept changes in their assigned task spheres.

Accordingly, the study presented in section 5.3 will examine how organizational boundary conditions and characteristics of change projects interact to induce openness towards new task spheres among nursing professionals. As in the previous chapter, I will first discuss extant empirical findings on professionals' institutional work within their organizations and identify gaps in the literature before addressing these gaps with a self-contained empirical study.

5.2 Theory: Professionals' Role in Organization-Level Change

Within organizations, professionals exert institutional work both collectively through their respective professional or hierarchical groups (e.g. Kellogg, 2012; Kellogg et al., 2006) and individually in their roles as managers or employees (e.g. Battilana, 2011). While the technological and market environments by which organizations are characterized restrict professionals' potential to pursue macro-political agendas within their organization, professional organizations have been shown to provide an important sphere for agency that may help advance professional projects on the field-level. As elaborated in section 3.2.2, organizations may serve as springboard for the professional projects of subordinate professional groups but may also be conducive in reinforcing the dominant status of a profession by providing an additional system of hierarchization.

Yet, professionals' engagement in institutional work on the organization-level rarely occurs as an explicit attempt to promote their professional project on the field-level but rather results from more immediate dynamics inherent to the multiple, sometimes conflicting, roles that professionals have to fulfill when they become members of an organization (see section 3.4.2). Antecedents of professionals' institutional work on the organization level can thus not be clearly categorized along the dichotomy of 'opportunities and threats' to their profession. Much rather, professionals' institutional work at the organization level is induced by tensions and ambiguities between professional and organizational roles.

Antecedents: When and Why Professionals engage in Organization-Level Change

As professional organizations represent contexts in which actors with diverse professional backgrounds have to collaborate in 'forced unity' to cooperatively secure organizational survival, tensions between different groups of actors and their respective roles are common (Apesoa-Varano, 2013; Hall, 2005; Kirkpatrick et al., 2011; Mitchell et al., 2011; Salhani & Coulter, 2009). Mostly, these tensions result from diverging ideas on which logics are to be integrated when defining organizational goals, strategies, and structures (Coombs & Ersser, 2004; Raelin, 1986; Snelgrove & Hughes, 2000). As noted above (see also section 3.2.2), research has focused much on how professionals engage in maintenance work by resisting the control of their work by managers. Scholars have emphasized that the "relationship between professionals and managers [is no longer] an antagonistic one" (Dent, 2003: 108), implying that professionals slowly open up to managerialism as inherent element of their working context and get increasingly involved in management activities (see also section 3.2.2). Still, tensions between management and professionals remain a dominant theme in the study on when and why professionals exert

institutional agency within the context of their organization. For example, Waring and Currie's (2009) ethnographic study of the implementation of patient safety systems in an English hospital shows that physicians are likely to engage in institutional work when they perceive managerial structures and practices to constrain the enactment of their professional role. While physicians' role as organizational employees would imply acquiescence to formal organizational structures such as risk management systems, Waring and Currie (2009) find that hospital physicians – even though they agreed on the general importance of risk management in medical practice – were unwilling to accept managerial approaches to organizational safety. Their critical stance towards the implementation of a critical-incident-reporting system as means of knowledge- and risk management primarily rested on physicians' rejection of having their work codified and assessed by non-peers. As Waring and Currie (2009: 772) point out, the reasons for physicians' negative reaction towards formal knowledge management systems lie in the importance of exclusive and implicit knowledge for physicians' power both within and beyond their organization. Generally, professional power is based on the widely shared perception that professional knowledge is tacit, embedded in practice, and that its successful application requires specific practical experience (Abbott, 1991). These characteristics of professional knowledge make it largely inaccessible to laypeople and thus justify professionals' privileged position in organizations and in society as a whole. Hence, any attempt of external codification and control of professional knowledge poses a potential threat to professionals' main source of power (cf. Adler & Kwon, 2013).

Consequently, Waring and Currie (2009: 766f.) report that physicians motivated their critical stance towards the new incident-reporting-system by emphasizing the inappropriateness of the managerial perspective for assessing and improving risk in medical practice. A closer look at the findings reveals that physicians provided both pragmatic and normative arguments for their rejection of the new risk management system. Pragmatic arguments related mainly to the usefulness of the proposed system for improving patient safety. The centralized risk-management-system comprised the accumulation of knowledge on patient safety through standardized reporting forms. Each department was supposed to use these forms to routinely report safety-relevant incidents and was further expected to employ standard procedures when communicating with the risk management department. Risk officers would then "translate and re-code reported information into a format that aligned with the assumptions and expectations of the national patient safety agenda" (Waring & Currie, 2009: 763) which included the codification of free-text narratives provided by the clinical staff into distinct risk variables. Physicians perceived this extensive gathering of information and the interpretation of clinical incidents by risk officers who lacked medical knowledge to be a pointless accumulation of data. They implied that the interpretation of data by non-medical risk officers would be flawed

due to their lack of technical expertise and their recommendations for service improvement would consequently be of little value for actual medical practice. As illustrated by interview data, physicians considered the managerially-lead incident-reporting-system to be little more than a display of bureaucratic rationality, a simple "collecting [of] data for the sake of it" (ibd.: 766). However, the mere perception of redundancy of the centralized risk-management-system was not the only reason for physicians to engage in institutional maintenance work. The fact that management acquired significant amounts of data about medical practice and inferred their own conclusions about the quality of physicians' work evoked normative considerations about the intentions of the risk management department. One the one hand, physicians felt that the reporting system was intrusive to medical practice, a "big brother thing", as one physician called it (ibd.:766). On the other hand, physicians believed that a system of mutual reporting – particularly one that heavily relied on filling out standardized forms – was incommensurable with the logic of medical professionalism which promoted informal peer control. As a consequence, the medical staff largely refrained from reporting safety-relevant incidents and thereby effectively undermined managerial plans. However, with rising public, political, and organizational pressures towards the implementation of structured systems to ensure patient safety, the simple rejection of these systems proved to be a form of maintenance work that was "difficult to sustain" (ibd.: 767). Physicians thus began to develop more elaborate and less openly conflictual strategies for maintaining the dominance of the medical professional logic in their organization. Overall, Waring and Currie (2009: 770f.) identify three distinct strategies through which physicians were able to buffer their work from managerial control. In the department of obstetrics and gynaecology, physicians engaged in "co-optation", appropriating control of the risk management system by integrating the new managerial methods of quality control into their existing local and physician-led procedures of quality assurance. The departments of rehabilitation and acute medicine engaged in an "adaptation" of risk management. Specifically, physicians in these departments developed an alternative incident-reporting system that allowed for anonymous reports, was less complicated and bureaucratic, and promoted the collection of data by a central physician instead of a non-medical risk officer. Through the development of this relatively advanced alternative system, physicians from these departments could easily justify their non-participation in the central system as patient safety was obviously well accounted for. Lastly, the department of anaesthesia was able to fully circumvent managerial intervention as this department had already had a voluntary reporting system in place for more than five years. Here, physicians could refer to the proven superiority of their system and could thus refrain from participation in the managerially-led risk management system.

Two points from Waring and Currie's (2009) study are particularly noteworthy when trying to understand professionals' institutional work within the context of their organizations. First, while the authors provide an illustrative case for the well-researched tension between management and professionals, they also show that managerial and professional ideas of appropriate organizational structure and practices do not necessarily diverge. With doctors stating that "the safety of patient care is paramount" to them (ibd.: 766), Waring and Currie (2009) uncover a situation in which the rejection of managerial systems is clearly associated with professionals' fear of losing power rather than with fundamentally different ideas on how hospitals should be designed. While potential loss of status and power are a common antecedent of any actors' institutional work (professionals and non-professionals alike) (cf. Battilana, 2006, 2011), the case study presented here draws attention to the political dimension of professionals' institutional work within their organizations. Specifically, physicians' reaction towards the central risk management system can be viewed as a local instantiation of the basic principles of their professional project. As professional power is based on the control of a specific area of expert knowledge that allows for the definition and exclusion of 'outsiders', professionals are careful to maintain the impression that their knowledge base is inaccessible to non-professionals. If managerially-led risk management systems had uncovered the potential codifiability of professional knowledge, physicians would have faced the risk of being 'manageable' like regular employees and the medical profession could have lost a major base for the justification of their extensive professional autonomy. Thus, while professionals have generally adapted well to practicing in large organizations (see also section 3.2.2), they still resist managerial control when it bears the risk of their profession being 'de-mystified'. Secondly, Waring and Currie's (2009) findings underline that even if professionals' institutional work is induced by a stereotypical tension between professional autonomy and managerial intervention, their response strategies are contingent and embedded in context. While Waring and Currie (2009: 773) attribute differences in institutional maintenance strategies primarily to physicians' different medical subspecialties, they also point out that professionals' institutional work needs to be studied against the background of its embeddedness in "local, organizational and institutional levels". As I will further elaborate on in the course of this section, this insight is particularly important to fully understand professionals' institutional work as situated practice and to avoid a conceptual over-politicization of professionals' agency within their organizations.

While the dichotomy between managerial control and professional autonomy as a cause of professionals' institutional work has become a classic tale in the sociology of the professions (Leicht & Fennell, 1997; Leicht et al., 2009; Reed, 1996) and – more recently – also in institutional research (Singh & Jayanti, 2013), professionals' institutional work may also be induced by tensions between different profes-

sional groups. Here, institutional work is not an attempt to sustain professionalism as basic principle of organizing but to promote or defend a specific kind of professional logic. However, like the conflicts between management and employed professionals, interprofessional tensions often play out as struggles about who is to be in control and whose definitions of reality prevail within an organization. A prominent and frequently cited example of intraorganizational tensions between different professional groups are conflicts between the medical- and the non-medical clinical staff in hospitals (Coombs & Ersser, 2004). While holitistic and efficient patient care is crucially dependent on close interprofessional collaboration (Keshet et al., 2013), professional roles often supersede shared organizational roles as clinical employees, resulting in efforts to replicate or undermine the interprofessional hierarchies on the field-level (Sanders & Harrison, 2008).

Organizational and professional role differences may become particularly relevant when the structural context of an organization changes. This is the case when e.g. technological or process innovations are being introduced. Like technological jolts on the field-level, the implementation of new structures and technologies can give impetus to professionals' institutional work since they may shift power bases. This is the case because their roles are embedded in and depended on the structures of an organization (Kitchener, 2000; Leicht & Fennell, 1997; Leicht et al., 1995). Organizational innovations such as the introduction of new technologies may decrease the taken-for-grantedness of organizational structures, including role divisions and professional hierarchies, as they often render existing expertise obsolete and thus open a new space of expertise which professionals can leverage to gain status (cf. Suddaby & Viale, 2011). While within organizations, professional groups who compete for dominance on the field-level are likely to achieve 'pragmatic truces' that allow for effective collaboration (cf. Nelson & Winter, 1982), organizational innovation may destabilize these agreed-upon role divisions and hierarchies. At the very least, organizational innovations will 'activate' the cognitive and normative orientations against which different professional groups make sense of new structures and practices (Ferlie et al., 2005; Fitzgerald, Ferlie, Wood, & Hawkins, 2002). As different interpretations of reality are likely to cause tension between professional groups, innovations in professional organizations are commonly accompanied by struggles over interpretive authority as different professional groups place their claims of expertise on the respective area of innovation.

An example of how the implementation of technological and process innovations becomes both a trigger and an object around which different health care professionals seek to establish their claims of interpretive authority is provided by Ferlie et al. (2005). The authors study the implementation of eight different kinds of innovations in health care organizations and find that ideological boundaries between professional groups critically affect their implementation success. Two cases illustrate

particularly well how organizational innovations may trigger institutional work among professionals. The first case is the implementation of a new computer-supported system to manage anticoagulation service provision to prevent strokes in acute care settings. Ferlie et al. (2005: 124) describe this case as a negative outlier case since this innovation never spread beyond the pilot project stage. Here, a complex system of inter-professional boundaries and the maintenance of homogenous cognitive and normative communities played a key role in the non-spread of the innovation. While the implementation of the new system involved "hospital-based cardiologists, haematologists, and interns on the one side, and doctors and senior nurses in primary care and new professional groups of computer systems designers and Health Services researchers on the other" (ibd.: 125), the conflict between physicians and nurses shows the most typical pattern of institutional work among health care professionals: The new system required a shift of administrative responsibility from interns to nurses that would have implied a new role for nurses. However, in the respective case, the responsible senior nurse "remained isolated" (ibd.: 125) and thus unable to promote the new system. The reason for this lack of cooperation can be found in the maintenance work of physicians who replicated the typical medicine-nursing hierarchy of the field by remaining doubtful about a nurses' competence to support this new technology. A second case in Ferlie et al.'s (2005) study that illustrates well how organizational innovations may motivate professionals to exert institutional agency is the introduction of a new service delivery system for the care of women in childbirth (ibd.: 120). Specifically, this innovation comprised a re-evaluation of risk in childbirth and encouraged the provision of more information to patients. While this innovation showed a generally more positive outcome than the case of computer-aided anticoagulation provision, it was still widely contested. In particular, midwifes' and obstetricians' diverging stances towards the medicalization of childbirth (ibd.: 128) caused these professional groups to either work towards the maintenance of medical dominance or towards new role divisions within childbirth services. While obstetricians argued that, due to ambiguous scientific evidence, risk in childbirth is not easy to define (and thus should remain mainly in the sphere of medical specialists), midwifes emphasized the importance of the mothers' wishes and the lack of evidence for a superior outcome quality in 'medicalized' births (ibd.: 127). Ferlie et al. (2005: 128) summarize their findings by pointing to "social […] and […] cognitive or epistemological boundaries between and within professions" that inhibit the diffusion of innovation within multiprofessional organizations such as hospitals. While the focus of their study is not explicitly on professionals' institutional work in the narrow sense, it holds some valuable insights on when and why professionals promote or hamper institutional change within their organization. On the one hand, organizational innovations may directly challenge given role divisions between professional groups, threatening

privileges or providing opportunities for status increase (as illustrated by both the case of computer-aided anticoagulation and the case of childbirth). In these cases, organizational innovation induces institutional work as a means to gain or maintain intra-organizational status. On the other hand, organizational innovations may disrupt given patterns of collaboration and depict an object of which organizational actors make sense against the background of their roles. Here, organizational innovation brings diverging interpretations of reality to the surface and may lead professionals to engage in institutional work in an attempt to maintain the relevance of their cognitive and normative frameworks within their organization (as illustrated by the concept of 'risk' in the case of childbirth services). In short, as any innovation necessitates interpretation, new technologies, structures, or practices may not only evoke intentional and projective attempts to gain power over other actors but may also induce less political institutional work in the sense of applying and defending specific, 'professional worldviews' within the organization.

In his well-cited mixed-method study on the structuration processes in radiology departments that occurred around the implementation of CT Scanners, Barley (1986) further illustrates how the introduction of new technologies may not only foster but 'force' professionals to engage in institutional work. Specifically, he shows that innovative technologies, which usually require special knowledge, may disrupt given role divisions in professional organizations to an extent that professionals have to completely restructure their roles around the new technology. Providing evidence from in-depth case studies in two hospitals, Barley's (1986) study shows that new technologies induce agency for two reasons. First, a change in technology – especially when the use of the new technology is knowledge-intensive – destabilizes the social hierarchies between different professional groups as these are based on exclusive and clearly defined areas of expertise. The use of new technologies often requires the application of specific, new knowledge that has yet to be assigned to a professional group's area of expertise. Accordingly, new technologies do not only generate uncertainty with regard to its use but also create an 'institutional vacuum' as they provide new spaces of expertise that are open to contestation. Second, technology itself is a social object, a potential resource, which professionals can leverage to establish new role divisions within their organization. Hierarchies become structured around the tangible object of technology which, in turn, becomes an inherent part of an organization's social order.

Barley's (1986) in-depth analysis of technology implementation as a challenge to intraorganizational social orders draws on the empirical cases of the radiology departments in two hospitals ("Urban" and "Suburban") in Massachusetts. Both of these hospitals introduced CT scanners, which, at the time of the study, were an innovative technology for diagnostic body-imaging. Radiologists and radiology technologists, the two main professional groups in radiology, commonly lacked

experience in operating these scanners. Hence, in both hospitals, the implementation of CT scanners proved to be a disruptive event. However, while both hospitals purchased the exact same type of CT scanner, the implementation of this new technology had quite different outcomes with regard to the role divisions between radiologists and technologists. This was the case as the composition of the respective implementation teams differed and different patterns of structuration emerged. In the "Urban" hospital, a young radiologist who specialized in computed tomography during his residency training and an experienced radiologist who was familiar with body-scanning literature were key members of the implementation team. Knowledge about the new technology thus remained with the radiologists as the hitherto dominant actors in radiology. During the first applications of the CT scanners, radiologists merely gave orders to technologists, never justified their sometimes contradictory orders, and even directly interfered with the control of the CT scanners. This behavior prevented technologists from learning about the new scanners, led to confusion, and thus reinforced radiologists' dominant role at Urban. Only when inexperienced radiologists began to take over CT duty, interaction changed. Radiologists, due to their lack of expertise in CT scanning, now commonly inquired technologists about appropriated courses of action while technologists provided them with advise when asked. Yet, the institutionalized authority structure was maintained since technologists were only approached for technical consultation while diagnostic expertise and overall responsibility remained with radiologists.

At Suburban, however, the implementation of CT scanners induced institutional change, disrupting and eventually reversing the role divisions between radiologists and technologists. In contrast to Urban, the implementation team at suburban included two technologists who were experienced in using the new body-scanning technology. Additionally, a new radiologist who had recently completed a fellowship in computed tomography complemented the team. In the initial phase of implementation, radiologists and technologists negotiated roles and duties in a collegial atmosphere which Barley (1986: 91) describes as "tentative climate of joint problem solving […] that more closely resembled the ideal of complementary professions working in concert". As technologists had sufficient expertise to safely operate CT scanners, radiologists gave them considerable discretion over routine decision and experienced technologists even began to administer injections. Still, the general role division between radiologists and technologists was not yet questioned. However, as less experienced radiologists were introduced to CT duty, the institutionalized order between the two professional groups began to erode. Due to radiologists' lack of experience, their orders were often based on wrong assumptions and included faulty suggestions. The more experienced technologists reacted with "clandestine teaching" (Barley, 1986: 91f.), subtly offering radiologists' corrective information without trying to lecture them. However, as radiologists were unfamil-

iar with interpreting the new images, the usual flow of diagnostic information from radiologists to technologists could not be sustained. As technologists began to regularly provide diagnostic information due to the practical contingencies of CT duty, the roles between them and radiologists were reversed, causing discomfort among both professional groups. As a result, radiologists displayed increasingly hostile behavior towards technologists, e.g. blaming them for technical malfunctions of the CT scanners. Trying to alleviate conflicts, technologists took over routine decisions without consulting the radiologists anymore. Radiologists, in turn, noticed their obvious redundancy and thus avoided being in the CT room with technologists. According to Barley's (1986: 94) observations, they engaged in a very peculiar type of institutional maintenance work to prevent their loss of authority: *"When assigned to CT duty, most radiologists remained in the radiologists' office and several even went so far as to close the door to the office and shut the window between their desk and the secretary's desk".* Naturally, these attempts to "save face" through avoidance (ibd.: 94) reinforced technologists' increasing autonomy and eventually helped institutionalizing the role reversal rather than preventing it.

Interestingly, the structuration process in Suburban depicts a case in which technology disrupted given role divisions and provided an opportunity for institutional change but was not perceived as such by the low-status group of radiology technologists. As Barley (1986: 94) notes, technologists were very hesitant to take over routine tasks and were generally very careful to not openly question radiologists' authority. While technologists eventually redefined their roles in a way that allowed the effective use of the new CT scanners, their institutional work can be described as reluctant, born out of practical necessity rather than political strategizing. Accordingly, Barley's (1986) findings underline that inter-professional tensions within an organization have to be distinguished from the highly political conflicts between professions on the field-level. In contrast to the field-level, where low-status professionals often seem to lurk for the opportunities to raise their status and strategically utilize societal changes and technological jolts to promote their professional project (Kitchener & Mertz, 2012; McDonald et al., 2009), professionals within organizations may not only lack this kind of political foresight but may even be unwilling to seize new, higher-status roles. Thus, while inter-professional tensions – particularly in the context of technological innovation – are likely to evoke institutional work within professional organizations, this work is not necessarily driven by political or even strategic considerations. As shown in Barley's (1986) study, new constellations of logics may emerge in an organization when professionals reluctantly enact new roles to re-establish workable hierarchies.

As the preceding paragraphs have illustrated, professionals' institutional work within organizations often results from (i) their claims to enact their professional role against organizational constraints like managerial control and (ii) from the negotia-

tion of role divisions (both organizational and professional) between adjacent professional groups (often induced and/or catalyzed by the uncertainty associated with technological innovations). In these cases, boundary work as the selective in- and exclusion of logics in specific areas of the organization is mostly equivalent to the protection or disruption of boundaries between different groups of actors who represent these (professional) logics. Yet, professionals' institutional work on the organization-level is not only induced by tensions between professionals and managers or between different groups of professionals.

As professionals derive their status within an organization from both their professional role and their role in the organizational hierarchy, they are more likely to experience role ambiguity that motivates them to take institutional action (Witman et al., 2011). How professional and organizational roles interact to create impetus for disruptive institutional work among professionals is well illustrated by Battilana (2011). In her study on the enabling effect of social position in promoting divergent organizational change in UK health care organizations, she finds that actors' professional and organizational status predict how likely they are to initiate divergent change in their organization. As hypothesized, members of low-status professions (i.e. non-physicians) were more likely to initiate change that diverged to a greater extent from the given templates of role division among professionals. Also, actors who held higher hierarchical positions in their organizations were more likely to promote change that diverged from the established modes of role division among professionals.[31] Interestingly and in contrast to the hypothesized effect, Battilana (2011: 828) finds that members of low-status professions who obtain a high hierarchical position in their organization are less likely to promote new models of role division between professionals. While she initially assumed that actors who belong to less privileged professional groups would draw on the resources provided by their high status in the organizational hierarchy to shift institutional practices to their profession's advantage, the opposite was the case. Battilana (2011: 830) accounts for this unexpected finding by proposing that members of low-status professions who made it to 'the top' of their organization may no longer feel the obligation to raise their professions' status, may even feel threatened by professional peers, or may identify more with their organizational role and strive to secure their

[31] Low professional status is hypothesized to induce disruptive institutional work as only changes in the status-quo hold potential for these professionals to gain status. However, the engagement of actors with a high hierarchical status in disruptive change – which may potentially undermine the system that endowed these actors with status – seems counterintuitive at first. Battilana (2011: 822) motivates this hypothesis with the idiosyncrasies of the NHS system that incentivizes the implementation of new, more efficient, modes of service provision in hospitals. As individuals in high hierarchical positions of public organizations are expected to comply with political objectives, hospital top-managers are more likely to implement change that aligns their organization with these goals. Hence, professionals engaged in disruptive institutional work within their organization when their role within the organizational hierarchy included the demonstration of compliance with regulatory demands.

legitimacy as top-managers by distancing themselves from their low-status profession.

Regardless of the underlying reasons, this particular finding in Battilana's (2011) work offers valuable insights for the study of professionals' role in institutional dynamics on the organizational level. First, it generally emphasizes that professional and organizational roles interact to induce or prevent specific forms of institutional work. Second, it illustrates remarkably well how professionals' contextual embeddedness in the hierarchical system of an organization may effectively detach them from their professional project on the field-level. While the findings show that professional status in itself was an important driver of disruptive institutional work, they also show that organizational status may not only interact with, but, in fact, negate the effect of professional status. A tentative interpretation of this result may be that professionals – regardless of their strong embeddedness in their profession – exert institutional work to secure and promote the systems from which they benefit the most. While their profession often *is* the system from which they gain the most in terms of power and status, their role in their organizational embeddedness may – under specific circumstances – provide them with more benefits than their membership in a profession and hence become more relevant to the decision on whether and how to engage in institutional change. In Battilana's study (2011), non-physicians in high organizational positions opted to maintain the status-quo of the structures from which they gained their highest status by *not* promoting new modes of role division between physicians and non-physicians within their organizations. Overall, the main insight here is the relevance of professionals' organizational role for their institutional work. While often downplayed in institutional research on professionals in organizations, they need to be viewed as both, professionals who have become members of organizations and members of organizations with a professional background (Brock et al., 2014).

In sum, research suggests that professionals engage in institutional work on the organization-level because of the inherently fuzzy boundaries between institutional logics in this setting, which leads to tensions and ambiguities. The relations between logics become fuzzy because managerial involvement disrupts the enactment of 'pure' professionalism, because different professionals have to closely collaborate despite of different cognitive and normative frames, and because professionals have to fulfill multiple roles that rest on different logics. As opposed to the field-level, professionals' do not respond to general opportunities and threats for their profession but to concrete tensions that are evaluated not only against normative ideals but also against practical contingencies (see also section 5.3). As will be elaborated in the following paragraphs, the 'real-life' context of an organization which detaches professionals from the abstract ideal of professionalism that popu-

lates field-level discourses is also reflected in the strategies they use to exert institutional work.

Processes: How Professionals engage in Organization-level Change

As professionals' institutional work within organizations is often found to be aimed at resisting changes in their professional and/or organizational role which may induce shifts in hierarchies, much attention has been given to how professionals work towards the *maintenance* of institutional arrangements, including organizational role divisions, structures, and practices, (Dent, 2003; Kellogg, 2011; Kellogg et al., 2006; Numerato, Salvatore, & Fattore, 2012; Singh & Jayanti, 2013).

Since organizations – in contrast to fields – provide a context in which different professionals work together more closely and hence find it easier to establish alliances to work towards or against change, strategies of cooperation and co-optation have often been found to be a central element of their institutional work efforts. For example, Kellogg (2012) and Currie et al. (2012) provide detailed accounts on how different health care professionals leveraged intraprofessional hierarchies to form or break up coalitions in order to eventually maintain the institutional status-quo within their organization.

How professional subgroups divided reformer coalitions to prevent an alternative logic of surgery from spreading through their organization, is well-illustrated by Kellogg (2012). In her study on the implementation of a work-hour reform in the surgical wards of two hospitals, she finds that defenders used "status-based countertactics" (ibd.: 1047) to emphasize intraprofessional hierarchies and thereby co-opt agents from the reformer coalition into the defender group. Specifically, Kellogg (2012) presents a comparative case study of the 'Advent' and the 'Calhoun' hospital, both of which tried to implement a politically prescribed work hour reform to reduce the work of surgical residents from 100 to 120 hours per week to 80 hours per week. While Advent eventually succeeded in adapting work practices to effectively cut the working hours of residents, reform implementation at Calhoun failed. Initially, residents and chiefs in neither of the hospitals were particularly open towards the planned changes. While chiefs and seniors were not opposing a cut in working hours per se, they did object to the practice changes that would have been necessary to allow for more moderate working hours. Chief and senior physicians would have been expected to encourage interns to hand off work to so-called "night floats", to support them in their post-round to-dos, and to instruct them to not come in on Saturdays (ibd.: 1552). The cut in working hours and a change in practices from individualistic, 'trusting no one'-working practices to a more cooperative organization of work in surgery violated the roles and practices that were central to surgeon's identity. Specifically, handing work over and cutting hours appeared incommensurable with the idea of being an 'iron man' who relied solely on himself

and was fully committed to his work, neglecting personnel relationships and well-being while still single-handedly fulfilling complicated tasks, even when under intense pressure (ibd.: 1552). As performance was primarily measured by the extent to which residents, both male and female, were able to display these macho behaviors, defenders of the old practices were able to use the importance of being an 'iron man' as a powerful leverage to disrupt reformer coalitions. Further, despite their common adversary and their belief in the benefit of well-rested residents, reformer coalitions were heterogeneous and consisted of three distinct subgroups: female chiefs, a few male chiefs, and interns (ibd.: 1553). Due to the heterogeneity of the reformer group and the importance of stereotypical male behavior as an indicator of status in surgery, defenders relied on gender-based stereotypes to de-legitimize practices and segregate male reformers from the reformer coalitions. On the one hand, opponents discursively constructed the new practices as being typically female, reflecting "emotionality, helpfulness, and sensitivity to the needs of others" (ibd.: 1555). On the other hand, defenders sanctioned male reformers' association with the reformer group by attacking their status, calling them "softies" (ibd.: 1555) and shunning them. Specifically, they combined a system of sanctions and rewards to disengage male reformers from the reformer coalitions. They excluded persistent reformers from what Kellogg (2012: 1556) calls the "Boy's Club", a social space that included typical macho activities like checking out nurses and rating the attractiveness of female visitors. As these behaviors created a sense of belonging and were inextricably linked to gaining and maintaining the 'iron man'-status on which surgeon's standing in a ward rested, male reformers – fearing for a loss of status among their peers – began to distance themselves from the female reformers and the now 'female' practice of cutting work hours. Further, opponents reinforced male reformers' disassociation from the reformer coalition by reintegrating them into the 'Boy's Club', showing notable solidarity with those who disengaged from reformer practices and "rewarding them with male camaraderie and games" (ibd.: 1556). While Kellogg (2012) observed these strategies in both Advent and Calhoun, they were only successful in Calhoun where the implementation of the work hour reform eventually failed. The explanation provided for these diverging outcomes gives an interesting insight on how professionals' institutional work strategies and idiosyncratic conditions within their organizational contexts interact to make such strategies more or less successful. While surgery is generally dominated by men who commonly made up about 70 percent of the surgical staff in both hospitals, an unusual shift in the gender distribution of the surgical ward of Calhoun had occurred prior and during the implementation of the work hour reform. Specifically, Calhoun experienced a strong increase of female surgeons in chief resident positions from about the usual ten or fifteen to 38 percent. This, in turn, caused male residents to experience a stronger 'baseline' threat to their status, expressing

concerns that "women are taking over" (ibd.: 1557). This perception of threat was reinforced by a female resident applying for a postresidency position in trauma surgery, a position that had hitherto been exclusively held by male surgeons. Beside this competitive threat, male residents also experienced a threat to their distinctiveness as females in Calhoun were more prone to disclosing typical 'male' behavior, e.g. by wearing the exact same work attire, telling drinking stories, and engaging in nicknaming (ibd.: 1558). Thus, the categories of 'male' and 'female' behavior were more at risk of being uncovered as social construction rather than inherent qualities of the respective group of residents. Accordingly, defenders had a particularly high interest in keeping the boundary between 'high-status-iron-men' and 'low-status-females' intact. As a consequence, male reformers were more concerned about losing their "male privilege" (ibd.: 1558) by associating with female reformers and advocating 'female' practices and thus more likely to abandon their reformist stance.

Overall, Kellogg (2012) illustrates well how professionals' leverage perceptions of group membership and associated privileges to split up reformer coalitions and thereby prevent institutional change within their organization. Further, she shows how specific conditions in the organizational context may lead to an increasing relevance of intra-professional differences, which professionals may use as a resource in their strategies of institutional work. Interestingly, Kellogg (2012) provides a case in which the changes in question did – at first sight – not seem to have major implications for the overall logic of surgery and had been endorsed by a political body of the medical profession (specifically, the American Council for Graduate Medical Education) but were still heavily contested. Yet, as the results show, professionals may reject even minor changes in work practices when these affect central components of their professional logic. What is considered a central component of their logic obviously depends on what the majority of professionals perceive to be the source of their privileges. In the case of surgery, this was a particularly high level of masculinism. However, such elements of logics are not static and may gain or lose relevance depending on contextual conditions. As Kellogg's (2012) results show, mundane coincidences such as a specific composition of an organizations' workforce at a given time may affect the salience of logic elements and thus drastically shape the outcome of professionals' institutional work efforts.

While Kellogg (2012) focuses on how reformer coalitions were divided to disempower them and thereby prevent institutional change, other research has focused on how professionals co-opt other actors within their organizational context to *create* coalitions across professional boundaries that allow for the effective maintenance of the institutional status-quo. In their study on clinical geneticists' institutional work in UK health care organizations, Currie et al. (2012) find that geneticists co-opted nurses and general practitioners to foster new modes of work division in a way that

helped them to subtly maintain their privileged status. Examining pilot projects within the mainstreaming genetics policy initiative of the NHS, the authors investigate how clinical geneticists worked towards the maintenance of their inter- and intraprofessionally high status as specialist doctors. They present findings from 11 in-depth case studies from three distinct work streams through which the mainstreaming genetics initiative was implemented. While the overall political goal was to make specialist treatment more efficient and more readily available to patients, three different kinds of pilot projects emerged as separate work streams to include genetics services into regular patient care. These work streams differed with regard to the kind of professionals by whom geneticists' services were to be provided. The 'Cancer genetics' (CG) work stream aimed at providing integrated care, including easier access to genetics services, within primary care. Here, specialized genetics nurses were supposed to deliver risk assessments and referral services. In the 'Non-cancer service development' (SD) work stream, genetics nurses were supposed to deliver genetics services in the mainstream areas of hospitals. The 'General practitioner with special interest' (GPSI) work stream included general practitioners to become knowledgeable in genetics services and provide them within the primary care setting. In contrast to the two former work streams, GPSI created intraprofessional competition between geneticists who, as specialist doctors, were endowed with a higher status than regular physicians.

While the cases studied show considerable heterogeneity between and within the workstreams, Currie at al. (2012) point to the importance of co-opting other professionals as an institutional strategy. This strategy was most obvious in the SD work stream. Specifically, in one organization that implemented the SD work stream, Currie et al. (2012: 947f.) find that geneticists did not resort to aggressive opposition to secure their task spheres against nurses but instead actively helped to redefine nursing roles in a way that was beneficial to both of their professional groups. Clinical geneticists encouraged nurses to autonomously lead the day-to-day management of the mainstreaming genetics project and supported them with educating and policing work to make nurses 'fit' for their new roles. While this approach appeared to promote institutional change, geneticists utilized nurses' new roles to delegate routine tasks, thereby securing the essence of their high status, that is, expert work. In contrast to the other pilot projects within this work stream, where open conflict and struggles over authority were more prevalent, this strategy of co-opting nurses proved to be more successful. Currie et al. (2012: 947) explain this by elaborating on how the co-optation of mainstream nurses lead to a "normative network of support" that secured the sustainability of the pilot project. Through this very subtle form of maintenance work, geneticists did not draw attention to the persistence of their dominant role as they did not show open resistance that is typically associated with professionals' maintenance work. Eventually, geneticists could not only secure

their status but successfully utilized their network to expand their influence intro mainstream clinical activity (ibd.: 950).

The creation of networks was similarly important to geneticists' maintenance work in the 'Cancer genetics' work stream that promoted integrated care. Here, clinical geneticists, striving to defend their specialist role against both physicians and nurses in mainstream medicine, created a network with doctors from different disciplines and carefully delegated unwanted responsibilities while extending their remits into the working sphere of other doctors. Interestingly, non-geneticists welcomed these changes as useful assistance rather than perceiving geneticists' involvement in their working areas as threat (ibd.: 953). Further, clinical geneticists worked towards the maintenance of the status-quo by supporting specialist cancer nurses to defend their higher intra-professional status against potential competition from the new genetics nurses. Specifically, geneticists designed the genetics mainstreaming projects in a way that ensured specialist cancer nurses to remain on top of the nursing hierarchy, thereby co-opting them as fellow 'higher-status professionals'. In the 'General practitioner with special interest' work stream, geneticists co-opted other medical professionals (e.g. the GPSIs) by emphasizing the common background of medical professionalism, which promoted specialization as a means to reduce medical risk. As an effect, GPSIs were more willing to accept persistent supervision by clinical geneticists, thereby allowing for the maintenance of intra-professional stratification.

Overall, Currie et al.'s (2012) study illustrates well how other than the inter-professional hierarchies on the field-level may become relevant when professionals attempt to defend roles that endow them with a special status. Here, medical professionalism – as the logic on which specialists' particularly high status rests – was being defended against modification in the sense of a more collaborative and less hierarchical structure of medical care. Ironically, geneticists utilized potential allies' interest in gaining or maintaining status to maintain their own central position in health care organizations. Specifically, the co-optation of nurses to subtly reinforce the specialist status of clinical geneticists shows how professionals establish alliances with members of subordinate professions who seek to rise in the hierarchy of their own profession. While institutional scholars have generally emphasized that – due to the social nature of institutions – successful institutional work includes the "mobilization of allies" (Battilana et al., 2009: 67), Currie et al.'s (2012) study shows how professionals utilize coalition partners' desire for a higher status to pursue their goal of maintaining extant systems of sub- and superordination. In a way, clinical geneticists did not mobilize 'true' allies who were similarly interested in the maintenance of institutional arrangements. Much rather, they exploited other actors as a resource to defend the dominance of medical professionalism as this logic promoted the ideal of 'superiority through exclusive expertise' and thus endowed geneticists with their particularly high status. Regardless of whether geneticists co-

opted physicians from other subspecialties or nurses, hierarchy and status always were central motives for the formation of coalitions. In the SD work stream, clinicians enabled nurses to raise their status, endowing them with autonomy and providing them with new, more prestigious tasks while enhancing their own status by protecting the core of their specialist tasks and freeing up additional time for their expert work. Co-opting nurses into this new system hence created "a situation of mutual gain" (Currie et al., 2012: 950) in which each professional group could expand their task sphere while clinical geneticists remained in control of their specialization area and thus, their source of higher intraprofessional status. In the GPSI stream, clinical geneticists were able to build a coalition with specialist cancer nurses as both of them had a common interest in maintaining their high status within their respective profession. Lastly, in the CG work stream, geneticists created a coalition within their own profession, leveraging the persuasive appeal of medical professionalism and physicians' common interest in lowering patient risk while subtly recreating hierarchies within the group of medical professionals. Thus, depending on which group of potential allies was perceived most useful in maintaining the specialist position and high status of geneticists, they built coalitions across professions, drawing on their common background as 'elite' within their respective profession, or teamed up with members of their own profession by downplaying intra-professional status differences and emphasizing threats to the profession as a whole.

As both Currie et al.'s (2012) and Kellogg's (2012) studies show, professionals may exploit status hierarchies that exist within and between professional groups to either break up or create coalitions to oppose institutional change. Thus, while the status that professionals obtain from their membership in a specific profession may be highly relevant to promoting or resisting field-level change (e.g. Micelotta & Washington, 2013), organizational settings foster the enactment of more differentiated roles and thus provide a context in which intra-professional differences become more salient for institutional work. Specifically, non-professional hierarchies as well as finer hierarchical gradations within the professional workforce may be used to foster or hamper institutional change. Professionals may selectively 'activate' different systems of hierarchy that are available within an organization (e.g. by utilizing intra-professional stratification) to generate a sense of similarity or difference among organizational members and thereby create or disrupt coalitions. These coalitions are an effective measure to change or maintain intra-organizational institutions such as roles, task spheres, or working conditions as (de-)institutionalization depends on whether a sufficient number of actors engage in the reproduction of structural or practical arrangements, thus making them normatively accepted and taken-for-granted social reality (Barley & Tolbert, 1997; Galaskiewicz, 1985). As opposed to the field-level, where status heterogeneity

within a profession is often actively managed to secure their political power against adjacent professions and other political stakeholders (Greenwood et al., 2002; Ramirez, 2013), professionals in organizations appear to be more pragmatic institutional workers who may also selectively disregard their professional affiliation. They are more likely to act as heterogeneous subgroups and choose their allies accordingly, even straightforwardly crossing professional boundaries to build alliances that enhance their chances of successful agency. As organizations offer spaces in which organizational and professional hierarchies interact, they provide a multitude of dimensions along which potential sub-groups can develop, thus making strategic coalitions as means of institutional work more readily available (cf. DiBenigno & Kellogg, 2014).

While finding allies is obviously a central component of professionals' institutional work within their organization, this strategy is commonly paired with discursive and non-discursive legitimization tactics. As the promotion or prevention of institutional change requires that new institutional roles, structures, and practices are viewed as (less) desirable and appropriate (Suchman, 1995: 574), institutional workers need to establish a convincing rationale as to why their organization should or should not be guided by new logic constellations. As elaborated on in section 4.2, professionals tend to rely on the manipulation of language to convey perceptions of (il)legitimacy. Accordingly, both of the studies discussed above include – more or less explicitly – discursive forms of institutional work. Currie et al. (2012: 956) emphasize that professionals' successful acquisition of allies was also based on the use of discursive strategies such as theorizing new modes of task division to be particularly risky. By presenting themselves as "arbiters of risk", geneticists were able to tactically de-legitimize changes in professional roles as the reduction of patient risk was a theme which doctors from all specializations could agree on as a legitimate goal of medical practice. While not explicitly elaborating on the discursive aspect of professionals' institutional work, Kellogg's (2012) study also points to the importance of linguistic means to maintain the institutional status-quo. Here, opponents of change relied on framing reformers' behavior as "weak" or "namby-pamby" to undermine their status within surgery and eventually break up reformer coalitions (ibd.: 1555).

However, in opposite to studies on professionals' attempts to promote or impede institutional change on the field-level (see section 4.2), research on professionals' institutional work in the context of their organization has focused less explicitly on the role of discursive strategies. While the linguistic turn in organization research has obviously sparked much interest in how organizational processes depend on and are altered through the use of language (Alvesson, 1993; Alvesson & Karreman, 2000; Bordia, Jones, Gallois, Callan, & DiFonzo, 2006), research on discursive processes in professional organizations is rather occupied with the ques-

tion on how field-level discourses inform organizational processes (Doolin, 2002; Thomas & Hewitt, 2011) and how organizational communication affects public discourse (Hardy & Maguire, 2010; Hardy et al., 2000; Hardy & Phillips, 1999) than with studying how professionals carefully arrange discursive strategies to shape intra-organizational institutions (for exceptions see: Iedema et al., 2004).

A reason for this particular difference in field-level and organization-level research can be found in both the lack of public political debates on the level of the individual organization and the variety of other influence opportunities that organizational structures offer professionals to successfully exert agency. While this should by no means imply that language is unimportant to professionals' intraorganizational institutional work, discursive strategies are often used in conjunction with other influence tactics as Daudigeos's (2013) study on staff professionals' institutional work in a multinational construction firm illustrates. His study, though dealing with a very specific subtype of clinical professionals, offers interesting insights on the "the real-life experience of institutional workers inside organizations, and their practical agency" (ibd.: 721). Starting with the question on how occupational safety and health (OSH) professionals exert influence despite their lack of formal authority, Daudigeos (2013) identifies several interlocking tactics that these staff professionals use to promote a culture of occupational safety. As opposed to members of 'classic' professions like medicine or law, staff professionals typically lack legitimacy as they are positioned outside traditional organizational hierarchies. Accordingly, staff professionals like OSH professionals struggle to exert influence in their organization. Investigating how OSH professionals promote the use of safety practices in their organization despite these constraints, Daudigeos (2013: 374ff.) finds that their institutional work unfolds through two main activities, that is, "relational legitimacy-building" and "unobtrusive influence tactics". Relational legitimacy building is achieved by external and internal networking. External relationships with social relations with "professional bodies, governmental institutions, and relevant academic institutions and research institutes" (ibd.: 735) enabled OSH professionals' creative institutional work as these provided access to valuable symbolic resources. Specifically, OSH professionals integrated arguments from their professional association in their discursive legitimization strategies. Further, diffuse perceptions of legitimacy were directly transferred from external parties to OSH professionals as the staff on the operational level lacked a deeper understanding of field-level relations, including the relevance of specific governmental and professional bodies. Internal networking relied on three tactics: OSH professionals tried to gain support from individuals with a high hierarchical status, they found allies in core-departments like sales to promote safety practices among customers, and they met with other OSH professionals to exchange information (ibd.: 736f.).

Unobtrusive influence tactics comprised the “adaptive framing of issues” and the “instrumental use of organizational processes, programmes, and systems” (ibd.: 738). Adaptive framing was a dynamic use of different arguments to legitimize safety practices. OSH professionals adjusted the normative appeal of their arguments to fit their audience, “selectively using managerial, administrative, accounting, legal, technical, and moral arguments” (ibd.: 738). Interview excerpts like “There is a real problem with the willingness of the management […]. There is always a need to show usefulness” (ibd.: 739) illustrate that these professionals rather integrated their counterparts’ guiding logic into their arguments than relying on the legitimacy of their own professional rationales. Further, OSH professionals used symbols like giving awards to operational staff who voluntarily adopted safety measures, using their definitional authority over the realm of organizational safety. The probably most interesting tactic of OSH professionals to exert institutional work was the instrumental use of organizational processes, programs, and systems. OSH professionals deliberately manipulated the information flows within these structures to institutionalize safety practices. This included selective provision of information to decision-makers (ibd.:739), fostering intra-organizational competition between subsidiaries by circulating comparative statistics on their respective safety performance (ibd.: 740), integrating safety contents into training programs while urging managers to enroll their employees in these programs (ibd.: 740), and even subtly shaping technical core procedures such as the design of construction plans through validation and advice (ibd.: 740). Lastly, OSH professionals leveraged the power of their organization to institutionalize safety practices among customers and subcontractors and further promote a holistic safety culture in the organizations’ internal and external environment.

Although Daudigeos’s (2013) study does not provide a case from a classic professional setting, it illustrates well how professionals combine their embeddedness in a profession with the social and structural resources they find in their organization to ‘sneak’ institutional change in. OSH professionals’ external ties with e.g. their professional associations allowed them to actively exert influence through a mechanism that institutionalism has traditionally conceptualized as normative isomorphism with individual professionals as passive carriers of external, normative pressures (DiMaggio & Powell, 1983). Specifically, OSH professionals used their access to external bodies to gain legitimacy both by directly borrowing rhetorical arguments from these collective actors and by positioning themselves as intermediaries between their organizations and the field, translating diffuse regulatory pressures into specific organizational practices. Trying to fully enact their roles as safety professionals in the face of their position outside the traditional organizational hierarchy, OSH professionals further utilized internal sources of legitimacy, borrowing authority from allies with high positions in the formal hierarchy or gaining access to

central organizational functions such as sales. This tactic illustrates well how professionals make use of legitimacy sources that are specific to the level of the organization when their status as 'professionals' does not suffice to successfully exert institutional work. Especially by allying with central departments, they were able to integrate safety practices into the operational core of the organization, fostering a broad diffusion of these institutions. The way in which OSH professionals employed discursive means also shows how these professionals combined aspects of professionalism with their organizational embeddedness to raise the effectiveness of their institutional work efforts. Their use of adaptive framing illustrates that these actors, though having interpretive authority over safety-related issues, were aware of the fact that arguments based on their own professional logic had little leverage within their organization as they only obtained a position at the periphery of the organizational hierarchy. Thus they dynamically adapted their rhetoric to accommodate the different occupational backgrounds of their audience rather than insisting on profession-specific, normative accounts to promote the use of safety practices. Yet, how actors combine resources associated with their professional and their organizational role is probably best illustrated by OSH professionals' intentional but unobtrusive manipulation of intraorganizational processes, programmes, and systems. Daudigeos (2013: 743) summarizes his findings as follows:

"Their manipulation of information flows related to their area of activity, and their virtual monopoly on their specific areas of expertise, allow them to facilitate the spread of specific organizational practice. In so doing, they rely heavily on the organization's existing infrastructures, such as its information system".

Obviously, OSH professionals relied on their authority to define organizational safety and their full control over safety-related information to select and distribute information in a way that helped them promote what they considered appropriate safety practices. What Daudigeos (2013: 743) refers to as "monopoly on their specific area of expertise" has already been discussed above, employing Schildt et al.'s (2011: 84) concept of "spaces of reason" which are a key source of professional power (see section 3.3.1). Professionals control specific areas of knowledge in which their discursive definitions of reality are unquestioned. Information can be presented in a specific way or even completely withheld from non-professionals who, as laypeople in the respective area of expertise, have to fully rely on professionals' assessment. Daudigeos (2013: 743) thus excellently illustrates how professionals leverage this source of power within their organizations. In their professional role, OSH professionals have authority over the contents of 'organizational safety'. In their organizational role as staff employees, they gained access to structures that helped them to diffuse the informational contents they deemed appropriate for the promotion of their safety goals. Or, as Daudigeos (2013: 743f.) more eloquently puts it: "*[...] professionals have the freedom to select evidence and create mental*

categories that influence other members' goals and behaviour, and our study reveals that this privileged position can be an important tool in their institutional work."

Besides showing how professionals combine resources from their professional and their organizational roles to achieve change within their organization, Daudigeos's (2013) study also provides an interesting insight on professionals' dual embeddedness in their profession and their organization. Extending the observation that organizational roles may counteract the enactment of professional roles (see the discussion of Battilana's (2011) study above), he finds that OSH professionals apparently felt a high moral obligation towards their profession that allowed them to exploit and manipulate organizational structures in an ethically questionable way for the sake of the 'higher good' they tried to promote (Daudigeos, 2013: 745). This insight further supports the idea that professionals' attempts of agency need to be studied in context, accounting for both their professional and their organizational role.

How extant structures are used to introduce new logics in professional organizations is further illustrated by Keshet (2013) who investigates the institutional work of actors who fall more clearly into the category of classic professionals. Specifically, she provides an ethnographic study that examines how dual-trained physicians, who are also knowledgeable in complementary and alternative medicine (CAM), promote the use of these alternative treatment concepts in regular hospitals and sick funds. Dual-trained physicians faced normative tensions within their professional role as they are embedded in two institutional logics that pertain to the same working environment. Thus, these professionals were prone to acting as institutional workers who sought to integrate CAM into the conventional health care organizations they worked in (ibd.: 612).

Keshet (2013) finds that these dual-trained physicians utilized isomorphic pressures to infuse health care organizations with the CAM logic of holistic rather than segmented, symptom-oriented care. Their institutional work efforts related to both the field- and the organization-level and show how legitimacy can be transferred to new practices by complying with the structural demands of dominant logics, in this case, the traditional biomedical logic. On the field-level, dual-trained physicians imitated the structures of conventional medicine, establishing professional (sub-)associations and holding special conferences (ibd.: 616-617). Within their organizations, the dual-trained physicians in Keshet's (2013) sample could leverage both their hierarchical status and their experience with conventional medical practice. The dual-trained physicians in her study "usually held a status of senior physician, which enabled them to initiate and champion new practices" (ibd.: 612). Being familiar with the specifics of traditional medical practice they subtly but effectively

embedded CAM as additional service in surgery departments. The tactics they used were similar to those that Daudigeos (2013: 738) identified as “unobtrusive influence tactics”, yet did not rely on tangible structures like IT-systems but on abstract concepts of appropriate patient treatment. Specifically, rather than challenging the traditional medical logic that focused on diseases and corresponding symptoms, they started to introduce their CAM treatments as an additional service to help with patient problems like e.g. anxiety or nausea that could not be addressed during the usual surgical routines (ibd.: 615). However, as they got into contact with the patients, they began to make a full diagnosis, connected the symptoms, and incrementally began to provide the kind of holistic care that was at cross with the biomedical logic (ibd.: 615-616). Through this initial compliance with the formal requirements of the traditional, biomedical logic, dual-trained physicians were able to bypass potential conflicts and – as already noted for Daudigeos’s (2013) study – managed to ‘sneak’ the new logic in. In sum, Keshet’s (2013) study provides additional evidence that within organizational settings, professionals’ can easily promote change by ‘borrowing’ legitimacy from existing structures while subtly infusing those with new logics.

Overall, professionals’ institutional work on the organization-level exhibits some interesting particularities that call for an explicit differentiation of professionals’ agency on the field-level from that on the organization-level. First, professionals’ institutional work in organizations is less often induced by general perceptions of opportunity and threat for the profession as a whole. Rather, institutional work evolves from tensions about areas of authority that define professional and organizational roles. Also, and in contrast to the field-level, professionals often fulfill dual roles in organizations which may lead to intra-individual tensions and induce specific kinds of institutional work as professionals try to resolve role ambiguities (see Battilana, 2011; Keshet, 2013). Further, as organizations provide a context in which the structuring of work is an immediately relevant aspect of institutional work, the political component of institutional change may become secondary. As nicely illustrated by Barley’s (1986) study (see above), lower-status professionals may even be reluctant to actively grasp opportunities to increase their status within an organizational context. Specifically, radiology technologists only began to redefine their roles when institutional change seemed inevitable to maintain organizational functioning. Second, organizational embeddedness does not only affect when and why professionals engage in institutional work but also how. Within organizations, professionals exert institutional work that differs both in scope and in kind when compared to their institutional strategies on the field-level. This is because organizations offer unique opportunities for institutional agency such as building alliances that transcend professional boundaries and utilizing organizational structures as unobtrusive paths of influence.

The findings discussed above clearly point towards the importance of accounting for professionals' organizational context as an arena of political *and* practical action. Even when focusing on intra-organizational dynamics that clearly reflect field-level discourses (such as the much trumpeted managerialism-professionalism-conflict), researchers must be aware that professionals in organizations face 'real-life', work-related contingencies beyond the largely abstract, political sphere that constitutes the field-level. Studying institutional work in professional organizations while assuming that organizations are a 'mere small-scale replication of the field', would thus not do justice to the technological, practical, and micro-political idiosyncrasies of organizations which may shape the processes and outcomes of institutional work considerably.

While scholars have acknowledged the relevance of specific organizational boundary conditions for the dynamics of change in professional organizations (Fitzgerald et al., 2002), we still lack comparative research that systematically investigates how organizational boundary conditions interact to inform professionals' institutional work. This gap in literature is both understandable and puzzling at the same time. On the one side, the complexities of professionals' institutional work and their interrelations with idiosyncratic organizational boundary conditions call for methodological approaches that allow for close attention to details. Consequently, researchers have primarily engaged in qualitative research, examining single or few cases to provide dense analyses of specific instances of professionals' institutional work (e.g. Kellogg, 2012; Reay et al., 2006). On the other side, more comparative studies are needed to systematically uncover relevant inter-organizational differences that affect professionals' institutional work. Due to the context-dependent, intertwined, and often improvised nature of institutional work, resorting to large-scale, quantitative studies does not appear suitable to provide a deeper understanding of how organizational boundary conditions affect professionals' institutional work. However, qualitative studies that leave the realm of in-depth process analyses and seek to uncover patterns of boundary conditions that shape intra-organizational institutional dynamics remain rare. This is surprising insofar as neo-institutionalism is no stranger to the study of organizational configurations and their relation to institutional dynamics (Greenwood & Hinings, 1996). Moreover, scholars have explicitly called for more configurational research to gain a fuller understanding of what combinations of boundary conditions motivate institutional work and affect its outcome (Battilana et al., 2009: 95). Yet, these calls seem to have been largely ignored in the study of professionals' institutional work on the organization-level.

Another shortcoming in the literature that should have become obvious from the preceding discussion of extant research is the implicit conceptualization of professionals as conservative actors who mostly engage in more or less obvious maintenance work. Similarly to the previously identified research gap, this is understanda-

ble, yet surprising against the background of the current scholarly discussion. The increased interest in how professionals resist managerial involvement in their work obviously results from the inherent tensions between professionalism and bureaucratic structures together with the empirical observation that today, a large part of professionals work in organizations (see section 3.2.2). Additionally, institutional work literature faces a chronic underexamination of maintenance work while studies of creative institutional work are overrepresented (Lawrence et al., 2013). The question on how professionals prevent their work from being infiltrated by management or adjacent professional groups provides an appropriate and relevant example for the study of institutional maintenance work (e.g. Currie et al., 2009). Accordingly, the strong focus on professionals' maintenance work seems like the logical consequence of the renewed liaison between the sociology of the professions and institutional research. Especially health care has become the prime example for tensions between professionals and management and hence also a main setting for the examination of how professionals' resist managerially induced change (Doolin, 2002; Hoff & McCaffrey, 1996; Numerato et al., 2012; Waring & Bishop, 2010). To be fair, only few studies claim an institutional perspective, and an elaborate understanding of how professionals avoid 'being managed' is of great practical relevance. However, the persistence of the idea that professionals mainly exert institutional agency to prevent changes in their organizational roles is somewhat surprising as the control-resistance-dichotomy in institutional research on professionals has already been criticized (McDonald et al., 2013: 52). This criticism, I argue, is very appropriate as the isolated focus on resistance obfuscates our understanding of the conditions that enable change in professional organizations and directs managerial attention towards the anticipation of struggles rather than the exploitation of opportunities (see e.g. Ferlie et al., 2005; Kellogg, 2012). From a theoretical perspective, the focus on professionals who become institutional workers to resist institutional change downplays the practical and pragmatic aspects of professionals' institutional work in their organization. As members of an organization, professionals do not necessarily focus on the wider political implications of institutional change within their organization. Thus, they respond to changes in their organizational roles not only as professionals but also as employees who take the practical contingencies of their daily working routines into consideration when evaluating role changes.

In sum, current literature is characterized by relative lack of studies to systematically investigate the relation between organizational boundary conditions and professionals' reaction towards institutional change while at the same time fostering the perception of professionals as opponents to change in organizations. Accordingly, instead of focusing on *how* professionals resist institutional change within the con-

text of their organizations, the following study will start with the question on *when and why* professionals react openly to proposed changes.

5.3 Empirical Study 2: Openness to Institutional Change - Altered Task Responsibilities in German University Hospitals

The following study seeks to add to research on professionals' institutional work within their organizational context by providing a systematic answer to the question of when and why professionals react openly towards institutional change[32]. In contrast to extant research that focuses much on how professionals exert maintenance work, either in the form of resisting managerial control or by defending their organizational and professional roles against other professional groups (Martin et al., 2009; Sanders & Harrison, 2008), this study tries to identify constellations of boundary conditions that affect professionals' initial reaction towards proposed institutional change. Specifically, this study investigates under which conditions nursing professionals are open to changes in institutionalized task-divisions that have the potential to majorly affect their professional roles. Drawing on a fuzzy-set qualitative comparative analysis (fsQCA) of change projects in the internal medical departments of 14 German university hospitals, I find three configurations of boundary conditions that foster nursing professionals' openness to changes in their working practices. While the three types "Pragmatic Progress" (high functional and low institutional pressure), "Authorized Professionalism" (high institutional pressure and involvement of a high-status change agent in a change project with low divergence), and "Guided Professionalization" (low institutional pressure and involvement of a high-status change agent in a change project with high divergence) equally cause nurses to be open towards institutional change, they differ in the mechanisms that caused this openness. Further evidence from semi-structured interviews suggests that configurations of boundary conditions only foster nursing professionals' openness towards changes in institutionalized roles when they provide them with *both* pragmatic and normative legitimization accounts.

Overall, this study expands extant research on professionals' institutional work in several ways. Obviously, this study rejects the idea that change in professional organizations should be studied under the premise of professionals being opponents of change, drawing attention to (potentially modifiable) boundary conditions that evoke positive reactions towards specific role changes. Further, by accounting for the localized circumstances in which professionals make sense of institutional

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[32] Earlier versions of this study have been presented at the EGOS Colloquium 2014 in Rotterdam, Netherlands and the Annual Meeting of the Academy of Management 2014 in Philadelphia, PA.

change, this study provides new insights to support the idea that "professional groups should not be excessively homogenized" (Waring & Currie, 2009: 773). In particular, for each of the configurations that induced openness towards change, nurses provided a specific and distinct explanation for their positive reaction towards change. This finding suggests that the same kind of professionals in similar organizations who react similarly to similar role changes may, in fact, be guided by different rationales. Complementing other research which suggests that the same logic may be supported by different organizational arrangements (Currie et al., 2012), this study tentatively proposes that the same kind of observable change may be rooted in different constellations of logics. Consequently, this study adds to institutional research by calling for a careful distinction between visible institutional practices and underlying rationales. Lastly, this study offers a methodological contribution to the empirical analysis of professionals' institutional work, addressing explicit calls to employ qualitative comparative analysis for the examination of institutional agency (Battilana et al., 2009: 95).

5.3.1 Introduction

The change of institutionalized practices has been at the heart of institutional research for over a decade (Dacin, Goodstein, & Scott, 2002). Within this line of research, the health care sector has been one focus of attention due to its strong institutional pressures (Scott, 2004) and the drastic changes brought upon health care systems all over the world by regulatory interventions (Kirkpatrick et al., 2011; Ruef & Scott, 1998) as well as the "professional projects" (Suddaby & Viale, 2011) of different health care professions. Scholars and practitioners alike have been striving to explain when and why institutional change occurs (Beckert, 1999; Holm, 1995; Seo & Creed, 2002) and how it is successfully implemented (Lawrence & Phillips, 2004; Maguire & Hardy, 2009). However, current research has largely focused on divergent changes on the field-level (Galvin, 2002; Leblebici et al., 1991; Ocasio & Joseph, 2005; Zietsma & Lawrence, 2010), initiated by powerful individuals or groups (Garud et al., 2007; Leca & Naccache, 2006; Tracey, Phillips, & Jarvis, 2011). Changes in the institutionalized practices within organizations have, however, received far less attention even though it is the organizational level on which most institutional practices are enacted (Goodrick & Salancik, 1996). Further, while extant research has provided us with valuable insights on how the process of institutional change unfolds, it has so far concentrated on the actors who initiate institutional change (Battilana, 2006, 2011; Battilana, Gilmartin, Sengul, Pache, & Alexander, 2010) and their struggles to legitimize these changes (Maguire & Hardy, 2009; Suddaby & Greenwood, 2005; Vaara & Tienari, 2008). Whenever recipients of changes in institutionalized practices (e.g. non-executive physicians or nurses in hospitals) are explicitly included into the study of institutional change,

they are often conceptualized as antagonistic force to change agents' efforts (Levy & Scully, 2007; McNulty & Ferlie, 2004). This rather one-sided depiction of change recipients as potential opponents obfuscates our understanding of when and why they are *open* towards changes in institutional practices. This question is of particular interest for professional organizations like hospitals as managerial discretion over professionals' work is usually limited (Ferlie et al., 2005; Fitzgerald, Ferlie, & Hawkins, 2003; Raelin, 1986) and resistance to change particularly hard to overcome (cf. Ackroyd et al., 2007). Addressing this gap in literature, this study examines when and why nursing professionals are open to changes in their task responsibilities. In order to provide a fuller understanding of professionals' reactions to changes in institutionalized practices, this paper explores how different boundary conditions of institutional change *jointly* affect professionals' openness to such change. Employing the configurational method of fuzzy-set qualitative comparative analysis (fsQCA), this study explores which configurations of functional and institutional pressures, divergence of change and involvement of high-status change agents are necessary and/or sufficient for hospital nurses to be open towards changes in their task responsibilities. Configurational approaches like fsQCA appear to be a valuable addition to existing research as they transcend the idiosyncrasy of single case studies, yet maintain the strengths of qualitative research by providing a holistic picture of the phenomenon in question (Meyer, Tsui, & Hinings, 1993).

This study offers two key findings. First, this study shows that nursing professionals are open to changes in their task responsibilities when they face (1) low levels of institutional pressure towards nursing professionalization as well as high workloads *(Pragmatic Progress),* when they face (2) high levels of institutional pressure towards nursing professionalization in conjunction with the involvement of high status change agents who sponsor a project with little divergence from the status-quo *(Authorized Professionalism)* or when they face (3) low levels of institutional pressure towards nursing professionalization in conjunction with the involvement of high status change agents during a divergent change project (*Guided Professionalization).* Second, by providing additional case evidence, this study suggests that professionals are open to changes in institutionalized practices when boundary conditions interact to trigger both pragmatic and normative legitimization accounts.

The contributions of this study are two-fold. First, the results of this study suggest that professionals' reactions towards altered task responsibilities are driven by both pragmatic considerations on process efficiency and the normative aspects encapsulated in their concepts of professionalism. Thus, this study shows that neither praxis-oriented nor normative explanations alone provide an adequate perspective on professionals' reaction to institutional change. Second, while "accounts of physicians' resistance to change in their traditional role identity continue to surface in the

literature" (Chreim et al., 2007: 1515), this study focuses on nurses' reactions to changes in their task responsibilities in an attempt to expand our perspective on institutional change in professional organizations towards an inclusion of secondary or 'semi- professionals' (Evetts, 2011). In doing so, this paper addresses recent calls to incorporate health care professionals other than physicians in the study of institutional change in health care organizations (Reay & Hinings, 2009: 648). This study will be structured as follows. First, I will outline the theoretical background by giving an overview of relevant context conditions and characteristics of change in institutionalized practices that may affect professionals' openness to such change. Next, I will introduce changes in nurses' task responsibilities as research setting. To empirically explore when and why nursing professionals are open to changes in their task responsibilities, I will perform a fuzzy-set qualitative comparative analysis with data on change projects in the internal medical departments of 14 German university hospitals. The resulting configurations will then be discussed in greater detail drawing on additional case evidence. The paper will conclude with a brief summary of the findings and their implications for research focusing on change in the institutionalized practices of health care organizations.

5.3.2 Theoretical Background

Openness to change is generally defined as "change acceptance and positive view of changes" (Wanberg & Banas, 2000: 132). Openness to institutional change presupposes that changes are viewed as "desirable, proper, or appropriate" (Suchman, 1995:574), i.e. legitimate against a set of wider norms and beliefs. Whether changes in institutionalized practices are considered legitimate depends on several boundary conditions that pertain to the context in which such changes occur and the characteristics of the change projects themselves. First, perceptions of legitimacy are majorly shaped by actors' task and institutional environment (Oliver, 1992). Through functional or institutional pressures, the legitimacy of old templates of work organization may decrease and new institutional practices may be adopted (D'Aunno, Succi, & Alexander, 2000). Second, current research emphasizes that the status of actors who initiate and implement institutional change is critical to whether new practices are perceived as legitimate (Battilana, 2006). Third, characteristics of the change project itself, namely the extent to which a new practice diverges from dominant templates of work organization, determine its legitimacy (Kraatz & Zajac, 1996). In the following section, I will elaborate in more detail on how these different characteristics and context conditions of institutional change may affect professionals' openness to new working practices.

Functional and Institutional Pressures

Openness to changes in task responsibilities first depends on the extent to which context conditions motivate professionals to consider new modes of task division. The task environment exerts functional pressures on actors to address their respective tasks in an effective and efficient manner (Hinings et al., 2004; Oliver, 1992). Hence, the adoption of new institutional practices and templates has been associated not only with social but also with functional pressures (Dacin et al., 2002; Roggenkamp, White, & Bazzoli, 2005; Westphal, Gulati, & Shortell, 1997). Whenever institutionalized practices fall short of efficiency demands, actors experience contradictions between taken-for-granted practices and functional pressures. These contradictions are likely to raise actors' reflexivity about once institutionalized practices and therefore increase chances that institutional practices will be reevaluated against the background of their efficiency and usefulness (Seo & Creed, 2002). Accordingly, functional pressures are considered important drivers of change in institutional practices when "functional necessity or perceived utility of an established practice" (Oliver, 1992: 578) decreases. While functional pressures may motivate professionals to reconsider the usefulness of institutionalized modes of task division, institutional pressures determine whether changes in institutional practices are perceived as appropriate.

Institutional pressures reflect how salient specific institutional logics are within a field or within an organization and convey expectations on how actors are supposed to behave to secure their status as legitimate members of an organizational field or a professional group (Ruef & Scott, 1998). In professional organizations, normative pressures resulting from membership in a profession play a particular important role (Currie & Suhomlinova, 2006) and have been found to significantly affect professionals' behavior in organizations (e.g. Ferlie et al., 2005). Scott (2008b: 225) notes that professional membership exerts normative pressures on actors' behavior through internal "collegial controls" and "normative controls [...] built into the role systems and identities associated with membership in a profession". Through training and socialization processes professionals internalize the norms and values encapsulated in their specific professional role (DiMaggio & Powell, 1983). Actors who fail to behave in line with their specific professional logic are likely to face contempt and reprehensions by their peers (Kellogg et al., 2006). Consequently, whether professionals are open to changes in their task responsibilities is contingent upon the compatibility of these changes with the logics prevailing in their direct institutional environment (Currie & Suhomlinova, 2006). Overall, both functional and institutional pressures may increase professionals' openness to institutional change through economic necessities and considerations on the appropriateness of altered institutional practices.

Involvement of High-Status Change Agents

Whether professionals accept and have a positive view on changes in institutionalized practices is further dependent on the actors involved in the initiation and implementation of the change project (Chreim et al., 2013; Fitzgerald et al., 2002; Reay et al., 2013). As institutional scholars have emphasized, individuals with a high intra-organizational status are generally in a better position to promote institutional changes due to the availability of material and symbolic resources (Battilana, 2006). Their formal authority endows these actors with both decision rights and access to resources that facilitate the legitimization of change. Specifically, high status change agents like senior managers possess the skills to frame changes in a way that resonate well with the dominant norms and values of an organization and its members (Battilana et al., 2009). In line with these arguments, Moore & Leathy (2012: 139) find in their study on the introduction of clinical nurse leaders in U.S. health care that nursing professionals experienced “the lack of support by nurse administrators” as one of the most fundamental problems when trying to establish their new role. However, in professional organizations, high-status change agents commonly occupy dual roles as professional peers and managers (Llewellyn, 2001). Hence, the involvement of these high-status actors in change projects may also be viewed as managerial intervention aimed at constraining professional autonomy on the operational level (Raelin, 1986). For example, in their study on the introduction of patient safety systems in a hospital, Waring & Curie (2009) find that managerial involvement may cause professionals to reject changes as they think that managers are “unable to understand the realities of clinical work” (ibd.: 771).

Overall, the involvement of high-status change agents in the initiation and implementation of altered institutional practices is likely to exert an important influence on professionals’ openness to these changes as managerial involvement provides legitimacy to altered institutional practices while also constituting a threat to professional autonomy.

Divergence from Status-quo

Institutionalists distinguish between convergent change in line with dominant institutional templates of work organization and divergent change which deviates from the dominant institutional arrangements (Beckert, 2010). Divergent change is commonly described as a challenging endeavor as it lacks the legitimacy associated with changes that reproduce and reinforce dominant field-level logics (Battilana et al., 2009). The extent to which new institutional practices diverge from established templates of organizing exerts an important influence on professionals’ reaction towards them as practices are tightly linked to professional roles as integral part of actors’ identities (Currie, Finn, & Martin, 2010). As Nelson and Irwin (2014) point out, there is a considerable overlap between "who we are" and "what we do” and

changes in institutionalized practices are interpreted against the background of their implications for professional identities. Particularly in professional organizations where interaction and status are majorly influenced by professional roles (Kitchener, 2000; Leicht & Fennell, 1997), divergent changes in institutionalized modes of task-division may be viewed as both opportunity and threat. When professionals experience a large discrepancy between their current roles within their organization and their professional projects (Suddaby & Viale, 2011), they will be likely to accept more radical shifts in their task responsibilities. In line with this thought, Battilana (2011: 821) theorizes and empirically demonstrates that "[n]ondoctors, being in a challenger position […] are more likely to be willing to transform to a greater extent the existing model of role division among professionals". Professionals who, however, feel advantaged by current institutional arrangements are unlikely to be open towards changes that diverge from the template which endows them with higher status and the associated privileges (cf. Schilling, Werr, Gand, & Sardas, 2012). Overall, the extent to which changes in institutionalized practices diverge from the status-quo is likely to affect professionals' openness to these changes as professional roles and role-based identities are contingent upon the practices through which they are enacted.

5.3.3 Rationale, Data, and Method

The Delegation of Medical Tasks in German University Hospitals

Nursing in Germany is currently undergoing profound changes with regard to nurses' training and their professional role in relation to physicians. In the past decade, German nursing associations have made tremendous effort to promote the professionalization of nursing. When contrasting nurses' professionalization projects in Italy and Germany, Dent (2002: 156) observes that German nurses have focused more on the workplace than on their legal status. Accordingly, a key issue in the professionalization effort of German nursing has been the redivision of medical tasks between physicians and nurses. However, that does not imply that the assumption of medical tasks is always viewed positively. While German nursing scholars generally consider increased delegation of medical tasks as a first step towards the professionalization of nursing (Dreier et al., 2010; Rogalski, Dreier, Hoffmann, & Oppermann, 2012), research has found that nurses may also reject the assumption of medical tasks in a "struggle to attain independence from doctor-driven work" (Dent, 2002: 158). The relevance of task delegation for nurses' professional project and their ambiguous reactions on the practice-level make this empirical phenomenon particularly interesting for the study of professionals' reaction to changes in institutional practices.

This study relies on qualitative data from change projects in internal medical departments of German university hospitals to explain when and why nurses are open towards the assumption of medical tasks. University hospitals provide a particularly favorable setting to study changes that affect professional roles as teaching hospitals have been described as "best site to learn about professionalism" (Apesoa-Varano, 2013: 333) due to their educational mission. Further, university hospitals represent a very homogenous basic population facing similar institutional and task environments. While one would expect professionals from organizations as homogenous as university hospitals to disclose similar reactions to comparable changes in institutional practices, this was not the case in the study presented here. In fact, reactions ranged from a resolute rejection of the proposed changes to an overwhelming openness. Further, it is noteworthy that while nurses' reactions to the change projects varied considerably, there was no case in which physicians objected to nurses exerting medical tasks.

Data

The nursing directors of all 32 German university hospitals were approached to provide interviewees from internal medical departments in which initiatives to delegate tasks from medical to nursing personnel could be observed. Overall, 18 hospitals were willing to participate in the research project, yet only 14 could provide information on delegation projects from internal medical departments. To ensure comparability between the delegation projects, all cases from other than internal medical departments were excluded from further analysis. On average, I conducted interviews with three interview partners in each hospital. Wherever possible, I interviewed the manager of the project as well as a member of the nursing staff (often the head of the ward) and a member of the medical staff to validate statements on the change project. Interviews were semi-structured and had an average duration of 55 minutes. Interviewees were assured anonymity to avoid social desirability bias. Also, participation in the interviews was voluntary. The interview data was used to collect information on nurses' reactions towards change (*Openness to Change*) as well as information on the characteristics of the change project itself (*Divergence from Status-quo*) and the *Involvement of High-Status Actors*. Information on the *Functional and Institutional Pressures* was collected using archival data from hospitals' mandatory quality reports. The measurement of the outcome and each explanatory condition is described in more detail below.

Method

To explore how context conditions and characteristics of change jointly influence nurses' openness to changes in their task responsibilities, I employed fuzzy-set fsQCA. While firmly established in the political sciences, organizational researchers have only recently begun to employ fsQCA in organization research (e.g. Crilly,

Zollo, & Hansen, 2012; Fiss, 2007). Building on Boolean logic, FsQCA is a particularly suitable method to discover configurations of conditions that lead to a specific outcome. In contrast to variable-oriented quantitative methods, fsQCA does not seek to explain the net effects of single variables but rather allows researchers to compare cases as combinations of several causal conditions (Schneider & Wagemann, 2012). Further, fsQCA allows researchers to uncover equifinal causal paths to the outcome of interest (Schneider & Wagemann, 2010) and conditions that reside on multiple levels (like the characteristics and the context of institutional change) can be incorporated into fsQCA without further requirements (Rohlfing, 2012). As fsQCA relies on the relation between set-memberships in conditions and outcome variables, each variable has to be translated into a set (e.g. the outcome *"Openness to Change"* has to be turned into the set *"High Openness to Change"*). Hence, the outcome and each explanatory condition presented below were redefined as sets before the analysis. FsQCA further requires the researcher to determine whether a case is more a member or a non-member of a given set. This procedure is called 'calibration' and includes the definition of three threshold values to indicate full membership, full non-membership, and a crossover point at which cases reach a point of maximum indifference regarding their membership in a specific set (Ragin, 2008). Depending on the kind of data used (quantitative or qualitative) the calibration procedure can rely on theoretical knowledge combined with in-depth knowledge of the cases and/or the empirical distribution of quantitative data (Schneider & Wagemann, 2012: 32f.). While external criteria are supposedly preferable when calibrating fuzzy-sets, lack of external qualitative and quantitative criteria for set-calibration is a common phenomenon in the social sciences (Ragin, 2008: 86). Hence, while relying on externally derived thresholds wherever possible, some sets had to be calibrated based on in-depth knowledge of the cases as well as knowledge of the empirical setting (cf. Fiss, 2011; Greckhamer, Misangyi, & Fiss, 2013). In the following section, I will explain in detail how the outcome and each of the explanatory conditions were measured and calibrated.

The outcome variable *"Openness to Change"* was measured drawing on the interview data described above[33]. Interviewees were asked to describe nurses' reactions towards the change project and elaborate on the extent to which change was welcomed among nurses. Set-memberships were determined using a qualitative coding approach (Schneider & Wagemann, 2012: 35f.). Interview data were first summarized into short descriptions of nurses' reactions towards the planned changes in the respective departments. These descriptions were then coded into six categories between 0 (i.e. nurses refused change) and 1 (i.e. nurses were very open to change) as

[33] Interview excerpts presented in the following have been translated from German by the author.

suggested by Ragin (2008:31). Table 5.1 gives an overview of the coding scheme while table 5.2 illustrates how each case was coded into a fuzzy-set category.

Table 5.1: Coding Scheme of "Openness to Change"

Description of Category	Fuzzy-set Coding
Very low openness to change: changes neither viewed positively nor accepted.	0
Low openness to change: changes viewed rather negatively and hardly accepted.	0.2
Rather low openness to change: changes viewed rather negatively but eventually accepted.	0.4
Rather high openness to change: changes viewed rather positively and overall accepted.	0.6
High openness to change: changes viewed generally positively and largely accepted.	0.8
Very high openness to change: changes viewed positively and accepted.	1

Table 5.2: Illustrative Quotes and Case Summaries for Outcome "Openness to Change"

Case ID	Summary	Illustrative Quotes	Outcome
1	The delegation of medical tasks became an ongoing point of contention. Nurses' openness to change was very low.	"[...] Our willingness [to participate in the project] is not very high." (Head of the Ward: 196) "[T]here are notable little wars […]". (Head of the Ward: 159) "Much is just being blocked. There is no collaboration." (Physician: 31)	0
2	Nurses expressed some concerns regarding increased workload which influenced the implementation process. Still, nurses were generally open towards changes.	"Well,…we had to dismiss concerns that one group is being overburdened while the other group [i.e. physicians, *note from author*] may increase their personal comfort." (Nursing Director: 35) "[…] Those who worked in practice also knew how annoying it is to call for the doctors, let's say, the third time, so he can apply that medicine…these very practical things, that everybody knows and that annoy everyone […]" (Nursing Director: 44)	0.6
3	While openness was not overwhelming nurses generally appreciated the opportunity to assume medical tasks.	"But regarding infusion…that would actually make things faster for us. We would be through with the patient in less time […] Well, that would actually be a relief" (Nurse on tasks to be delegated: 124) "When we first started with the topic we did experience resistance from the heads of the team. They said 'We have to protect our employees; they are working at their limits.' But […] that is not an issue anymore." (Project Manager: 93)	0.6
4	Nurses were very open towards changes in their task responsibilities.	"It was […]There was no resistance or anything like that." (Nursing Director: 37) "Well, I think that the employees thought it was very useful. Because, in the end, it structures and facilitates your daily routine." (Head of the Ward: 167)	1
5	Nurses refused to assume the medical tasks in question. The situation was described as difficult with regard to the delegation project.	"It was rather like…well, the nurses just refused to assume medical tasks…" (Nursing Director: 56) "[…] That is a point of contention ever since I can remember." (Head of the Ward: 25) "The way I experience it, is: ‚We don't want this here'. Maybe that is a specific problem of [our department]." (Physician: 118)	0
6	Nurses were majorly opposed to assuming medical tasks. It took significant efforts to implement the delegation project.	"We had our problems in the beginning, I am not gonna lie about that. It was not welcomed with open arms." (Head of ward: 37) "It was pretty bad at the beginning. Motivation was pretty bad. " (Head of the Ward: 430) "Of course, there was resistance among nurses. There are still nurses who are not comfortable with it." (Physician: 23)	0.2
7	Nurses were generally open towards task delegation. Reservations were few and only situational in times of resource scarcity.	"Well, I think because of our rather good staffing level it [the project] turned out very positive…it was not so much about workload… it was rather seen positive here [in our hospital] (Nursing Director, 41) "They realized that [it means] you don't have to call [the doctors] all the time […] So, many see the positive development it brings…However, it is always a double-edged sword. If you don't have the time, then it's considered stupid." (Head of the Ward: 54)	0.8
8	Many nurses in this department were skeptical towards the delegation of tasks because of workload considerations.	"Well, yes, it was just like it sometimes is in life. It did not cause us to stop the project […] but […] there were some people who were discontent, who saw this as additional workload, as overstraining." (Nursing Director: 52) "Many had the impression ‚We are full with work, there is no more space in this 'bucket' full of work and they keep putting more into this bucket." (Head of the Ward: 197)	0.4
9	Nurses were very open towards the delegation project. While few uttered concerns about an increasing workload, employees' reaction was generally described as 'excited'.	"Well, you have to say […] there was[...]a great consent, almost excitement, if you want to say so […] So, in general we were able to build upon a broad consent among our employees" (Project Manager: 112) "And if you ask [employees] in the ward 'So, how are you dealing with this?'[...] There will not be a single one telling you: 'We are scared' or 'Help! "What will we have to deal with here?'" (Head of the Ward: 40)	1

Table 5.2 (continued): Illustrative Quotes and Case Summaries for Outcome "Openness to Change"

Case ID	Summary	Illustrative Quotes	Outcome
10	Nurses had severe reservations about the delegation of tasks because of workload and legal considerations.	"In the beginning, nurses had a lot of reservations […] That was a little difficult […]" (Project Manager: 23) "It was tough […]. And the nurses had already said 'We don't wanna be the doctors' henchman; that is important!'[…].But we had to be extremely cautious. It was not a topic where nurses were generally willing [like:] 'Yes, we are gonna do that'[...]" (Project Manager: 105)	0.2
11	Nurses were eager to assume medical tasks in question. Only very few concerns about new medical responsibilities were mentioned.	"It was ok for the nurses and for the doctors. We agreed exceptionally quickly. [Nurses] asked 'Gee, why aren't we allowed to do that? [….]" "So, it was basically 'preaching to the choir'?" (Interviewer) "Yes, exactly!" (Head of the Ward: 163)	1
12	Nurses were very open towards assuming medical tasks. Overall, the project was described as 'no big deal' with regard to concerns.	"[T]hey were very positive about that, they almost pushed to the front and wanted to participate [in the project]. "(Project Manager: 54) "[They reacted] well! Well, most said ‚Finally!' […] Now we don't have to wait for the doctor to draw blood in the morning, [now] we can integrate this completely differently into our work processes." (Head of the Ward: 87)	1
13	Nurses were very open towards the delegation project because of patient and work process considerations.	"Everyone was interested [in the project]. A good collaboration – also in the patients' interest." (Head of the Ward, 35) "So, I feel it was perceived as useful without exception […] I think everyone thought it was sensible. (Head of the Ward, 192)	1
14	Few concerns about technical and jurisdictional questions were uttered. However, nurses were described as open towards the project.	"I didn't seriously experience [reservations] in this ward […]" (Nursing Director, 189) „Well, I think it was […] especially with regard to the application of chemotherapy…there was a lot of myth attached to it. […] But it has always been that [….] a relatively [big] part of the nurses said ‚Actually, we are on site anyway and know [how to do this]." (Head of the Ward, 149) "Well, I didn't encounter anyone who would say ‚No can do'." (Head of the Ward, 307)	0.8

The *"Functional Pressure"* that nurses experience in a department was measured using archival data from the hospitals' official quality reports (G-BA, 2014a). These reports belong to the official reporting demanded by German hospital law (§ 137 Abs. 3 Satz 1 Nr. 4 SGB V). I approximated the functional pressure which nurses in a department experience through their relative workload. With increasing workload, actors are forced to address their tasks in a more effective and efficient manner and hence experience functional pressure to reconsider institutionalized modes of task division. Measuring the relative workload of nurses in a department involved several steps as hospital departments may not only differ in the quantity and quality of medical cases to be treated in a certain time period but also in their absolute personnel resources. In a first step, the number of both nursing full-time-equivalents (FTEs) and medical cases per year were collected for each department. In a second step, the relative complexity of the cases treated in each department was approximated by calculating the average cost weight for the ten most common cases. These cost weights are provided by the G-DRG-System (German-Diagnosis-Related Groups) that is part of the German health care reimbursement system and were established to capture the relative complexity of medical cases (Pierdzioch, 2008). The cost-weights determined from the ten most common cases were multiplied with the absolute number of cases treated in each department per year. The overall number of nurses in a department was then divided by the weighted number

of cases per year[34]. The resulting measure captures the number of nurses per 'normalized' case per year with a lower number of nurses per 'normalized' case per year equaling higher functional pressure. I relied on the TOSMANA Threshold Setter (Cronqvist, 2009) to derive thresholds for non-membership, full membership as well as a cross-over point for each case using data on the respective basic population. Each case was then calibrated accordingly.

The extent of *"Institutional Pressure"* towards altering nurses' task responsibilities was also measured using archival data on nurses' formal education to be found in the quality reports issued by the hospitals (G-BA, 2014a). Specifically, I used the quantity of different categories of advanced nursing training available in the respective department to measure institutional pressure towards the assumption of medical tasks. Advanced nursing training includes specialized training like "oncology nursing" but also additional academic education like bachelor's and master's degrees in nursing. Departments that disclose a high number of different categories of additional nursing training obviously sponsor a nursing logic that includes academization and specialization similar to that of the medical profession[35]. A high extent of advanced nursing education would thus be in line with the nurses' professional project on the field-level which promotes increased qualification and a corresponding, systematic expansion of nurses' task spheres as important steps in the further professionalization of nursing (DBfK, 2013: 5). Hence, I consider the extent of additional training categories to be a valid measure to capture the extent to which field-level pressures towards a more professionalized nursing role – including the adoption of new task responsibilities – have translated into intra-organizational institutional pressures. Employing the TOSMANA Threshold Setter (Cronqvist, 2009), three thresholds (non-membership, full membership and the cross-over point) were derived for each case using data on the respective basic population (e.g. all oncology departments of German university hospitals). Each case was then calibrated accordingly.

The extent of *"Involvement of High-Status Change Agents"* in the task delegation projects was measured using interview data. Interviewees were asked to describe by whom the change project had been initiated and implemented. Similar to the outcome variable, the measurement relies on qualitative information on each case derived from the interview data (Schneider & Wagemann, 2012: 35f.). To create distinct categories, the complete interview material was first coded inductively to identify meaningful qualitative differences between cases that are definite members

[34] The resulting measure was multiplied by 100, thus reflecting the number of nurses per 100 'normalized' cases per year as the initial measure proved to generate numbers too small for analysis in fsQCA.

[35] Accounting for the fact that departments with a larger overall quantity of nursing personnel are more likely to exhibit a larger number of additional nursing training categories, the number of training categories was weighted by the overall number of nurses in the respective department.

(and non-members, respectively) of the set "High Involvement of High-Status Change Agents". The coding outcome disclosed that *"Involvement of High-Status Change Agents"* in the change project could be differentiated by the extent to which senior management was involved in both the project initiation and the implementation process. Cases were coded into a four-value fuzzy-set accordingly. Table 5.3 describes the coding scheme in more detail.

Table 5.3: Coding Scheme of "Involvement of High-Status Change Agents"

Description of Category	Fuzzy-set Coding
Project initiated and implemented by department management.	0
Project initiated by department management. Supported by senior management.	0.33
Project initiated by senior management. Joint implementation effort with respective department management.	0.67
Project initiated and implementation pre-structured by senior management.	1

The extent to which a change in task responsibilities qualifies as a *"Divergence from Status-quo"* was measured using interview data in conjunction with a task categorization framework by the German Hospital Institute (Offermanns, 2008) First, interviewees were asked to name the tasks included in the respective change project. These tasks were then coded into categories between 1 (low-complexity medical tasks to be delegated without special training) and 5 (high complexity medical tasks that necessitate special training) provided by the German Hospital Institute. This coding scheme explicitly lists the tasks belonging to each category and hence provides an objective framework for categorizing each medical task included in the delegation project. As all change projects included the delegation of more than one task, an integrated measure was developed to determine to which extent the change project as whole can be described as divergent. This integrated measure was created by first coding each task of a change project according to the scheme described above and then calculating the squared sum of the coding results.[36] This approach was taken to account for the different implications of tasks of different medical complexity with regard to their divergence from the status-quo of medical dominance. Using the squared sum of the medical tasks' complexity category allowed for a sharper distinction between change projects that mostly included tasks already at the periphery between medical and nursing tasks and projects that mostly

[36] For example, the intravenous application of chemotherapy was considered to be a complex task due to the associated risks of extravasation (i.e. when cytotoxic agents infiltrate the tissue surrounding the vein where they can cause massive damage such as tissue dying off). Hence, the German Hospital Institute assigned this task to the fifth category (high complexity medical tasks that necessitate special training). On the other side, drawing blood from a vein was assigned to the second category of rather low-complexity medical tasks which could be delegated after a brief instruction. The measure for "Divergence from Status-quo" accounts for these large qualitative differences between the different tasks by e.g. assigning delegation projects that comprised one highly complex, clearly medical task a raw value of 25 (i.e. 5^2) while assigning delegation projects with two rather low-complexity tasks a value of 8 (i.e. 2^2+2^2). This procedure is grounded in the idea that the status-quo of medical dominance can be attacked by either a comprehensive delegation of low-complexity tasks (implying a re-structuration of clinical role divisions) or a less comprehensive but more radical shift in responsibilities.

included tasks that had formerly been at the center of the medical sphere. This measure implies that divergent changes can be achieved by both the delegation of numerous low-complexity tasks and the delegation of relatively few but highly complex medical tasks. This measure of divergence is in line with recent calls to give up the "dichotomous approach that contrasts divergent and non-divergent change" and to rely on more nuanced measures of divergence that reflect "the extent to which changes diverge from the institutional contexts within which they are implemented" (Battilana et al., 2009: 93). In the absence of valid external thresholds to determine to which extent a task delegation project constitutes divergent change, the distribution of the sample was first inspected for obvious value gaps. The TOSMANA Threshold Setter (Cronqvist, 2009) was then employed to derive thresholds for non-membership, full membership as well as a cross-over point.

Table 5.4 depicts the raw data collected for each delegation project while table 5.5 comprises the thresholds derived for the explanatory conditions that had to be coded indirectly. The set membership values resulting from the calibration of the outcome and all explanatory conditions were integrated into the fuzzy-set data matrix (Fiss, 2011; Ragin, 2000). The fuzzy-set data matrix (see Table 5.6) provides the empirical basis for further analysis of the data in fsQCA.

Table 5.4: Cases and Raw Data

Case ID	Internal Medicine Department	Functional Pressure	Institutional Pressure	Involvement of High-Status Change Agents	Divergence from Status-quo	Openness to Change
1	Radiooncology	2.03	0.13	0	32	0
2	Oncology	1.39	0.04	1	93	0.6
3	Nephrology	3.52	0.07	0.67	41	0.6
4	Oncology	1.59	0.03	0.33	50	1
5	Oncology	0.56	0.19	0	41	0
6	Oncology	1.92	0.09	0.67	102	0.2
7	Gastroenterology	0,67	0.08	1	61	0.8
8	Oncology	1.68	0.03	0.67	36	0.4
9	Cardiology	1.50	0.01	1	36	1
10	Oncology	2.29	0.02	0.67	77	0.2
11	Gastroenterology	1.06	0.04	0	45	1
12	Oncology	2.66	0.03	1	82	1
13	Oncology	1.11	0.05	0	79	1
14	Oncology	1.45	0.01	0.67	61	0.8

Table 5.5: Thresholds of the Explanatory Conditions

Condition		Full Membership	Crossover Point	Full Non-Membership
High Institutional Pressure				
	Cardiology	0.06	0.04	0.03
	Gastroenterology	0.07	0.05	0.02
	Nephrology	0.08	0.04	0.03
	Oncology	0.12	0.07	0.02
	Radiooncology	0.16	0.10	0.05
High Functional Pressure				
	Cardiology	1.05	1.6	2.15
	Gastroenterology	1.6	2.2	2.8
	Nephrology	1.8	2.7	3.9
	Oncology	1.3	2.05	2.4
	Radiooncology	1	2.25	3.25
Divergence from Status-Quo		26	67	88

Table 5.6: Fuzzy Set Data Matrix

Case ID	Functional Pressure	Institutional Pressure	Involvement of High-Status Change Agents	Divergence from Status-quo	Openness to Change
1	0.71	0.85	0	0.07	0
2	0.93	0.12	1	0.98	0.6
3	0	0.89	0.67	0.13	0.6
4	0.81	0.08	0.33	0.22	1
5	1	1	0	0.13	0
6	0.37	0.79	0.67	0.99	0.2
7	1	0.99	1	0.39	0.8
8	0.72	0.1	0.67	0.09	0.4
9	0.64	0	1	0.09	1
10	0.02	0.06	0.67	0.81	0.2
11	0.99	0.2	0	0.17	1
12	0	0.09	1	0.89	1
13	0.98	0.24	0	0.85	1
14	0.90	0.03	0.67	0.39	0.8

Analysis

The fuzzy-set qualitative comparative analysis was exerted using the software package fsQCA 2.5 (Ragin & Davey, 2009). FsQCA includes several methodological steps of which the most important are explained below. FsQCA generally distinguishes between necessary and sufficient conditions. To be considered necessary for the outcome to occur, a condition must always be present when the outcome is present (Rohlfing & Schneider, 2013). A condition is commonly regarded necessary when it meets a consistency value of at least 0.9 (Ragin, 2006). Each condition presented above (as well as its negation) was tested using the fsQCA 2.5 *necessary conditions* procedure. However, none of the conditions proved necessary for the outcome *"Openness to Change"* to occur. Conditions are considered sufficient for the outcome to occur if the outcome is always present when the condition is present. In fsQCA 2.5, *sufficient conditions* are analyzed using the Quine-McClusky Algorithm. The Quine-McClusky algorithm can only be applied if the researcher first translates the fuzzy-set data matrix into a truth table that displays the dichotomized combinations of conditions of a given fuzzy-set data matrix. With four explanatory conditions the truth table for the present study includes 16 (2^4) rows.

However, it is common in social sciences that not every theoretically possible combination is covered by an empirical case (Ragin, 2009). In the present study, only rows that are covered by at least one empirical case were included in the analysis. Further, fsQCA requires the researcher to specify a consistency threshold that indicates a minimum extent to which fuzzy-set membership in the conditions is associated with membership in the outcome (Schneider & Wagemann, 2012). In line with current methodological recommendations, I applied a consistency threshold of 0.80 (Skaaning, 2011). The results of the analysis are presented below.

5.3.4 Findings

The standard analysis procedure in fsQCA 2.5 produces three kinds of solution terms: a complex, an intermediate and a parsimonious solution. The complex solution is also referred to as “conservative solution term” as this solution is based on observable empirical data only and does not require the researcher to make any assumptions about logical remainders (i.e. non-observed cases) (Schneider & Wagemann, 2012: 162). Hence, in accordance with the explorative focus of this study, I refrained from presenting the parsimonious or intermediate solution[37] and will draw on the complex solution for further interpretation. The findings of the complex solution are summarized in table 5.7. The notation style employed here is based on Ragin & Fiss (2008) and is commonly used in set-theoretic research (e.g. Crilly et al., 2012; Greckhamer, 2011). In this notation, black dots (●) indicate conditions that are present in the respective solution while crossed-out cicles (⊗) indicate conditions that are absent. Blank spaces are used to indicate a condition that may be either present or absent (‘don’t cares’).

Table 5.7: Complex Solution of Sufficient Explanatory Conditions for Openness to Change

		Solution	
Conditions	**1**	**2**	**3**
Functional Pressure	●		
Institutional Pressure	⊗	●	⊗
Involvement of High-Status Change Agents		●	●
Divergence from Status-quo		⊗	●
Consistency	0.854	0.958	0.787
Raw Coverage	0.586	0.186	0.326
Unique Coverage	0.397	0.127	0.109
Cases Covered[38]	2,4, 9, 11,13,14	3,7	2,12
Overall Solution Consistency		**0.839**	
Overall Solution Coverage		**0.850**	

[37] These are available from the author upon request.

[38] Cases 1,5,6,8 and 10 were excluded from further analysis because they failed to meet the consistency threshold of 0.80.

Results (see table 5.7) indicate that there are three sufficient solutions explaining under which conditions nurses react openly towards changes in their task responsibilities. The overall solution consistency of 0.839 is above the consistency threshold of 0.8 applied in extant research (e.g. Fiss, 2011). While the consistency of the solution terms 1 and 2 is also well above the consistency threshold, solution 3 fails to meet this threshold by 0.013. However, with a consistency value above 0.75, solution term 3 still adequately resembles the subset-relations between explanatory conditions and the outcome found in the empirical data (Ragin, 2006; Ragin, 2008). The overall solution coverage of 0.850 is high, implying that 85 percent of the fuzzy-set memberships in the outcome *"Openness to Change"* are explained by the three solution terms. Particularly noteworthy is the relatively high unique coverage of solution term 1 which, on its own, explains almost 40 percent of the fuzzy-set memberships in the outcome. The fact that case 2 is explained by solutions 1 and 3 shows that there are equifinal causal paths to the outcome *"Openness to Change"*. The following section provides an in-depth discussion of each solution term drawing on additional evidence from the cases covered by each solution.

5.3.5 Discussion

Solution 1: Pragmatic Progress

Solution 1 suggests that under conditions of *"Absence of Institutional Pressure"* within a department in conjunction with *"Functional Pressure"* nurses react openly towards changes in their task responsibilities. This solution depicts a situation in which nurses are confronted with high workloads while not experiencing a high degree of formal professionalization in the sense of advanced nursing education in their department. As interviewees explained, nurses in these departments were open towards changes in their task responsibilities mostly because of efficiency considerations. While the existing low degree of institutional pressures to pursue a specific, 'professionalized' nursing role leaves room for the development of multiple, locally adapted concepts of nursing, the relatively high workloads in these departments motivate employees to (re-)define their professional role according to efficiency demands. As the project manager from Case 9 explained, the redefinition of nursing has been a point of discussion in the course of project implementation. However, the main focus remained on the question of how nursing roles have to change to improve process efficiency:

"And these points of discussion were also 'How do we define ourselves as nurses [...] in the future?' And you have to move away a little from old traditions to be able to say 'Yes, of course, we can bed [patients] very well and care [for them] very well and wash patients very well [...] but you have to think about [...] how can I design the profession in a way that fits the given boundary conditions, meaning

that it fits the work processes well, becomes effective and [...] is aligned with [employees'] qualification [...]" (Project Manager, Case 9: 112).

Evidence from the Cases 13 and 14 further illustrates that nurses legitimized changes in medical task division mainly by drawing on efficiency considerations in the sense of improved working processes. Specifically, nurses often described former working processes as tedious and time-consuming and physician availability as the bottleneck of many treatment processes:

"It's a relief and we really enjoy doing this and the patient may leave more quickly [...] Applying it [note: infusion therapy] on our own is way faster than having to search for the doctor and then wait again [...]" (Head of the Ward, Case 13: 197.)

„It was a common wish and desire [...] the question on how to design processes and how [...] for example, to improve patient flow [...]" (Nursing Director, Case 14: 213).

Improvements in process efficiency were also described as nurses' main focus with regard to the redivision of task responsibilities in Case 4. Additionally, political considerations regarding the redivision of tasks and resulting aspects of professionalization were explicitly described as irrelevant, further supporting the interpretation that, in the situation described by this solution, changes in task responsibilities are evaluated against a practical rather than a professional perspective:

"Have there been any references to the field-level debates [...]?" (Interviewer)

„No. It was not discussed in that way. It rather resulted from practice [...] they looked at the patient process and thought about what made sense in the process – for the patient!" (Head of the Ward, Case 4: 117)

Similarly, when asked about a potential normative component of the redivision of tasks between physicians and nurses, the nursing director of the hospital of Case 13 referred to a *"healthy pragmatism"* (377) by which the department in question was characterized. While almost all interviewees from the cases described by Solution 1 emphasized that anticipated improvements in their respective working processes were a major driver of nurses' openness to changes in their task responsibilities, they also commonly referred to considerations on patient well-being. For example, in Case 11 the head of the ward explained nurses' openness towards a redivision of task responsibilities as following:

"It's like this: we are having the chemotherapy delivered by [another department]. And sometimes the last chemo is being delivered by 3.30 or 3.45 in the afternoon. [...] That means I can start the chemo by 4.45 the earliest. But by then the ward physician is often gone and the doctors on duty would have to do that. That's virtually impossible! [...]And it was often the case that the last chemo was applied by 2.30 in the night. And then we said: 'That's unacceptable; we have to find another

solution!' [...] and now every trained nurse may apply chemo – [that's] time saving. And [it creates] patient satisfaction, first and foremost. Because when you get woken up at 2.30 by the doctor on duty you are gonna 'thank' him, right?" (Head of the Ward, Case 11: 39-42).

While in some of the cases covered by Solution 1, nurses expressed concerns about anticipated workload increases, process and patient considerations were commonly prioritized. As the head of the ward in Case 9 described, slogans like *"Sure, then we are going to do this and that and then we will have to rip ourselves apart even more" (29)* were not uncommon despite of a generally high openness towards a redivision of tasks. However, nurses seemed to realize that they had to take on responsibility for specific medical tasks to keep the working processes going:

"I am sure that it's better when an experienced nurse does particular tasks than when a medical student [...] does that, who gets here and has to be trained first [...] sometimes they even show up with outdoor shoes and without proper scrubs [...]Many of them haven't even seen a tourniquet. And then the sheets or the pillowcase or whatever is full of blood…Now we are doing that ourselves, the patients are satisfied and we are getting the blood in time. I think that's pretty good." (Head of the Ward, Case 9: 121).

As interview data suggests, the lack of a strong concept of professionalized nursing drew the focus of discussion to pragmatic aspects of work organization while high patient loads drew attention to process inefficiencies that affected both nurses' work organization and patient satisfaction negatively. Notably, the configuration of conditions described by Solution 1 caused nurses' sensitivity to patient well-being to supersede individual workload considerations. In this solution, the normative legitimization accounts nurses provided when explaining why they reacted openly towards the planned changes reflect what is commonly considered a "traditional" nursing role that evolved around a logic of "unconditional care" (Kirpal, 2004: 217). Hence, while Solution 1 describes a situation in which nurses did not refer to the field-level discourse on task delegation and nursing professionalization, nurses' openness towards altered task responsibilities is still also fostered by normative considerations. However, new modes of task division were not perceived as legitimate because of their potential to change nurses' role and status. Nurses rather viewed the assumption of medical tasks as a chance to provide better care to the patients. Thus, in the cases described by Solution 1 the redivision of tasks gained normative legitimacy by appealing to empathic patient care as a strong normative theme at the very roots of the nursing profession.

Overall, this solution discloses that professionals are open to changes in their task responsibilities when context factors challenge institutionalized practices in a way that allows professionals to find legitimization accounts for new modes of task divi-

sion regardless of their divergence and the involvement of high status change agents. Specifically, in Solution 1 *"Functional Pressure"* interacts with *"Absence of Institutional Pressure"* to foster a problem-centered perspective on the redivision of task responsibilities that can be summarized as *"Pragmatic Progress"*. The absence of normative prescriptions on the professional development of nursing allowed a process- and patient-oriented view on task delegation. While it may at first seem counter-intuitive that high workloads are a part of a configuration fostering openness towards the assumption of new tasks, the functional pressure in these departments exacerbated the effect of even minor process inefficiencies. Under these conditions, nurses are often confronted with the *"patients' resentment" (Head of the Ward, Case 11:65)* because of idle time and delayed discharge. Somewhat ironically, Solution 1 shows how the pursue of a traditional, 'caring' nursing role together with frustration about inefficient work processes led to an encroachment of the medical sphere. This solution thus also illustrates how professional roles may change on the macro-level by micro-level attempts to better fulfill and improve a given role at a given time.

Solution 2: Authorized Professionalism

Solution 2 indicates that nurses were open towards changes in their task responsibilities under conditions of *"Institutional Pressure"* within their department in conjunction with the *"Involvement of High-Status Change Agents"* during the change project which is characterized by the *"Absence of Divergence from Status-Quo"*. This solution describes a situation in which nurses in a department with a high degree of formal professionalization are confronted with rather minor changes in their task responsibilities which are supervised and supported by the nursing directorate. In contrast to Solution 1, Solution 2 describes a situation in which normative considerations about nurses' professional role as well as their qualification were more central to the causal path leading to nurses' openness to change. Interview data suggests that, in this situation, openness to change is driven by both, considerations on process efficiency and the desire to increase recognition of nurses' qualification. Similar to the cases covered by Solution 1, a redivision of medical tasks was perceived as a means to facilitate and accelerate working processes:

"Searching for a doctor is very laborious. You have to call him, which annoys nurses. If however, they are personally responsible, they [...] do the entire process and complete it. You can actually tell that [...] it is more of a relief than stress."(Project Manager, Case 3: 63).

"[It was seen as positive], because it has been attempted to integrate these activities into the processes. So that the processes improved [...] [quoting nurses] 'I'll better do the job myself before I'll let others organize my work.'" (Nursing Director, Case 7: 107).

However, process considerations were complemented by nurses' desire to re-design working processes in a way that reflects their qualification. As a nurse from Case 3 pointed out, the opportunity to perform medical tasks was an integral part of what she considered a job that matches her qualification as trained nurse:

"[T]hey [the nursing students] are actually being trained to do that. They can do it. [I mean], why not? That's what professional training is for, right? And that is what I also learned […]it was out of the question for me to just make beds and wash and feed patients. [If I wanted to only do that] I would have gone to a nursing home." (Nurse, Case 3:135).

Similarly, the project manager described nurses' general motivation to participate in a task-redivision-project as follows:

"We are re-structuring and want to increasingly work according to our qualification. And in this context, we could assume medical tasks and delegate other tasks.' - That's how it was for the professional group of nurses." (Project Manager, Case 3:55).

Being confident about their qualification, nurses had occasionally assumed some of the tasks in question 'off the record'. In both cases explained by Solution 2, nurses welcomed the involvement of senior management in the redivision of tasks as it provided structure and legitimacy to the hitherto inofficial case-by-case mode of task delegation. In Case 7, the head of the ward explained that *"delegation of medical tasks […] was 'legalized'" (Head of the Ward, Case 7: 28)* through the change project and that the formalization of delegable (as well as non-delegable) tasks by senior management endowed nurses with legal security when exerting medical tasks but also with the formal legitimacy to refuse the assumption of specific tasks:

"It is recorded in there [in the formal guideline] that you don't have to do it. For example, that is very important when a really persistent doctor says 'But you have to do that'. Then the [nurse] will print it out for him and tell him 'Here it is in black and white: I don't have to do this." (Head of the Ward, Case 7: 146).

In Case 3, the aspect of recognizing nurses' qualification by senior management seemed to play a more important role than the "legalization" described in Case 7:

"[…] There was a part saying 'We are doing this from time to time anyway, it wouldn't work any other way. And it is good that it's finally seen.' […] 'We have done that the whole time and no one recognized it before.' (Project Manager, Case 3: 76).

Notably, in both cases explained by this solution nurses were more open than resistant towards changes (with a membership of 0.6 in the set *"Openness to Change"* and 0.8, respectively) yet neither of the two cases qualifies as full member in the set *"Openness to Change"*. Hence, Solution 2 captures cases in which the

configuration of conditions is just sufficient to generate more openness than resistance towards change. A main reason for this result can be found in high institutional pressure towards a professionalized nursing role as part of this solution. While nurses were confident enough to exert supposedly simple medical tasks on a case-by-case basis, a high degree of formal professionalization in these departments also raised their awareness of professional boundaries. For example, the head of the ward in Case 7 emphasized that she and *"almost all of my colleagues"* rather wanted *"to do [our] actual job well than to assume someone else's tasks"* and that they *"enjoy[ed] primary nursing tasks more than taking over some doctor's tasks" (Head of the Ward, Case 7: 56).*

Accordingly, she believed that the formalization of delegable tasks by senior management plays a decisive role in the redefinition of nurses' primary tasks:

"I think that […] the intravenous injections, that is not like we see that as 'delegation' anymore. It is just the standard. And the other [tasks; note: tasks to be delegated in the future] […] it would be probably helpful to make them a standard. And to also foster acceptance by saying 'Ok, that's now part of my original tasks' […]." (Head of the Ward, Case 7: 209).

Overall, Solution 2 discloses that nurses react openly to changes in their task responsibilities when characteristics of the change project and situational factors fit in a way that allows nursing professionals to legitimize changes in the division of medical tasks as appropriate means to formally reinforce dominant concepts of evolving nursing professionalism. Solution 2 illustrates particularly well how different boundary conditions of changes in professional task responsibilities interact to foster openness towards these changes. While the institutional environment in the departments covered by Solution 2 sponsored a highly professionalized nursing role, providing nurses with the confidence to exert 'small' medical tasks on a case-by-case basis it also raised awareness of professional boundaries and the desire for professional self-determination. For these nurses, legitimization of the formerly 'inofficial' task delegation and recognition of their qualification by senior management was a major driver of their general openness towards the planned changes. Hence, this solution can best be summarized as *"Authorized Professionalism"*. The fact that the medical tasks to be delegated do not qualify as divergent change is a necessary part of this overall sufficient configuration as it allows nurses to enact a professionalized nursing role while professional boundaries between nursing and medicine remain intact, preventing nurses who are confident in their role as well-trained health care professionals from becoming physicians' "henchmen".

Solution 3: Guided Professionalization

Solution 3 states that nurses were open towards changes in their task responsibilities under conditions of *"Absence of Institutional Pressure"* within their department in conjunction with *"Involvement of High-Status Change Agents"* during the change project that included tasks which qualified as *"Divergence from Status-Quo"*. The situation described by Solution 3 is similar to Solution 2 with regard to the normative considerations about nurses' current and future role in health care. In contrast to Solution 2 but equal to Solution 1, Solution 3 depicts a situation in which the respective departments are not defined by a high degree of formal professionalization. Accordingly, in the absence of institutional pressures towards specific forms of nursing professionalization, nurses' attention focused on practical improvements in their work situation. As both project managers from Case 12 pointed out, efficiency gains were apparently an important driver of nurses' very positive stance towards the assumption of medical tasks:

"They [the nurses] can absolutely improve the structure of their whole work and they can get through the processes more quickly. And that is what many, very many, have reported as very positive." (Project Manager 1, Case 12: 65)

"[…] they just notice 'I don't have to wait, I can do that right now, the patient isn't ringing the bell and keeps asking – where is the doctor? When will I get my infusion? I need a new [intravenous] access, this one doesn't work anymore'– So, on that level, they think that it is very useful." (Project Manager 1, Case 12: 154)

However, the divergence of the changes implemented in the departments covered by Solution 3 in conjunction with the high degree of "*Involvement of High-Status Change Agents"* implies a fundamental change in working structures that is legitimated by senior professionals' active support. Consequently, the situation described by Solution 3 provided nurses in the respective departments with an opportunity to redefine their professional status. As the head of the ward from Case 12 pointed out, the rationale behind nurses' openness towards changes their working structure combines process and professional considerations:

"[It was about] [c]hanges in the working process. We thought about how we could reposition the profession of nursing differently. A second thought [was]: how can we transfer tasks that don't necessarily have to be exerted by nurses to other occupational groups? And that is how it came into existence that we implemented changes in tasks. Changes in working structures. (Head of the Ward, Case 12: 59)

"[…] It was about time – a restructuration of working processes was important to all professional groups. I am thinking doctors shortage, nurses shortage. How can I cover tasks? With which professional group?[...] Also, […] many cleaning tasks were still exerted by nurses and are now being assigned to the service personnel

[…] As a nurse you don't need three years of training to clean a bed. I don't need this." (Head of the Ward, Case 12: 137)

Despite the fact that potential process improvements and associated efficiency gains were comparably important, Solution 3 differs from Solution 1 in the mechanisms causing nurses' openness to change. While patient considerations were not unmentioned by the interviewees, they did not appear to be the primary source of openness towards the delegation projects. In Solution 1, low resource endowment and low levels of formal professionalization in a department interacted to foster a problem-centered perspective on task delegation with nurses who seemed to 'accept their fate' as being responsible for well-working processes for the patients' benefit. Solution 3, however, describes a situation in which nurses were more focused on opportunities to evolve professionally and to broadly improve working processes. Given the comprehensive redefinition of working processes, including the delegation of complex medical tasks in the departments described by Solution 3, nurses were anxious about their legal status when assuming medical tasks. Accordingly, the involvement of the nursing directorate in the change project was described as particularly important as it provided "*legal security" (Nursing Director, Case 2: 44)* and a "*safe ground" (Head of the Ward, Case 12: 161)* for the exertion of medical tasks. Overall, Solution 3 discloses that nursing professionals are open towards changes in their task responsibilities when context factors and characteristics of change interlock in a way that provides them with legitimization accounts to experience the planned changes as safe means to achieve both considerable efficiency gains and increased professionalization (as opposed to existing professionalism). The three conditions *"Absence of Institutional Pressure", "Involvement of High-Status Change Agents",* and a change project that constitutes *"Divergence from Status-Quo"* interact to create a situation in which nurses are enabled to redefine their professional role in a way that matches local working processes with nurses' qualification. In the departments described by Solution 3, the absence of specific institutional pressures leaves room for individual, department-specific modes of nursing professionalization. While the divergent changes promoted in the delegation projects captured by Solution 3 allow radical process improvements that promise large efficiency gains, these extensive re-structuration projects also necessitate the support of senior professionals. Accordingly, this solution is best described as "*Guided Professionalization"*.

Professionals' Openness to Change in Institutional Practices: Pragmatic and Normative Accounts

The three solutions discussed above show that nurses are open to changes in their task responsibilities when either context conditions alone or context conditions and characteristics of change interact to provide them with *both* pragmatic *and* normative accounts to experience the changes in question as legitimate. All three configurations of conditions presented above trigger efficiency considerations that outweigh potential concerns about increasing workloads. However, they diverge in the normative accounts they provide. While Solution 2 and 3 describe situations in which nurses' openness to changes in their task responsibilities is (also) fostered by normative considerations on how nurses should be employed according to their existing and evolving qualification, Solution 1 describes a situation in which nurses pursue a more traditional nursing role that puts patient needs at the center of nurses' attention. However, all solutions incorporate two aspects of professional development. Nurses reacted openly towards enhanced task spheres when they experienced these changes as improvements in working processes *and* when they perceived a fit with the professional role they followed in the given situation. The interpretation that professionals' openness to change necessitates the availability of *both*, pragmatic and normative legitimizations accounts, is further corroborated by interview evidence from the cases in which nurses resisted changes in their task responsibilities. For example, in Case 5, the head of the ward explained that the assumption of medical task was perceived as useful since *"it takes more effort to call someone than to just do it myself" (65)*. Yet, nurses' openness to new modes of task division was very low as change in institutionalized practices lacked normative legitimacy due to *"the old doctor-nurse-conflict [about] who is responsible for what and who is burdening whom with work" (Head of the Ward, Case 5: 157).* Specifically, nurses were critical towards the assumption of task which they perceived as genuinely medical: *"The oncologist is actually the one to treat patients with infusion therapy. If nurses start to do this, what will the oncologist be doing then?" (Head of the Ward, Case 5: 41)*

Consequently, context conditions and characteristics of change must interact in a way to provide professionals with legitimization accounts that reflect the usefulness *and* appropriateness of institutional change. However, case evidence also suggests that the availability of pragmatic and normative legitimization accounts does not imply that professionals need to experience equilibrium between the pragmatic and normative legitimacy of new practices as long as they perceive both practical and professional benefit of institutional change.

5.3.6 Limitations and Conclusion

This paper employs institutional theory combined with a fuzzy-set qualitative analysis of 14 change projects in university hospitals to explain when and why nurses react openly towards changes in their tasks responsibilities. Results indicate that openness to changes in task responsibilities is contingent upon boundary conditions of change that allow professionals to find *both* pragmatic and normative accounts to legitimize changes in their working structure. A key finding of this study lies in the apparent importance of pragmatic process considerations for changes in institutionalized practices. This finding adds to recent "less dramatic" explanations of institutional change as phenomenon originating in everyday organizational practices (Smets et al., 2012: 898). Yet, the findings also underline that, while field-level discourses hardly influence professionals' reactions to change in specific organizational situations, boundary conditions of practice changes must allow for normative legitimization accounts rooted in professionals role concepts. Future research might draw on these findings to inquire how pragmatic and normative legitimizations accounts must complement each other for professionals to react openly towards changes in institutional practices. Further, the results of this study should remind institutional researchers to carefully distinguish between change in institutional practices and changes in the normative accounts that underlie professional roles. As indicated by Solution 1 of this study, professionals may be open to changes in their task responsibilities while not pursuing a new professional role. In fact, professionals considered an expansion of their task spheres in a paradox effort of 'changing to stay the same' which disconnected their intra-organizational institutional agency from their professional project on the field-level (see also: McCann et al., 2013).

While this paper holds contributions for the study of change in institutional practices in the context of professional organizations, readers should bear in mind that the generalizability of my study is limited due to its qualitative approach and a restricted focus on specific change projects in the context of university hospitals. Further, this study relies on a group-based measure of "*Openness to Change*". While the enactment of altered institutional practices is a collective social phenomenon, future research might include the level of the individual to allow for a more fine-grained view on professionals' openness to change.

6 Professionals and Routine-Level-Change

Professionals' institutional work on the routine-level is special in many respects. Routines are the patterns of professionals' daily work – the mundane and common, the tragic and boring patterns of their work with clients, colleagues, and superiors (Becker, 2004; Greenhalgh, 2008; Pentland & Feldman, 2005). Routines are the most micro-level structures in which institutional agency takes place; they are nested in organizational contexts and serving as an arena for the enactment of field-level logics (Powell & Colyvas, 2008: 277-282). Yet, routines are also executed to address specific tasks in specific times and places, making them susceptible to internal dynamics that may eventually foster institutional change. As a consequence, institutional work on the routine-level occurs within a complex interplay between enablers and constraints to agency. On the one hand, agency on the routine-level seems easier as adaptations in routines are commonplace and the political implications of actors' adherence to or rejection of logics are less obvious. Thus, institutional change or maintenance on the routine-level occurs more subtly and is less often accompanied by explicit struggles about the general appropriateness of new roles, new practices, and new structures that emerge from changes in the routine (e.g. Barley, 1986). On the other hand, routines are tightly embedded in multiple ideological and material systems that may constrain agency. Practical and technological necessities on the task-level, for example, may prevent the consistent enactment of specific institutional logics (Smets & Jarzabkowski, 2013; Smets et al., 2012), organizational control systems may sanction deviance from extant practice (Nathanson & Morlock, 1980; Ritzer & Walczak, 1988; Sorensen & Sorensen, 1974), and early neo-institutionalism would even predict routine participants to be unable to imagine alternative arrangements within their routines due to their institutionally conditioned cognitive frames (Feldman & Pentland, 2003: 99). Professionals' institutional work on the routine-level is thus a product of multi-level influences that interact to induce or prevent agency. Specifically, whether and how professionals change or maintain their routines may depend on macro-institutional factors from the field-level, the technological and social structures of the organization in which a routine is embedded, characteristics of the routine participants, and characteristics of the tasks to be addressed by the routine (cf. Adler & Kwon, 2013).

To account for the multiple nestedness of routines and their dual function as micro-level arenas of logic enactment and coordination devices to 'get work done', the following chapter will integrate institutional and routine literature to provide a comprehensive view on when, why, and how professionals exert institutional work on the routine-level. While both literatures provide important insights on routines as arena in which actors may exert institutional agency, neither does fully address that routines are both social structures that convey meaning and endow actors with a

certain (professional) identity (see also section 3.2.3) and coordination devices through which organizational functioning, efficiency, and eventually economic survival is achieved. Institutional literature, due to its primary interest in how social structure shapes and is shaped by individual and collective action, tends to view routines as either stable structures that carry institutional norms and values and thereby constrain actors (Zucker, 1987) or – more recently – as social practices in which institutional logics are enacted and reconfigured (Smets & Jarzabkowski, 2013; Smets et al., 2012). Interestingly, the duality between structure and agency has been addressed in routine research with the conceptual differentiation between the ostensive and the performative aspect (Feldman & Pentland, 2003; Pentland et al., 2012; Rerup & Feldman, 2011: 587; see also section 3.2.3) but has yet to find its way into institutional research.

Routine research, on the other side, could profit from a more explicit acknowledgement of the socially embedded nature of routines. Feldman (2000: 614), for example, points out that "[r]outines are performed by people who think and feel and care. Their reactions are situated in institutional, organizational and personal contexts". She implies that routine change is not a mere convergence to their most efficient form but an ongoing dynamic that originates from actors' socially conditioned reactions to performative feedback. Yet, recent calls for a more contextualized view of routines and their role "in (re)creating institutional contexts (and vice versa)" (D'Adderio, Feldman, Lazaric, & Pentland, 2012: 1782) underline that the embeddedness of routines is still one of the major 'blind spots' in routine research.

While integrating institutional and routine research in the study of professionals' institutional work on the routine-level may advance both of these literatures, it also helps to gain a more detailed understanding of the processes that underlie professionals' engagement in institutional change or maintenance on the routine level. This is (i) because professionals' work is particularly strongly shaped by social expectations and (ii) professionals' work typically occurs around a clients' specific problem in a specific situation that requires the case-specific application of complex knowledge. One the one hand, professionals are socialized into a dense network of norms and values on what constitutes 'professional conduct' and derive their identity from exerting special work in a specific way (see also section 3.2.3). Thus, professionals are prone to consistently enacting their professional logic within their work, suggesting high degrees of stability in their routines. This aspect of professional work corresponds with central assumptions of neo-institutionalism such as the reproduction of socially conditioned norms that lead to structural stability in routines (Zucker, 1977). On the other hand, one of the elements that constitute 'professional conduct' is the purposeful application of tacit knowledge to a clients' *specific* problem under great levels of autonomy. This idiosyncratic nature of expert work would suggest that agency within professional routines is better explained by

routine literature which emphasizes the inherently improvised nature of routine performances. Additionally, professionals, as noted above, are not only professionals: In their roles as managers and employees they may even intentionally distance themselves from their professional logic and change their routines according to efficiency demands or in order to raise outcome quality even if their professional logic would prescribe different courses of action.

In short, professionals' institutional work on the routine-level is more ambiguous than their agency on the field- and the organization-level as is occurs as a response to institutional pressures and immediate practical contingencies that affect professionals' routines simultaneously. The goal of this chapter is to investigate how different configurations of these boundary conditions affect professionals' institutional work on the routine-level. To do so, I will first provide the empirical background to the study that will be presented in the third section. Specifically, I will elaborate on how the recent changes in German health care affected treatment routines and how health care professionals reacted towards these alterations in their daily work. In the second section, I will provide a concise literature review, integrating findings from institutional and routine research, to illustrate when, why, and how professionals generally engage in institutional work within their daily routines, drawing special attention to the incremental, subtle nature of institutional work on the routine-level. I will close this chapter with an empirical study that addresses the question of when and why medical professionals enact formal rules in their treatment routines. Employing a 'routines as generative systems'-perspective, this study seeks to identify configurations of boundary conditions that lead health care professionals to partly renounce their individual autonomy within their working routines and instead adhere to formal rules. This study expands routine research by explicitly accounting for the *multiple* levels in which a routine is embedded, putting particular emphasis on the institutional pressures and the socialization processes that characterize professionals' work. Further, this study adds to research on professionals' institutional work by systematically elaborating on how both social and practical considerations of professionals' work induce change on the micro-level. Specifically, this study sheds light on when and why medical professionals enact artifacts that essentially collide with key aspects of their professional logic, namely their professional autonomy. It suggests that medical professionals enact formal rules in their routines when these rules can be used as a resource for either coordinative and legitimization purposes.

6.1 Setting: Standardization of Medical Routines in German Health Care

Changes in routines are often logical consequences of field-level-changes as the design of organizational routines that are considered appropriate against the background of wider sets of norms and values supports organizational legitimacy (Guler et al., 2002; Kennedy & Fiss, 2009; Lounsbury, 2001; Roggenkamp et al., 2005; Walston, Kimberly, & Burns, 2001; Westphal et al., 1997). Thus, whenever the social expectations on how organizations should be structured change, so will the routines that constitute the core of any organization (Becker, 2004, 2005). Accordingly, the political pressures towards more cost-efficiency and accountability (see chapter 4.1) and the rise of managerialism in German health care (see section 5.1) have also affected the operational core of health care organizations, that is, professionals' everyday working routines.

With a rise in efficiency and accountability pressures together with an increase in multi-morbid patients, new medical technologies and a rapid expansion of treatment options, practitioners are confronted with countervailing forces that need to be balanced within their routines. On the one hand, the professional logics of health care workers, medical professionals in particular, would prescribe autonomous routine performances that are primarily guided by physicians' expert assessment of each patient's individual needs. On the other hand, resource scarcity within hospitals and tight quality controls by SHI-funds put constraints to the enactment of medical autonomy within treatment routines.

Both efficiency pressures and the call for more accountability in health care fostered efforts to reduce process and outcome variability in medical services. These have been translated into a notable rise in the standardization of health care routines, e.g. in the form of comprehensive catalogues of standard operating procedures (SOPs) or through clinical pathways that predefine each step of a specific treatment routine (Börchers, Neumann, & Wasem, 2007; Roeder, Hensen, Hindle, Loskamp, & Lakomek, 2003; Roeder & Küttner, 2006). This rise in standardization has evoked mixed reactions among the medical profession; specifically because it has diverging implications for medical practice. On the one hand, 'evidence-based medicine' has been advocated by the medical profession itself as a way to integrate state-of-the art medical scientific knowledge into daily medical practice and as a means of quality assurance (Raspe, 1996, 2003). Clinical guidelines that promote evidence-based medicine are provided and regularly updated by the Association of the Scientific Medical Societies in Germany (AWMF) and are supposed to aid clinical decision-making while not being legally binding (AWMF, 2015). However, these general guidelines comprise a broader corridor of scientifically proven 'minimal care', to be adapted according to an individual patients' needs rather than a

strict definition of each step of the routine that has increasingly been propagated in hospitals after the introduction of the DRG-system (Lelgemann & Ollenschläger, 2006). Within hospitals, clinical pathways – while also based on scientific evidence and practical experience – are often implemented with particular efficiency- and quality-goals in mind (Lohfert & Kalmár, 2006; Roeder, 2003; Roeder & Küttner, 2006). Given the idiosyncratic nature of medical practice and guidelines' implicit proposition of an 'average patient' under 'average circumstances', the use of clinical pathways has been decried by practicing physicians as "cookbook medicine" (Sturm, 2013: 223). Official statements of physicians implied that strict clinical pathways are an instantiation of the (false) belief that medical routines can be regulated and optimized in a mechanical way and that the excessive use of guidelines may threaten the individuality of both the patient and the treating physician (Clade, 2002). While physicians commonly employed normative appeals to the special bond between a physician and his patient to substantiate their argument that the very nature of medical work forbids a strict alignment of medical practice with formally defined rules (Helmchen, 2005), their ambivalent stance towards measures of treatment standardization is also notably informed by their fear of losing control over their work (Helmchen, 2005; Kolkmann, 2002b; Kolkmann, 2002a; Nauck & Jaspers, 2013).

Generally, medical professionals are normatively committed to provide care according to scientific principles (Berger, Richter, & Mühlhauser, 1997). Their goal to consistently align their work with state-of-the-knowledge is, for example, reflected in the strongly formalized system of medical education and qualification. This reduction of variance in medical work through the consistent application of a clearly defined body of scientific knowledge is even one of the reasons why the medical profession is granted extensive regulatory autonomy (Freidson, 1970b, 1984). Accordingly, medical routines necessarily carry in them a certain extent of standardization that results from peer-control and physicians' moral commitment to provide their patients with scientifically proven, state-of-the-art-medicine (Timmermans & Berg, 2003).

However, as medical practice is increasingly exerted within the boundaries of large organizations and managerial control has become the new norm in health care provision (see section 5.2), physicians have become more aware and more critical of the implications of standardized medical routines (Clade, 2002; Encke, 2002; Helmchen, 2005). Clinical pathways have become an attractive tool for hospital managers to not only ensure that their organization provides state-of-the-art health care, in line with political quality goals, but to also raise efficiency, by e.g. reducing patients' length of stay (Rotter et al., 2010; Rotter, Kugler, Koch, & Gothe, 2006; Stephen & Berger, 2003). While clinical pathways have been discussed to enable physicians in dealing with the increasing complexity of their work against the

background of technological and scientific progress and multi-morbid patients (Wienke, 1998), the instrumental use of these rules to achieve managerial goals has commonly sparked physicians' resistance (Encke, 2002). This is because the enactment of clinical pathways directly restricts physicians' characteristic autonomy, implying that they become limited in adapting their performances according to their patients' individual needs, their own experience, and specific contextual conditions (Kolkmann, 2002a). This limitation of medical autonomy has implications for physicians' professional identity as discretion over the operational core of their work is one of the key principles of medical professionalism (Cavenagh, Dewberry, & Jones, 2000; Rappolt, 1997; Sullivan, 2000), and has thus long remained untouched by the ever increasing regulation in German health care. While physicians have repeatedly emphasized that they do not object to using scientifically proven guidelines as a tool to keep treatment in line with the latest medical standards (Berger et al., 1997; Kienzle, 2007; Prütz, 2012), the context in which clinical pathways were implemented left little room for arguing that these were solely meant as a tool to support clinical decision making. Specifically, with the DRG-system in place and the ubiquitous propagation of managerial techniques, medical professionals' became increasingly pressured to justify their routines not only from a medical but also from an economical perspective (BÄK, 2007; Bär, 2011; Boldt & Schöllhorn, 2008). As a consequence, the implementation of clinical pathways was often perceived as giving further leverage to managerial interests, providing non-medical managers with an additional means to exert control over medical work (Clade, 2002; Kolkmann, 2002b). Even though physicians always remained in charge of how to treat a particular patient, clinical pathways served as a template for 'medical standard practice', thus making medical routines accessible to non-medical managers and enabling them to question each practitioner's performance (Roeder, 2003). Accordingly, reports from hospital practice indicate that physicians felt restricted in their medical autonomy. Examining the implementation of pathways in the urology department of a German university hospital, Pühse et al. (2007) report that physicians exposed a critical stance towards pathways despite the fact that these pathways had initially been developed as a formal agreement among practitioners on appropriate courses of action within treatment routines. Specifically, even though (justified) deviations from the pathways had been allowed, practitioners criticized the rigid prescriptions of how they should proceed when documenting, diagnosing, and treating a patient (Pühse et al., 2007: 3091).

On the other side, more and more members of the medical profession have acknowledged the benefits of employing clinical pathways in their daily work. In particular, pathways have been discussed as a means to inform and actively integrate the patient into the treatment process, as a tool to support coordination among different health care professionals, and as an instrument to foster training and learn-

ing processes within medical routines (Schwarzbach & Ronellenfitsch, 2008: 2514-2515). However, physicians who promoted the advantages of clinical guidelines were usually cautious to emphasize that these rules are to be used as decision-making support tool to help practitioners align their work with current scientific knowledge, yet should never be applied in a technocratic, deterministic manner (Nast et al., 2013).

Apparently, physicians anticipated both the practical and the symbolic implications of a proliferation of clinical guidelines. As noted above, especially hospital physicians risked a further loss of control over their work as clinical guidelines made the formerly implicit and often ‘mystified’ practice-part of medical knowledge accessible to managers, thus allowing non-peers to more closely examine the performances of medical professionals. While clinical pathways primarily pertain to health care professionals’ daily routines, their proliferation had strong political connotations as it questioned the superiority of medical autonomy and peer-control as means of coordination. Given that many medical professionals considered clinical pathways to be an adaption of industrial methods to the clinical context, their diffusion represented a challenge to the very core of the medical profession, that is, the autonomous application of complex knowledge while considering the specific needs of each patient (Clade, 2002; Encke, 2002; Helmchen, 2005; Kolkmann, 2002a). Consequently, the enactment of guidelines in medical routines has not only been discussed with regard to their immediate effects on medical routine performances but became the subject of political debate. While the German Medical Council acknowledged the value of guidelines as a way to translate scientific knowledge into medical practice, it also explicitly condemned any attempt to misuse such standards for economic purposes and warned of their potential to de-professionalize medicine (Bundesärztekammer, 2002; see also: Graf-Baumann & Meyer, 2008: 2). Some medical officials expressed even more drastic opinions on the alignment of medical routines with care pathways. In an interview, Jörg-Dietrich Hoppe, late president of the German Medical Council, urged practitioners to carefully consider whether and how to employ pathways in their daily work as a voluntary standardization of medical treatment may foster the public perception of doctors as “arbitrarily interchangeable service providers” (Flintrop, Stüwe, & Gerst, 2008: 927). Taking an even more critical stance, Vilmar (2008), honorary president of the German Medical Council, describes the development and use of pathways as an economic tool for controlling and rationing health care services not only as a threat to medical autonomy but as a threat to “human freedom as such” (ibd.: 92)[39].

In sum, the standardization of health care routines, while constantly on the rise, is heavy with meaning against the current developments in German health care. From

[39] Both quotes have been translated from German by the author.

a practical perspective, the enactment of clinical pathways may be considered both a bureaucratic hassle that increases documentation and complicates medical work and a helpful tool that facilitates coordination and learning in diagnostic and treatment routines. From a symbolic perspective, the alignment of medical performances with formally defined rules may demonstrate commitment to state-of the art medicine but also submission to an economically motivated rationing of health care (Kolkmann, 2002b). Specifically, the decline of medical autonomy and the 'demystification' of medical knowledge may not only affect individual practitioners' professional identity but holds far-reaching political implications: Medicine may increasingly be viewed as mere provision of predefined services which would considerably weaken the medical professions' position in health care politics and make their privileges (such as self-government) harder to defend against the state, SHI-funds, and even adjacent professions (see also section 5.1).

These countervailing forces make it hard to predict whether and when physicians in hospitals will integrate pathways into their routines. Most hospitals, on the other side, have a high interest in structuring their processes according to well-defined formal rules to address the efficiency and accountability pressures that rest upon them. Given that many hospitals invest considerable resources into developing and implementing clinical pathways while physicians, as professionals, remain free to not enact these rules in their daily work (Encke, 2008: 26), it is important to understand what drives physicians' decision to consistently align their performances with clinical pathways. Accordingly, the study in section 6.3 will deal with the question on when and why professionals are willing to restrict their autonomy and allow pathways into their routines. Before presenting this study, I will provide an overview on when, why, and how professionals generally exert institutional work within their routines. Specifically, I will integrate findings from institutional and routine research to identify theoretical gaps in the study of when, why, and how professionals integrate or reject new logics along the courses of their daily work.

6.2 Theory: Professionals' Role in Routine-Level Change

On the routine-level, professionals carry out institutional work as both professionals with specific, socially conditioned identities that are reflected in what they do and how they do things (see section 3.2.3) and as routine participants who engage in effortful accomplishments to address specific tasks in specific contexts (Pentland & Rueter, 1994: 488). Given this dual purpose of routines as sites for processes of social construction and as systems of work coordination, professionals are incentivized to exert institutional work on the routine-level either when it promises to create

more appropriate routines in the normative sense or more efficient working processes through better outcomes, less input, or both[40].

Antecedents: When and Why Professionals engage in Routine-Level Change

As already implied in section 3.4.2, institutional change on the routine level may occur when professionals enact different logic constellations in response to performative feedback, eventually leading new logics to 'creep up' into their ostensive aspects. Elaborating on the mechanisms that lead to internal routine dynamics, Feldman (2000: 620) distinguishes between "repairing", "expanding, and "striving". Routine participants repair a routine when their performances prove to generate outcomes that are different from the originally intended outcome or when they "produce an unintended and undesirable outcome". Continuous repairing of a routine may result in routine stability and thus often corresponds to institutionalists' idea of maintenance work: While being aware of alternative performances, actors deliberately seek to prevent change in their routines as the given arrangement proves to be more efficient or more appropriate (cf. Lawrence & Suddaby, 2006; Lawrence et al., 2009a; Lawrence et al., 2009b). Expanding and striving, as two further mechanisms of internal routine dynamics, are more likely to generate change in routines. Expanding may occur when routine performances open up new opportunities and actors make use of these. Striving, in turn, may occur when actors perceive the outcome of their actions to fall short of their ideals (while not necessarily short of intended results). As Feldman (2000: 620) points out, striving implies that routine participants "continue to alter the routine so that it allows them to do the job in a way that seems better to them", allowing for both a normative and a pragmatic interpretation of what constitutes 'doing a better job'.

While each of these routine dynamics may lead to institutional work in the sense of a selective enactment and rejection of different institutional logics, I would like to point out that change and stability in routines is not necessarily the outcome of institutional work but may take place *within* a given set of logic constellations that is not challenged or altered. To give an example, medical professionals may adapt their treatment routines when encountering adverse outcomes such as unusually high complication rates among their patients by adjusting the frequency of consultations or by administering different drugs. Yet, neither of these options would imply a deviation from the medical professional logic. If, however, medical professionals opted to alter their routines by regularly consulting with nurses about treat-

[40] The literature review is based on the same search and selection procedure as described in chapter 4. Yet, due to the focus on both institutional and routine research, the initial search procedure was complemented with the following search terms, resulting in 42 additional studies that have been considered for the literature review on professionals' institutional work on the routine-level: "profession*" AND "routine change"; "profession*" AND "change in routines"; "profession*" AND "change in organizational routines"; "profession*" AND "routine dynamics"; profession* AND "organizational routine*".

ment schemes, they would subtly (and possibly unintentionally) exert disruptive institutional work by allowing for a greater influence of nurses' professional logic.

Given the goal of this thesis, the following paragraphs will focus only on instances of agency that (also) relate to the maintenance or change of cognitive and normative principles that guide routines. However, and in contrast to institutional work scholars' notion that institutional work is "purposive action […] aimed at creating, maintaining and disrupting institutions" (Lawrence & Suddaby, 2006: 215), I will also include cases in which professionals engaged in non-projective institutional agency that promoted the enactment of specific logic constellations but was not an intentional attempt to alter or defend institutional arrangements. I will do so because incremental changes in routine participants' perceptions on appropriate courses of action are an important driver of (de-)institutionalization processes on the routine level but may emerge as a simple 'by-product' in the strive for efficient and effective working routines (McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013).

How routine outcomes that fall short of professionals' goal to satisfy client needs induce an unintentional re-combination of logics in professionals' routines is illustrated by Smets and Jarzabkowski (2013). While I have already provided a short discussion of this paper in section 3.3.2, I would like to highlight some aspects that illustrate particularly well how performative feedback from within the routine first uncovers differences in the ostensive aspects of routine participants (see also section 3.2.3) and then encourages the enactment of new logic combinations to re-establish a functioning routine. Smets and Jarzabkowski's (2013) study on cross-national transactions in a multinational law firm, that involved the collaboration of German and English lawyers, shows that urging pressures to improve routine outcomes may induce both reflexivity and motivation among professionals that enables the creation of new routines. The authors particularly emphasize that a "work-level-crisis" (ibd.: 1299) in which inefficiencies and delays caused client dissatisfaction, led German and English lawyers to reconsider their collective working routines. As the rejection of each other's professional logics as guiding principles for the consultation and service routines caused unsatisfactory outcomes, the two groups of lawyers were unable to maintain their diverging ostensive aspects. While routine researchers have already emphasized that actors may adapt their routines in response to outcomes remaining under aspiration levels (Feldman & Pentland, 2003), Smets and Jarzabkowski (2013) provide an interesting institutional explanation on why routine performances may not achieve the intended outcome. In their case study, German and English legal professionals – due to their differences in socialization – have developed diverging ideas on how legal service routines are to be exerted. Thus, the crossnational routines were characterized by multiple ostensive aspects which resulted in coordination problems and, eventually, led to lower

outcome quality. This possibility of multiple ostensive aspects has only recently been acknowledged in routine research (Safavi, 2014), but has important implications for professionals' institutional work on the routine-level. As professional socialization is usually a strong aspect of routine participants' identity, which they develop and enact within their work (Pratt et al., 2006), diverging ostensive aspects in multiprofessional routines are not easily integrated and necessitate reflexivity and purposeful effort to translate into coordinated performances. Smets and Jarzabkowski's (2013) findings underline this argument as they reveal that it took four cycles of institutional work for lawyers to resolve the logic complexity within their work and generate a shared ostensive aspect. While at first, logics were separated by keeping individual performances in line with each of the logics (cycle 1) and explicitly constructing performances and underlying logics as incommensurable (cycle 2), persistent negative feedback from routine performances pushed lawyers towards a re-evaluation of their representations of what constitutes an appropriate legal service routine. Accordingly, they began to improvise, first generating hybrid performances around specific client needs (cycle 3) before finally establishing formal modes of training and socialization that fostered the development and stabilization of ostensive aspects (cycle 4).

Two insights from this study are noteworthy for expanding our understanding of when and why professionals engage in institutional work on the routine-level. First, on the routine-level, it may not be the co-existence of several logics as such that drives institutional work but rather its effects on the coordination of performances. This is because ideas on appropriate work organization primarily show in their enactment rather than being explicitly discussed, as routines are not arenas for political negotiation. In short, diverging institutional frameworks induce agency because they inform the ostensive aspects of the routine participants which, in turn, become obvious in professionals' performances as the immediate applications of their ideas of appropriate conduct. Second, internal routine dynamics that stem from performative variability are not only generally more likely in professionals' routines due to their inherent complexity and client orientation (Faraj & Xiao, 2006), but may also be driven by diverging ostensive aspects that are more likely to occur when professionals with different institutional backgrounds need to collaborate within routines (cf. Currie & White, 2012; Elissen, Van Raak, & Paulus, 2011).

While both routine researchers and – more recently – institutionalists provide convincing accounts as to why antecedents of institutional dynamics on the routine-level may be found in the routine itself (Feldman, 2000; Greenhalgh, 2008; Hilligoss & Cohen, 2011; Jarzabkowski et al., 2009; Pentland et al., 2012; Reay et al., 2013; Reay et al., 2006; Rerup & Feldman, 2011; Safavi, 2014; Smets & Jarzabkowski, 2013; Smets et al., 2012; Williams, 2001), several studies suggest that professionals' institutional work on the routine-level may be induced by exter-

nal interventions that expand or shift the logic constellations that have hitherto dominated professionals' ostensive aspects (Barley, 1986; Bruns, 2009; Harris et al., 2014; Kellogg, 2009; Kellogg, 2011). In contrast to internal dynamics in which ostensive aspects are shaped by feedback from performances, external interventions may directly disrupt existing accounts on how a routine is to be exerted, leading to a response that – in the case of professionals – often includes the purposive maintenance of their routine.

An often-cited example of an external intervention that may disrupt professionals' ostensive aspects of their routines is the introduction of formal (procedural) rules that contain explicit descriptions on what routine participants should focus their attention on, which steps they should include in their routine, and how they are supposed to execute each step of the routine (Brunsson & Jacobsson, 2000; Busch, 2011; Jacobsson, 2000; Rozich et al., 2004; Savage & Langlois, 1997; Timmermans & Berg, 2003). Formal rules may induce institutional agency on the routine-level when they have the potential to alter or enhance the logic constellations that shape professionals' ideas on how to go about their work. Specifically, when their respective professional logic and formal routine prescriptions provide mutually exclusive behavioral repertoires, professionals are confronted with a forced-choice-situation that necessitates purposeful institutional work to either maintain or adapt their routines. While research on professionals often suggests a general incommensurability between the typically autonomous professional work and the adherence to formal rules (e.g. Scott, 1982: 229), the introduction of rules into professionals' routines does not necessarily induce the strict maintenance of a given routine. For example, Bruns (2009) as well as Garrow and Grusky (2013) show in their studies on the enactment of rules in professionals' work that professionals may partially and selectively maintain or change their routines in response to rule implementation, depending on the extent of conflict between their guiding logic and the rule.

Bruns's (2009) ethnographic study in a molecular biology laboratory of a leading U.S. research university shows that the implementation of formal rules may induce institutional maintenance work among professionals in the form of a selective enactment of rule elements. Employing a routine-theoretical perspective, Bruns (2009) investigates when and why scientists' routine performances systematically differ from the routine prescriptions of organizational safety rules. Her case study provides a typical example in which state regulation had been translated into standard operating procedures on the organizational level to ensure professionals' compliance with legal requirements. Specifically, an Environmental Health and Safety office (EHS) had been formed to provide safety trainings and formal rules to ensure that laboratory scientists exerted their routines in line with safety regulations. The maintenance of a high level of laboratory safety was crucial to secure the legitimacy

of the research facility and protect it from legal sanctions. Hence, the goal of the EHS was to "eliminate or minimize hazards that the research could inflict on the scientists, the public, and the environment" (Bruns, 2009: 1407). While general safety rules were issued by the EHS, these had to be adapted to the specific circumstances and health risks in each of the laboratories. The examined laboratory was classified as "bio level 2", implying that scientists were regularly handling potentially infectious human cell lines, radioactive material and liquid nitrogen, as well as sharp instruments which increased their risk of injury and infection (ibd.: 1408). Thus, safety rules in this laboratory included the general EHS guidelines on personal safety as well as further specifications on how to dress, when to use gloves, and how to proceed when specific substances are being handled. Yet, regulatory pressures and university's great efforts to generate a climate of safety did not ensure that scientists diligently engaged in all of the prescribed safety practices. According to Bruns's (2009: 1413) observations, scientists' performances were strongly aligned with safety prescriptions that ensured the protection of their experiment. Rule elements that (only) related to the protection of scientists' physical health were, however, at best randomly enacted. Bruns (2009: 1407-1410) explains this by pointing towards the two-dimensional nature of safety in the setting of scientific research. Scientists' idea of safety was primarily related to the protection of their experiment. On the one hand, the professional norm on "nonintervention" (ibd: 1410) prescribes that scientists should absolutely prevent any contamination of their experiment to ensure that they do not interfere with the experimental outcome. On the other hand, securing the experiment against contamination also has concrete practical implications for researchers as "laboratory experiments are very delicate" (ibd.: 1410) and the reproduction of an experiment could set scientists back by months or even years of work. Safety as organizational goal, in turn, was primarily conceptualized as the protection of scientists' and public health and thus instrumental to avoiding legal prosecution and the loss of organizational legitimacy (Bruns, 2009: 1407f.).

From an institutional perspective these divergent ideas of safety can be viewed as an expression of two logics, namely, scientific professionalism and the logic of bureaucracy. Within their daily routines, scientists worked towards the maintenance of their professional logic that emphasized the primacy of the experiment over their own safety and over the formal rules of their organization. Interestingly, scientists did not explicitly resist those safety rules that did not add to the accuracy of the experiment but opted to frequently ignore them in their daily work. An excerpt from Bruns's (2009) fieldwork illustrates particularly well that the non-enactment of rules that promoted scientists' personal safety was not an intentional act of deviance but rather a consequent enactment of the scientific logic that put the focus on the integrity of the experiments. When Bruns (2009: 1417) asked a postdoctoral student

why she would not wear gloves during her work on a Petri dish, she responded that the cells she was examining were already dead, implying that she could not possibly harm the experiment. Bruns (2009: 1417) further elaborates that her interview partner did "not consider the possibility that the cells contain an infectious virus that she could be exposed to in case of an accident". While institutionalists might argue that the non-enactment of rules was merely a non-reflective automatism, Bruns (2009: 1416) explicitly points towards a discrepancy between interview data and scientists' performance, implying that scientists were well-aware of their organizations' safety rules as they "readily reproduced the understanding of safety promoted in EHS trainings, manuals, and inspections" during interviews but opted to only selectively enact these rules in their performances. Here, scientists' institutional work consisted of what institutionalists might refer to as selective decoupling (cf. Boxenbaum & Jonsson, 2008). Specifically, scientists fully aligned their performances with their professional logic which led to the enactment of only those elements of organizational safety rules that were conducive to the protection of their experiments. A particularly interesting insight from Bruns's (2009) study is how the interaction between formal rules, as an external intervention, and performative feedback from within the routine induced a specific form of agency among scientists. As carriers of bureaucratic elements, the enactment of formal rules can be assumed to collide with professionalism in general (Adler & Kwon, 2013; Bozeman & Rainey, 1998; Sorensen & Sorensen, 1974). However, as Bruns (2009:1420) implies, specific rule components were in line with scientists' professional logic that emphasizes the importance of protecting the experiment to obtain publishable results. Consequently, scientists utilized specific elements of the organizational safety rules to bring their performances in line with their professional norms and to socialize new team members accordingly. Rule components that did not appear to be conducive to the protection of scientists' experiments were, in turn, only randomly translated into practice. Especially this non-enactment of rule components illustrates well how scientists' maintenance work resulted from an interaction between external interventions and performative feedback. On the one hand, the introduction of safety rules induced reflexivity among scientists about their everyday performances, as a quote from one member of the laboratory illustrates. When asked to be photographed, he gave permission but added: "Maybe I should wear glasses . . ." (ibd.: 1418), implying that he was aware of his deviation from organizational safety rules. On the other hand, scientists' negligence of rule elements that referred to personal safety was seemingly justified by their experience that the laboratory has been largely accident-free for at least six years (Bruns, 2009: 1410). Bruns (2009: 1417) concludes that, "[t]he memory in the laboratory that the scientists operate on does not contain any recent occurrence of accidents" which contributed to "making personal safety seem less urgent". Thus, for purposes of personal protection scientists

relied on their characteristic decision-making autonomy and their expertise even though organizational safety rules explicitly demanded to “treat all compounds as potentially harmful” (ibd.: 1409). Specifically, Bruns’s (2009: 1418) observations and interview data reveal that scientists typically rationalized the non-enactment of rules by implying that they were able to assess the risk of the respective performance. For example, one scientist who refrained from wearing long pants or safety glasses while handling a slightly radioactive substance noted that the material was not very harmful, concluding that he did not “have to protect [himself] too much” (ibd.: 1418). This selective enactment of organizational safety rules can be viewed as a consequent enactment of scientists’ professional logic through both, their focusing on the protection of their experiments against contamination and their demonstration of professional autonomy and expertise. Yet, I would like to point out an important detail that may add to our understanding of how logics may be combined within professionals’ daily routines. While scientists obviously maintained the dominance of their professional logic and freely decided whether and when to enact rules on personal safety, they also opted to align their performances with rules on experiment safety and socialized new members of the laboratory accordingly, thus integrating typical bureaucratic elements (i.e. formal rules as means of coordination) into their work. This was because formal rules that protected the experiment against contamination helped to achieve outcomes that are deemed desirable within the scientific professional logic while, for personal safety rules, the benefit of rule enactment did not outweigh the necessary restriction of professional autonomy. Consequently, Bruns’s (2009) study may be conceptualized as an instance of maintenance work on the routine-level but still shows how new logics may be selectively included in professionals’ work when they provide them with resources that support the enactment of their professional logic. This conclusion is well in line with recent institutional research which emphasizes that professionals may be guided by more than one logic, especially when these logics are complementary (Goodrick & Reay, 2011). While professional logics and the logic of bureaucracy are generally assumed to be conflictual (Freidson, 2001; Sorensen & Sorensen, 1974), scientists’ selective enactment of formal rules on the routine-level shows how professionals may borrow elements from other than their own logic and thereby incrementally und unintentionally work towards institutional change.

Overall, Bruns’s (2009) study nicely illustrates that professionals’ institutional work on the routine-level may come into existence when external interventions induce reflexivity about their performances while commensurability of these interventions with professional norms and performative feedback affect whether professionals engage in the change or maintenance of their routines. Further, it shows that professionals’ (selective) divergence from formal organizational rules is not necessarily an instance of strategic effort to exclude bureaucratic elements from their

work but may be ‘agency by passive omission’ rather than ‘agency by active defiance’ that typically occurs in the non-political context of everyday working routines.

Garrow and Grusky (2013) offer another study that addresses the question of when and why formal rules are being enacted in professional settings. While their quantitative study does not provide detailed accounts on routine participants’ rationale behind the (non-)enactment of rules in their routines, it draws attention to the multilevel contexts of professional work that may affect whether and how professionals’ exert agency within their routine performances.

Specifically, they examine the influence of field-level logics on the enactment of formal rules in professional settings. They focus on the implementation of regulatory guidelines for HIV/AIDS pretest counselling in social work, hypothesizing that (in)compatibilities of these artifacts with field-level logics serve as a precursor to institutional agency on the routine-level. The authors test their hypotheses using a sample of 90 HIV/AIDS health organizations and 216 frontline practitioners in Los Angeles County. All of these organizations offered HIV pretest counselling, yet, as the authors note, they do not operate according to the same dominant logics (ibd.: 111). Accordingly, counselling routines were embedded not only in different technological and practical contexts but also in diverging normative and cognitive systems. In addition, and as typical for professional settings, practitioners had large degrees of discretion when structuring their work. As Garrow and Grusky (2013: 105) point out, they become “lower level policy makers” (ibd.: 103) since the “enforcement of CDC guidelines is weak”. Thus, regulatory force and direct control of professional practice can be excluded as potential explanation for the extent to which practitioners align their work with formal prescriptions.

To examine the effect of higher-level institutional logics on practitioners’ micro-level agency, they cluster the organizations in their sample into four organizational fields according to their central logics. The medical logic, according to which hospitals and emergency departments were structured, focused on the re-establishment of health as a biochemical state through medical interventions (ibd: 111). The public health logic applied mostly to public health clinics and featured the prevention of infectious diseases through education, preventive medical care, and treatment (ibd.: 111-113). The social movement logic characterized small, nonprofit organizations for HIV and AIDS advocacy whose primary clients were risk groups such as homosexuals or homeless people. This logic specifically comprised “advocacy, prevention, education, and psychosocial services” (ibd.: 113). Finally, the multi-service-logic, which represented the normative and cognitive framework according to which nonprofit health organization for uninsured, low-income clients were structured, promoted a holistic approach to HIV counselling. This logic combined

medical, social, and psychological perspectives to foster the overall well-being of the client in all of these areas (ibd.: 113).

As the guidelines of the Center for Disease Control and Prevention (CDC) specifically prescribed HIV pretest counseling to include elaborate information on several relevant, interdependent topics surrounding potential HIV infection (that is, the transmission and prevention of HIV, the process of testing, the implications of a positive or negative test result, and the reduction of risk), the authors chose "Comprehensiveness of HIV Pretest Counseling" as the dependent variable. They measured this outcome with an aggregated index that indicated how many of 11 individual topics had been covered during counselling (ibd.: 110). Garrow and Grusky (2013: 113) theorize the medical logic to be least in line with the CDC recommendations for HIV counselling, and the public health and social movement logics to be most commensurable with the process and outcome goals of the CDC. The multi-service logic, they conclude, "is moderately consistent with the aims and assumptions of HIV test counselling" (ibd.: 113). Consequently, they propose that practitioners who work in hospitals and emergency departments are least likely to align their performances with the CDC recommendations while practitioners from public health clinics and nonprofit organizations for HIV and AIDS advocacy are assumed to be most likely to fully enact the CDC guidelines.

To specifically uncover the net effect of field-level logics on agency within professionals' daily work, the authors further accounted for several, multi-level variables that may affect whether and to which extent actors are willing to align their work with political guidelines. These included both individual-level variables and organization-level variables. Individual level variables comprised professional orientation which captured whether the respective practitioner was a professional (i.e. a physician or a nurse), practitioners' general work experience, their training in and knowledge of HIV testing and counselling, and clients' need profile (measured by both their HIV status and by whether they belonged to a risk group) (ibd.: 114). Organization-level variables comprised overall workload, degree of formalization (measured by automation and reliance on formal rules) as well as further control variables such as size, age, and ownership type (ibd.: 115).

As hypothesized, Garrow and Grusky (2013: 116) find that professionals provide less comprehensive HIV counselling, thus keeping their routines unaligned with the prescriptions of the CDC. While the authors explain this finding with physicians' and nurses' particular focus on biomedical causal connections that largely excluded psychological and social factors (ibd.: 107), it also illustrates that professionals' make use of and defend their characteristic autonomy when confronted with formal regulation. However, even when accounting for this and all other individual and organizational influence factors that may affect whether practitioners' enact regula-

tory guidelines, Garrow and Grusky (2013: 118) can verify their hypothesis that field-level logics have a considerable effect on whether formal rules translate into routine performances. Employing further post hoc analyses, they discover that "only the medical and social movement logics differ significantly in counseling comprehensiveness" (ibd.: 119). The medical logic was associated with the least comprehensive HIV counselling, implying that the performances of practitioners who worked in the respective field diverged greatly from CDC guidelines.

Although this study does not specifically focus on professionals' institutional work on the routine-level, it provides several important insights regarding the nestedness of professionals' institutional agency and the relation of professional logics to formal means of work control. First, this study clearly shows that routine performances are strongly affected by the normative and cognitive frameworks on the field-level, thus illustrating the multi-level embeddedness of routines in social systems that – at first glance – may appear irrelevant to the daily, often improvised, work performances of individuals. The impact of field-level logics on practitioners' likelihood to align their routines with political recommendations is particularly interesting for our understanding of when and why professionals enact or reject rules as carriers of a bureaucratic logic (see Adler & Kwon, 2013: 954). As earlier research has shown, professionals' socialization plays an important role in their everyday work as being a member in a profession and behaving accordingly is a central element of routine participants' identity (Brown & Lewis, 2011; Fagermoen, 1997; Korica & Molloy, 2010; Mitchell et al., 2011). However, as Garrow and Grusky's (2013) findings suggest, professional membership may not be the only and not even the primary antecedent of professionals' agentic behavior in routines. Specifically, whether and how professionals engage in institutional work on the routine-level may not only be affected by their professional logic and 'pressures from below' such as performance feedback and idiosyncratic tasks (see e.g. Bruns, 2009) but also by their embeddedness in larger institutional systems. While Garrow and Grusky (2013: 125) concede that their findings may be biased due to a possible self-selection of practitioners into organizations that best reflected their personal "world views", their study still provides compelling evidence to further nurture the idea that professionals are far from being a homogenous group whose behavior is exclusively guided by its professional logic (see also Goodrick & Reay, 2011; Waring & Currie, 2009: 773). Second, while professionals as specific group of actors may be guided by other logics, this study also illustrates how strongly professional logics can shape routine participants' behavior, even if these actors do not formally belong to the respective profession. The finding that practitioners – regardless of their professional orientation – covered less topics in their HIV counseling when they worked in organizations that embodied the medical logic implies that the medical professional logic may unfold its effects on the routine-level not only through

medical professionals (i.e. physicians) as routine participants. Specifically, medical professionalism 'infected' non-professionals when it was the dominant logic within an organization, causing non-professionals like social workers to detach their work from regulatory guidelines even if their own professional logic would suggest otherwise. In a way, these non-professionals became agents for the medical profession by maintaining the dominance of the medical logic in HIV counseling routines even though they had not been socialized as medical professionals.[41]

Overall, Garrow and Grusky's (2013) central findings can be conceptualized as being similar to those of Bruns (2009): Professionals may exert institutional agency within their routines when their dominant logic collides with the prescriptions of formal rules. Yet, Garrow and Grusky (2013) provide a new perspective on where professionals' dominant logic may originate, suggesting that professionals' agency within routines may be the outcome of incompatibilities between formal rules and the dominant logics of their organizations while tensions between formal rules and routine participants' specific professional logic may be secondary.

The relevance of professionals' multi-level embeddedness for institutional work within their routines is further elaborated by Adler and Kwon (2013), who additionally take into account the complex interrelations between professionals' individual preferences, their embeddedness in organizations and fields, and the characteristics of their respective profession. Drawing on the example of clinical guidelines in medicine, the authors develop a model that specifically conceptualizes formal rules as "carriers of institutional change" (ibd.: 930), with changes in a profession being the result of a "contested diffusion process" around these artifacts (ibd.: 930). According to the authors, whether individual professionals will allow a new logic into their routines by enacting formal rules depends on individual preferences and experiences as well as characteristics of their organization and is moderated by the degree of professionalism within their organization and their occupation. The extent to which professionalism moderates the relation between organizational and occupational variables is, in turn, moderated by field-level variables, specifically the characteristics of professional associations, demands for accountability, and competitive pressures (ibd.: 951-953). By developing this complex model on innovation diffusion in professional settings, Adler and Kwon (2013) raise several interesting points that earlier studies have failed to address when examining professionals' institutional work on the routine-level. A central point of their model is certainly that a general (in)compatibility between professional logics and the formal prescriptions encoded in e.g. clinical guidelines is not a sufficient explanation as to why professionals enact or reject these rules and the logics they convey. Adler and

[41] Unfortunately, the authors do not report interaction effects between professional orientation and field-level logics on comprehensiveness of HIV counseling, thus leaving open whether professionals in settings in which their logic dominates are more or less likely to align their performances with CDC guidelines.

Kwon's (2013) model on guideline diffusion as contested and complex process (ibd.: 954) suggests that professionals' institutional agency on the routine-level may be induced by a situated fit of their (socially conditioned) preferences with the rule or lack thereof, respectively. Whether such a situated fit comes into existence, is, in turn, dependent upon social and structural boundary conditions to be found in their organization and the wider institutional environment.

While, unlike routine researchers (e.g. Howard-Grenville, 2005; Parmigiani & Howard-Grenville, 2011), Adler and Kwon (2013) do not specifically elaborate on practical, task-related boundary conditions, they acknowledge that professionals' reaction towards guidelines is not only dependent upon institutional and social factors but is, for example, also driven by the strategies, structures, and systems their organization provides (ibd.: 943-946). A particularly noteworthy feature of their model is the emphasis on *interrelated* dynamics as antecedents to professionals' agency. Specifically, they theorize the extent of professionalism to moderate the relationship between organizational and individual variables and professionals' likelihood to engage in what Adler and Kwon (2013: 930) call the "mutation of professionalism". The implications to be drawn from their model for the study of professionals' institutional agency on the routine-level are as follows: Professionals' institutional work within their routines may be induced by the introduction of artifacts like guidelines. Yet, the direction of their agentive behavior – this may be the adoption or rejection of these rules as prescriptions for their performances – is informed by a complex interplay of multi-level variables, implying that professionals' institutional work on the routine-level should never be studied as isolated process. Routines are not only nested in institutional and organizational structures but there may also be complex interrelations between these different levels that eventually play out as agentic behavior within the routine. Additionally, Adler and Kwon (2013) explicitly elaborate on different extents of professionalism within occupations, again underlining that professionals' institutional agency is not only depending upon the context in which their routines take place but also upon the kind of profession to which they belong as 'appropriate professional conduct' may differ significantly between different professions.

All of the studies discussed above have conceptualized the introduction of formal rules as an important antecedent of professionals' institutional work on the routine-level. This is the case because formal rules, by providing specific prescriptions on how to perform routines, do not only fulfill a coordinative function but – as Adler and Kwon (2013: 954) note – also embody specific logics. Generally, the introduction of formal guidelines challenges the typically non-formalized, autonomous way of organizing work which is a central element of professionalism (Armstrong, 2002; Rappolt, 1997). This, however, should not imply that the introduction of rules in professionals' routines necessarily leads to institutional maintenance work in the

sense of non-enactment. As the preceding reviews should have illustrated, professionals may enact rules when these prove to be a useful tool to achieve goals that are considered desirable from a professional perspective (see Bruns, 2009) or when professionals' contextual embeddedness attenuates the 'offensiveness' of formal routine prescriptions to their professional identity (see Garrow & Grusky, 2013). In sum, rules may disrupt professionals' taken-for-granted ways of working by prescribing on how actors should guide their attention and how they should go about their work. Yet, whether the introduction of external routine prescriptions may result in change or maintenance of the routine depends on the social and practical context conditions in which a routine is situated (see Adler and Kwon, 2013).

The introduction of formal rules provides a classic example of an external intervention on the routine-level that may induce institutional agency as rules specifically comprise a prescription of appropriate conduct that may explicitly collide with professionals' concepts of how to execute their work. Yet, institutional work on the routine-level may also be induced by structural or technological changes in the wider context of routines which destabilize the routines without imposing specific alternative templates (Rerup & Feldman, 2011). Examples are provided by Fältholm and Jansson (2008) and Barley (1986), whose study on the implementation of CT scanners in radiology departments has already been discussed earlier under the aspect of professional role change (see section 5.2).

Fältholm and Jansson (2008) examine the restructuration of a Swedish hospital in a qualitative interview study. Their research question on why the implementation of process orientation fails, leads them to focus on health care professionals' routines as source of structural stability. Fältholm and Jansson's (2008) study comprises a typical case of restructuration that could have taken place in many Western health care systems. During the merger of two hospitals, hospital management sought to change the structural design of these hospitals to reflect a strong process orientation as it is usually found in successful industrial corporations. In an attempt to enable the re-structuration of the new hospital according to patient or diagnostic groups and to foster inter-professional collaboration, the formerly 50 clinics were clustered into eight departments (ibd.: 222). However, despite of this structural change, the distinction of former medical specialties re-emerged as health care professionals maintained their institutionalized routines that were organized around functional areas rather than diagnoses or patient groups. While the authors explain this primarily with "integrating secondary routines" (ibd.: 230) that comprised deeply institutionalized ideas on how hospitals should be structured, I would like to add that these second-order routines are most likely the result of physicians' normative ideas on how to structure medical work. Specifically, as the newly implemented structures transcended the boundaries between medical specialties to foster the development of new, process-oriented routines they failed to provide physicians with an

opportunity to enact their professional identity. This is because medical professionals obtain their identity mainly from their specialization, thus striving to design routines to reflect expertise as a dimension along which work should be structured. As Fältholm and Jansson note (2008: 230), the initial re-clustering of clinics into departments "rendered members of the medical profession 'homeless' and eventually led to the introduction of sections". These sections were small-scale replications of the former clinic structure that emerged from professionals' maintenance work on the routine-level. In effect, these new structures seemed to even "further reinforce traditional and deeply integrated organizational routines within the hospital and therefore hamper the development toward a process orientated organization" (ibd.: 230). While Fältholm and Jansson (2008) do not elaborate much on physicians' specific strategies to maintain their routines, their study illuminates that external interventions may induce institutional work among professionals when they challenge identity-relevant aspects of routines such as the criteria along which routines are developed (in this case, the functional orientation of medical specialization).

In opposite to Fältholm and Jansson (2008), Barley's (1986) case study describes a situation in which external interventions did not provide any normative ideas on how professionals' routines should be designed. As already briefly touched upon in the comprehensive discussion of his study on section 5.2, professionals' institutional work on the routine-level may be induced by an interaction between shocks in the context of the routine and learning from routine performances. Due to the implementation of the new CT scanners in radiology, both radiologists' and radiology technologists' ostensive aspects of the diagnostic routine were rendered useless. While "radiologists' dominance was routinely enacted" (Barley, 1986: 87) before the arrival of CT scanners, the unfamiliar technology disrupted routine participants' ostensive aspects (see also: Edmondson et al., 2001), including the taken-for-granted hierarchy between radiologists' and radiology technologists' professional logics. Thus, in both of the examined departments, radiologists and technologists had to re-establish a routine around the new technological artifact by improvising and adapting their performances. Through learning processes they found new, practicable ways of interaction and eventually established new diagnostic routines that ultimately lead to a reversal of professional roles (see section 5.2). In contrast to the introduction of formal rules, CT scanners as such did not prescribe any new behavioral repertoire and thus did not induce institutional work as a strategy to defend professional logics. Much rather, these artifacts led to insecurity about appropriate courses of action which resulted in the (somewhat reluctant) enactment of new logic constellations in the routine. Accordingly, Barley's (1986) study illustrates well how institutional work on the routine-level does not only occur as a (more or less purposeful) attempt to defend routines as arenas of identity enactment but as a mere improvisation against the background of new technologies.

Overall, the review of extant research suggests that there are three major antecedents to professionals' institutional work on the routine-level all of which induce agency as they disrupt or at least destabilize professionals' taken for-granted concepts on how to go about their work (i.e. the ostensive aspects of their routines). First, feedback from the inherently improvised routine performances may urge professionals to reconsider their ideas of appropriate conduct and may promote the enactment of new logic constellations. Especially in the typically multi-professional routines of modern organizational life, negative performative feedback like insufficient routine outcomes may uncover differences in the guiding logics of routine participants that need to be resolved through institutional work to secure the functioning and effectiveness of routines (see Smets and Jarzabkowski, 2013). Second, external interventions like the introduction of formal rules may prescribe specific courses of action that carry in them new logics which professionals may either enact to foster bottom-up change in their profession or reject to maintain their extant professional identity (see Adler and Kwon, 2013). Third, changes in the structural or technological context of routines may eliminate the possibility to continue enacting institutionalized ways of work organization and hence necessitate new forms of coordination that may bring about new constellations of logics to guide professionals' daily work (see Barley, 1986). As noted in the introductory paragraphs of this section, routines are both mechanisms of work coordination and arenas of identity enactment. Antecedents of institutional agency on this level of professionals' work thus either directly challenge the social orders that are demonstrated in routine performances or urge actors to reflect upon the efficiency of given routines. As I will further elaborate in the following paragraphs, this simultaneity of the social and the pragmatic in routines and their immediate relation to the accomplishment of work (much more immediate than in the negotiation of roles on the organizational level) leads to processes of institutional agency that are subtle, unspectacular, and sometimes hardly noticeable but nevertheless important in stabilizing or disrupting institutional arrangements.

Processes: How Professionals engage in Routine-Level Change

Despite institutionalists' rising attention to the micro-processes of institutional dynamics (Johnson, Smith, & Codling, 2000; Powell & Colyvas, 2008; Reay et al., 2006), research that specifically focuses on how professionals exert institutional work on the routine-level remains scarce. Professionals – as "inhabitants" of institutions (Delbridge & Edwards, 2013; Hallett & Ventresca, 2006) – make their profession 'come to life' by developing and reproducing their professional logic in their daily social interactions (Everitt, 2013). Yet, as routines primarily focus on the accomplishment of specific tasks such as treating patients, institutional work on the routine-level often remains subtle, not articulated in explicit negotiations about appropriate structures and practices, but actualized in the way professionals enact their

routines (Rerup & Feldman, 2011: 578-579). Thus, on the routine-level, professionals integrate, reject, combine, and mutate logics against the background of having to complete the task at hand in an effective and efficient manner. Put more simply: They exert institutional work along the way of doing their job. Albeit some institutional work scholars argue that the mere reproduction and (non-)enactment of logics in routines is not an instance of institutional work as it lacks the intention to disrupt, create, or maintain institutions (Lawrence et al., 2013; Lawrence & Suddaby, 2006; Lawrence et al., 2009a), recent research has emphasized that implicit, non-projective agency that takes place on the routine-level is an important part of institutional change and stability (Jarzabkowski et al., 2009; Smets & Jarzabkowski, 2013). For example, Kroezen et al. (2014) show that the professionalization of low-status professionals is not only dependent on whether regulatory changes grant them expanded authorities but also whether these are enacted on the ground. Specifically, they find that Dutch nurses failed to translate new professional jurisdiction on the prescription of medication by nurses into actual status gains within their workplace as they reproduced the logic of medical dominance within their routines, e.g. by consulting "with their medical specialist before or after prescribing a medicine" (ibd.: 113). On the other side, demonstrating professional knowledge and conduct in everyday-work is a precondition for achieving and defending the regulatory boundaries of professions on the field-level (Abbott, 1988; Deverell, 2000; Fournier, 2000; Martin et al., 2009). Accordingly, while institutional agency within routines may often appear unspectacular and is often overseen as routines are primarily established to accomplish work and secure the functioning of the organization (Becker, 2004; Greenhalgh, 2008), it adds to the disruption, change, and maintenance of professions and the institutions that surround them (see also section 3.4.2).

Two studies that illustrate particularly well how professionals work towards the maintenance or change of specific logics constellations along with and against the contingencies of their daily work are those of McPherson and Sauder (2013) and McCann et al. (2013), both of which I will discuss more deeply in the following paragraphs.

McPherson and Sauder (2013) provide an illustrative case study on how professionals smooth the way for institutional dynamics on the routine-level by selectively enacting logics other than their own professional logic within their daily work. In their ethnographic study on the micro-level interactions that take place in the daily routines of a drug court, they find that – in contrast to the predictions of classic neo-institutional theory – professionals may strategically deviate from their own professional logic to influence court decisions in a way that reflects their preferred outcomes. Specifically, the authors focus on how different professionals employed different sets of logics when negotiating cases that evoked uncertainty and disa-

greement about appropriate courses of action. Drug courts, as an alternative branch of the jurisdictional system that is supposed to deal "with legal offenses related to drug use" (ibd.: 169), are described as an organizational field in which four distinct logics prevail. According to McPherson and Sauder (2013: 172), these are the logic of criminal punishment, the logic of rehabilitation, the logic of community accountability, and the logic of efficiency. Each of these logics represents a specific field-level manifestation of larger societal logics (i.e. the logic of the state, the profession, the community, and the corporation; see also section 3.3.1) and while all of the four logics were equally salient in the everyday interactions at the drug court, actors were more closely associated with one or another logic. Probation officers and sheriffs were most-embedded in the logic of criminal punishment that emphasized the importance of obedience to authority and the benefit of formal sanctions and control. While drug courts are explicitly designed to provide alternative approaches to sanction and prevent drug-related crimes, they need to maintain their "associations with traditional court practices in order to be taken seriously as part of the correctional system" (ibd.: 172). Accordingly, the logic of punishment remained an important part of the drug courts' working processes. The logic of rehabilitation which focused on the "whole person", (ibd.: 174), encouraged rehabilitation and change instead of punishment, and was mostly linked to counselors and clinicians, whereas the logic of community accountability focused on the interest of the general public rather than on the participant as an individual and was primarily associated with the public defenders. Lastly, the logic of efficiency was the primary logic of state's attorneys and directed "attention toward maximizing utility and following a rational business model" (ibd.: 175) since the drug court was supposed to provide quicker and more cost-effective processes than regular courts.

In their ethnographic study of the drug court's internal team meetings that took place before the official court proceedings to negotiate sanctions and discuss each case from different positions, McPherson and Sauder (2013: 178) observe that the above-mentioned actors regularly drew on logics other than their "home-logic" to frame participants' motives and behaviors in a way that would direct the court's eventual decision towards their preferred outcome. More specifically, team members invoked different logics when the specific situation at hand would generate unanticipated levels of uncertainty that forbid the application of default procedures and when disagreement among the involved professionals ensued. This was the case for 25 percent of all cases negotiated during McPherson and Sauder's (2013) period of observation and usually occurred when team members were unable to reach quick consensus because they lacked experience with a specific participant's situation, because of unclear evidence, or because of an open contradiction between participant's behavior and the logic that was hithertho employed to assess his case (ibd.: 176). The latter illustrates particularly well how professionals had to adapt

their use of logics to performative feedback from their routine: In one specific case, the defendant openly admitted to using the drug court program as “ticket out of jail” (ibd: 176), a behavior and motive that was apparently incommensurable with a rehabilitation logic that assumed the participant’s true desire to change and to seek recovery. Thus, this case severely constrained the repeated usage of the rehabilitation logic to frame the participant’s actions. Eventually, a probation officer was able to portray the participant as having a “prison mentality” (ibd.: 176) which resulted in his exclusion from the drug court program.

As McPherson and Sauder (2013: 180) point out, actors – while naturally favoring their home logic when framing a case – used logics in a surprisingly flexible manner, not only deviating from their home logic but also employing the same logic to argue for different interpretations of the case and to suggest different courses of action such as more or less severe sanctions. Accordingly, the authors conclude that actors reflectively drew on logics in an purposive attempt to “push the court’s decisions in desired directions” (ibd.: 177). Substantiating their claim that logics were, in fact, used as tools to influence court decisions and not as post-hoc rationalization accounts, the authors point out that actors utilized logics to give sense to the discussed cases *prior* to any actual court decision (ibd.: 177). An additional quantitative evaluation of the case data further proves that the use of logics did not only generally affect the court’s final decisions (in 87 of 107 cases, the court’s decision deviated from an estimated default decision) but that there was also a striking correlation between the course of action that had been suggested by the respective professional and the severity of the final verdict with 85 percent of the recommendations being translated into a court decision. Interestingly, what the authors denote as “hijacking” of institutional logics (ibd.: 180), that is, the use of logics with which the respective professionals were not primarily associated, proved to be more effective in influencing court decisions. In 87 percent of the cases in which team members invoked the primary logics of other professional groups, their recommendations were reflected by the court’s verdict whereas only 73 percent of “home logic” use translated into the desired outcomes (ibd.: 180). The authors explain this finding with the signaling effect of logic use: Drawing on non-home logics signals that team members ‘step out of their box’ and thus helps to facilitate negotiations as it enables consensus-building among actors with different cognitive and normative orientations (ibd.: 180-181).

Further elaborating on why professionals tended to relatively freely draw on the different logics available in the drug court, McPherson and Sauder (2013: 182-183) suggest that “hijacking” logics was not only a strategic measure to promote actors’ individual interest. They attribute the use of logics in team meetings to both its pragmatic and social function. First, besides the obvious value of logics as strategic tool to influence court decisions, the authors suggest that drawing on non-home

logics also "publicly endorses the legitimacy of competing frameworks in a way that might be beneficial in future discussions and negotiations" (ibd.: 183), thus endowing the respective professionals with goodwill from other team members. Second, as McPherson and Sauder (2013: 183) discovered that professionals did not exclusively employ other logics to argue for sanctions that would be in line with their home-logic (e.g. probation officers arguing for more severe sanctions, or clinicians demanding less severe sanction), they suggest that hijacking logics also has the social function of creating "cohesion among group members" (ibd.: 183). This is because the selective utilization of different logics within the team meetings would also represent a collective legitimization of logic multiplicity that was a precondition for the drug court's overall functioning as an arena of multi-professional collaboration (ibd.: 183).

Despite the authors' observation that professionals in the drug court maintained logic complexity by being "surprisingly fluid in their use of available logics to solve the practical problems of the court" (ibd.: 179), they also find that team members faced restrictions in their application of logics, thus illuminating how professionals' institutional work on the routine-level is constrained by their embeddedness in social and practical boundary conditions. They distinguish three types of constraints that limited professionals' access to logics as tools to actively frame court cases in a specific way, specifically, procedural, definitional, and positional constraints. Procedural constraints applied when formal rules and norms (such as procedural guidelines of national associations) pre-determined the course of action. This constraint accounted for the 75 percent of court cases in which internal team negotiations merely consisted of agreeing that the case should be handled according to the default logic (ibd.: 175). If professionals had employed logics in these 'standard cases', they would probably have jeopardized their personal legitimacy as any additional discussion about such cases would have been considered "unnecessary and even inappropriate" (ibd.: 183-184). Definitional constraints relate to the suitability of a specific logic in creating arguments for more or less severe sanctions. The logic of criminal punishment was particularly effective for demanding more severe sanctions whereas the opposite was true for the rehabilitation logic. Both the logics of community accountability and efficiency were largely neutral with respect to their usability as tool to argue for more or less punitive actions. Finally, positional constraints restricted professionals' in their use of logics because of their relative position within the network of actors in the drug court. As McPherson and Sauder (2013: 185) point out, probation officers served as central hubs within the drug courts, thus being more adept in using different logics while counselors were rather peripheral actors, not well-embedded in the network of drug court actors, and accordingly invoked non-home logics significantly less frequently.

McPherson and Sauder's (2013) study provides several interesting insights on how professionals exert institutional work within and through the accomplishment of their daily routines while specifically accounting for the institutional, social and practical boundary conditions that may enable and constrain agency on this level of professionals' work. First, and in stark contrast to early neo-institutional accounts that emphasize professionals' inability to distance themselves from their own logic (DiMaggio & Powell, 1983; van Mannen & Barley, 1984), they show that the selective and purposeful use of different logics may become a regular part of professionals' working routines. At the same time, the authors acknowledge that not all professionals could freely use any logic for any purpose, contributing to the idea that research on professionals' institutional work needs to account for professionals' contextual embeddedness. While McPherson and Sauder (2013: 185) attribute interprofessional differences in the frequency of 'hijacking logics' to professionals' relative position in the drug court's network, this finding would also resonate well with recent research that points towards the degree of professionalization as an antecedent to professionals' openness to include new logics into their work (Adler & Kwon, 2013). Second, McPherson and Sauder (2013) provide a more nuanced understanding on professionals' institutional work on the routine-level as both a byproduct of pragmatic and strategic task accomplishment and as purposeful endeavor to stabilize the multiprofessional collaboration that is necessary to secure the functioning of the routine and, eventually, the organization. Given that professionals' work increasingly takes place in complex environments in which several logics simultaneously prevail (see section 3.3.1), McPherson and Sauder (2013) add an interesting insight to the study of how professionals exert institutional agency within their routines: While professionals are more prone to drawing on their own logic when giving sense to their tasks (in this case, the assessment of drug court participants), they do not slavishly stick to their cognitive and normative frames. Much rather, they exploit others' logics strategically to promote their desired outcomes, but they also acknowledge others' logics to stabilize routines even if it means that their logic will never fully govern the routines in which they participate. Thus, this study illustrates that professionals may not only exert institutional maintenance work in their routines to protect their work from being infiltrated by other logics but that they may actually loosen the boundaries between their and other logics to enable routine stability in a multiprofessional working context. The authors summarize this aspect of their study by concluding that "the need to meet the pressing demands of the local organization (e.g., the drug court) overrides more remote professional and institutional differences" (ibd.: 186), thus making professionals' institutional work a means to secure the functioning of the routine rather than the attempt to generally resolve institutional complexity (see also Barley, 1986; Smets & Jarzabkowski, 2013).

Third, while emphasizing the pragmatic and local nature of professionals' institutional work, McPherson and Sauders (2013: 182-183) also point to the political dimension of professionals' flexible use of different logics in their routines which blurs the boundaries between their own and other professional logics. They imply that this constant switch in perspectives illustrates how professional jurisdictions are negotiated on the ground as the selective employment of non-home logics represents the (temporary) appropriation of authority over what I have already discussed above as "spaces of reason" (Schildt et al., 2011), that is, specific areas of expertise. Overall, this study provides a balanced view on professionals as pragmatic enactors of institutional logics who – despite their professional embeddedness – may become agents of routine stability who accept and even promote logic complexity to secure the efficient functioning of multiprofessional working routines.

McCann et al. (2013) elaborate more explicitly on how professionals' institutional work within their daily routines may relate to their professional project on the field-level, or, in the specific case they study, fails to do so. The authors employ an ethnographic research approach that is complemented with semi-structured interviews to examine how paramedics in an UK ambulance trust subtly engage in institutional work along their daily routines. In the UK, paramedics have only recently been treading the path of professionalization, developing from a former blue-collar occupation to a full profession, or – as the authors suggest – a "para-profession" (ibd.: 753). On the field-level, paramedicine exhibits typical features of a profession such as being organized in a professional association, requiring formal certification and training, and offering courses in tertiary education (ibd.: 756-757). These features are, however, relatively new to paramedicine and have evolved in response to regulatory pressures from the NHS which integrated subordinate health care professions such as paramedics into "Allied Health Professions (AHPs)" that were controlled and regulated by the "Health Professions Council (HPC)" (ibd.: 755). In effect, paramedicine did not take the conventional route to professionalization but experienced "professionalization from above" (ibd.: 756). This kind of externally structured professional project emerged from a paradox governmental intervention which promoted the professionalization of health care occupations while restricting the self-governance of these emerging professions through a tight system of formal performance measures, thus discouraging the development of normative codes of conduct within the profession and replacing peer-control with managerial control (ibd.: 756). Accordingly, practitioners were not fully socialized into the new model of paramedic professionalism, maintaining what McCann et al. (2013: 765) describe as "blue-collar professionalism" within the context of their daily routines. The authors find two major themes that characterize the routine-level work of paramedics. The first is the organizational control of their work (ibd.: 760). While emergency ambulance work is commonly associated with rather high levels of dis-

cretion due to its ‘on the road’ nature that prevents direct managerial control, the authors find that the paramedics in their study were, in fact, tightly controlled by management. Due to managers’ physical absence from paramedics working space, they coordinated and constrained paramedics’ routines through “remote control” which included extensive “radio communications and electronic position monitoring of vehicles” (ibd.: 760). Yet, when paramedics arrived at the accident and emergency departments (A&E), managers also exerted direct control, even “shooing people off” (ibd.: 761) in an attempt to hit quantitative performance targets despite resource restrictions. Measures of remote control were, for example, strict standards regarding the allocation of meal time slots. Also, paramedics were regularly demanded to justify their actions over radio, making them very cautious about deviations from protocols such as being off the road for too long as this would have caused suspicion and further managerial investigation (ibd.: 761-762). These organizational boundary conditions led to a strong internalization of ‘command-and-control’ as guiding principles of paramedics’ work who engaged in “self-limiting their discretionary actions, except when clearly forced to do so by emergency situations” (ibd.: 762). Yet, even in emergency situations, paramedics were uncomfortable with breaking protocol and remained as close as possible to the rules while preparing explanations for any deviation (ibd.: 763). This strong enactment of the managerial logic was, however, not owed to the belief that managerial forms of coordination led to superior outcomes but rather a pragmatic adaptation to the contextual conditions in which paramedics’ routines were situated. Obviously, this kind of acquiescence to the practical constraints of their work was not conducive to paramedics’ professional project on the field-level as frontline staff failed to demonstrate professional autonomy within their daily routines.

The second central theme that emerged from McCann et al.’s (2013) ethnographic study – “the reproduction of blue-collar professionalism” (ibd.: 765) – provides more insights on how the professional identity of frontline paramedics led to institutional maintenance work which hampered the full professionalization of paramedicine. While paramedics in emergency ambulance work mostly followed “rules to the letter“(ibd.: 763), they created what could be called ‘pockets of autonomy’ along their routine performances. These provided them with a sense of value against managerial oppression and the demanding, often ‘dirty’ work they had to endure on a daily basis. At the same time, however, this enactment of a blue-collar professional identity undermined the field-level professional project: This is because paramedics’ blue-collar professionalism was more about cutting corners, being “streetwise”, and taking pride in handling the risky and unpleasant parts of emergency health care rather than claiming autonomy over an abstract field of expert knowledge (ibd.: 766-767). McCann et al. (2013) provide several examples of how paramedics maintained their idea of professionalism during their daily work. A

particularly interesting observation was the very considerate handling of patients that demonstrates the “implicit moral position” (ibd.: 767) of ambulance crews. Specifically, paramedics ostensibly tried to shield sick patients from the sight of a deceased patient in the crowded area of an A&E department; thus, showing empathy and a moral obligation appeared central to their professional identity. While a sense of moral superiority is clearly associated with classic professionalism (Durkheim, 2013; Postema, 1983), paramedics enacted a specific kind of morality that separated them from other health care workers: Even against the background of immediate time and performance pressures, paramedics behaved thoughtfully and focused on the patients’ dignity when other professionals (e.g. nurses) failed to do so, thereby showing their characteristic “deep sensitivity born of street experience” (ibd.: 767). Yet, the authors also report some questionable practices that were enacted as part of blue-collar professionalism. These were obviously aimed at protecting a sense of discretion against the background of hard working conditions, managerial oppression, and contemptuousness. For example, ambulance teams intentionally slowed down the process of patient transportation when carrying non-emergency patients to cope with the constant time pressures they normally faced. Further, purloining material such as sheets and pillows was considered normal and even the researchers were encouraged to engage in this informal kind of resistance that had become a regular part of paramedics’ daily work (ibd.: 768-769). Both of these practices appeared to have become an integral part of paramedics’ ostensive aspects, a ‘normal step’ within the respective routines. While neither of them particularly contributed to the goal of providing adequate emergency care to patients, these small acts of deviance helped to maintain paramedics’ professional identity as ‘street-smart’ professionals who operate under strong managerial influence but are not under full managerial control.

In sum, McCann et al.‘s (2013) study shows that professionals exert institutional work along and within their regular routine performances by enacting their specific ideas of appropriate conduct while also dealing with the practical constraints that place routines between ideals and necessities. While the general insight that professionals’ institutional work on the routine-level occurs against the background of practical contingencies is in line with earlier research (e.g. Keshet et al., 2013; Reay et al., 2013; Reay et al., 2006; Smets & Jarzabkowski, 2013; Smets et al., 2012), McCann et al. (2013) also provide some unique insights on how institutional agency is exerted within the context of professionals’ routines.

First, while McCann et al. (2013) examine the special case of an emerging profession, their findings challenge the idea that professionals try to enact field-level concepts of professionalism within their routines. In explicit contrast to early neo-institutionalist notions of professionals as carriers of norms who shape organizational structure by enacting these norms (DiMaggio & Powell, 1983), McCann et

al. (2013) show that intra-organizational boundary conditions do not only restrict the enactment of professional logics within routine performances but may lead to the development of separate concepts of professionalism. In the case of emergency ambulance work, managerial control was internalized to an extent that paramedics constructed paramedic professionalism as a permanent 'workaround' against the realities of 'dirty work under time and performance pressures'. As a consequence, ambulance workers did not display any consequent attempt to exclude managerial logics from their routines. Professional identity was developed and enacted through the appropriation of small 'pockets of autonomy' – as I would call them – which popped up during the daily routines of ambulance work (see also: Kellogg et al., 2006). As a consequence, paramedics' strong embeddedness in a restrictive organizational context did not cause an incomplete enactment of field-level professionalism but fostered the emergence of a separate professional project.

Second, this study underlines the importance of professional identity to explain agency in routines. While other studies have emphasized that pragmatic aspects of work organization that may lead professionals to disregard their professional logic to secure the overall functioning of the routine (e.g. McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013), McCann et al. (2013) focus on how paramedics maintain a sense of professional self by adapting their routines in a way that reflected discretion and dignity. Importantly, paramedics, while discontent with the tight and sometimes inapplicable rule system, did not resort to a defeatist attitude but developed their own interpretation of professionalism in the context of managerial control, taking pride in their 'street wisdom'. Lastly, McCann et al.'s (2013) study also points to the importance of institutional work on the routine-level for professional projects as a whole. As the case of paramedics shows, professionalization simultaneously takes place in the field, in the organization, and in the routine. While establishing regulatory frameworks and professional associations on the field-level are important structural pre-conditions for developing and maintaining a profession, these may become hollow relicts of failed professionalization when frontline-practitioners fail to act accordingly. Even though the case of paramedics is special in many respects, it should be taken as a reminder that the contextual conditions in which professionals have to exert their routines may not only detach them from the professional project on the field-level and hamper the enactment of their professional logic. As McCann et al. (2013) show, the internalization of practical constraints may induce the fragmentation of a profession into 'political professionals' and 'frontline professionals' who – while formally embedded in the same profession – pursue different normative concepts of professionalism.

As the preceding literature review has shown, professionals' institutional work on the routine-level reflects both their interest in enacting a specific professional identity and their awareness of practical necessities that constrain the utilization of rou-

tines as a political arena. Accordingly, any instance of professionals' institutional work on the routine-level must take into account that routines are a level of professionals' work on which social expectations and pragmatic aspects of work coordination matter equally. However, especially research on when and why professionals are willing to enact artifacts that carry specific normative implications seems to disregard that professionals' routines are located in a complex *interplay* between social and practical boundary conditions. In particular, the integration of formal rules into professionals' routines has been studied under the more or less implicit assumption that the degree of compatibility between the behavioral prescriptions of formal rules and professionals' general ideas of appropriate conduct are the main explanatory variable for professionals' (non-)adherence to rules (Bruns, 2009; Garrow & Grusky, 2013). Given that autonomy over one's routine performances constitutes a core feature of professionalism, scholars have even proposed that rules – as a typical bureaucratic mechanism of coordination – are generally incommensurable with professional practice (Marcus, 1985; Ritzer & Walczak, 1988; Scott, 1982; Sorensen & Sorensen, 1974).

However, as the increasing embeddedness of professionals in large organizations has fostered the proliferation of bureaucratic means of coordination in professionals' work (see section 3.2.2), professionals can regularly be witnessed to enact formal rules within their routine performances (Currie & Harvey, 2000; Knai et al., 2014). Against the predictions of classical neo-institutional theory, this is a puzzling phenomenon as one would expect professionals to consistently resist the enactment of rules because of their strong professional norms and their socialization as autonomous actors whose identity is contingent upon the discretionary application of their expert knowledge (Armstrong, 2002; Marcus, 1985). Recent micro-institutional studies have found that professionals may selectively distance themselves from their professional logic to enable coordination within their routines (McPherson & Sauder, 2013). Still, the insight that professionals may temporally deviate from the norms of their profession against the practical contingencies of their work does not explain when and why professionals prefer the coordination of their work via rules as opposed to the coordinative mechanisms prescribed by their profession, that is peer-control and professional norms.

As elaborated on in the discussion of Adler and Kwon's (2013) conceptual paper on medical guidelines as carriers of institutional change, explanations of when and why professionals exert institutional work within their routines by enacting (or rejecting) rules and the logics they convey must take into account the multiple levels in which professionals' work is embedded. Despite Adler and Kwon's (2013) theoretical contribution, extant research still lacks empirical studies that (i) acknowledge the simultaneous embeddedness of professionals' routines in organizational, task, *and* institutional contexts and that (ii) systematically uncover config-

urations of interdependent boundary conditions to explain when and why professionals are willing to integrate rules into their routines when these obviously conflict with core ideals of their profession. Accordingly, the following study will examine when and why professionals pave the way for institutional change in their profession by accepting rules into their daily routines while specifically accounting for the social and practical pressures that characterize professionals' work.

6.3 Empirical Study 3: When Do Rules Persist in Routines? A Fuzzy-set Analysis of Care Pathway Enactment in Clinical Treatment Routines

The following study, while employing routine-theoretical-perspective, seeks to add to both routine-research and research on professionals' institutional work on the micro-level[42]. Examining when and why medical professionals enact care pathways in their treatment routines, it sheds light on the antecedents of micro-level institutional work that may add to institutional change in the profession at large. As Adler and Kwon (2013: 954) point out, care pathways embody the "logic of efficiency and accountability", thus ruling out the explanation that medical professionals enact care pathways because they generally fit with their professional logic (cf. Garrow and Grusky, 2013). Much rather, and as elaborated above (see section 6.1), medical professionalism and the application of formal process rules are commonly regarded as incommensurable. This is because the adherence to rules necessarily reduces physicians' potential to demonstrate the autonomous application of expert knowledge as a core principle of their professional logic (Pearson, Goulart-Fisher, & Lee, 1995). Further, this very autonomy that physicians are granted in their treatment routines impedes managerial control, thus making the adoption or rejection of care pathways dependent on whether contextual conditions lead physicians to perceive "guideline adoption as consistent with their professional autonomy" (Adler and Kwon, 2013: 936). Additionally, current research emphasizes that professionals' decisions on which logics to enact or reject in their routines may emerge "from practical-evaluative improvisations" (Smets and Jarzabkowski, 2013: 1284). Thus, any explanation that focuses solely on the institutional aspects of professionals' agency in routines necessarily draws an incomplete picture of the realities in which institutional work occurs. At the same time, and as elaborated above, professionals remain social actors, willing to conform to their professional norms within their daily work as 'what they do' is central to the development and the maintenance of their professional identity (see section 3.2.3).

[42] This study was jointly conducted with Hendrik Wilhelm. Earlier versions have been presented at the EGOS Colloquium 2012 in Helsinki, Finland and the Annual Meeting of the Academy of Management 2013 in Orlando, FL.

Consequently, to examine when and why physicians enact care pathways, this study relies on a routine-theoretical perspective to conceptually distinguish abstract ideas on appropriate conduct (stored in the ostensive aspect of a routine) from the practical aspects of task accomplishment (the performative aspect) that interact to induce change or stability in professionals' routines. This study proposes that the enactment of care pathways depends on configurations of four boundary conditions that together reflect the social pressures and practical necessities that characterize professionals' daily work. Specifically, this study suggests that institutional pressure from the field-level, extent of professional expertise, task frequency, and task complexity interact to foster rule enactment in professionals' routines. Drawing on a fuzzy-set qualitative comparative analysis (fsQCA) of 19 medical-treatment routines performed in ten internal-medicine departments of university hospitals in Germany, this study uncovers three configurations of the aforementioned boundary conditions, each of which offers a distinct explanation as to why physicians prefer to align their work with care pathways despite the central importance of autonomy for medical professionals. These configurations can be distinguished according to how physicians utilize rules in these situations, generating the solutions 'reducing risk,' 'securing status,' and 'surviving stress'. Building on these findings, this study proposes a configurational model of rule enactment by professionals participating in organizational routines, thus contributing to the question of when and why written organizational rules are enacted by autonomous professionals.

The following study expands extant research on professionals' institutional work in three ways. First, it illuminates the interdependent nature of practical and social boundary conditions of professionals' work, explaining the enactment of rules as the outcome of its social appropriateness, coordinative efficiency, or both against the specific work situations in which professionals operate. Second, this study explicitly accounts for the multi-level-embeddedness of professionals' routines which are not only affected by their immediate organizational and task-contexts but also reflect professionals' awareness of social expectations in the field. Accordingly, this study adds to our understanding of institutional agency on the routine-level as a response to pressures that emerge from other levels, thus cautioning scholars to study institutional work not only against the background of its immediate contexts (see also Garrow & Grusky, 2013). Lastly, like the study presented in section 5.3 of this thesis, the following study offers a methodological contribution to extant research by using a comparative approach to the question of when and why professionals engage in institutional agency that might change their profession. Specifically, the use of fsQCA allows accounting for the idiosyncrasies of each case while providing systematic insights on the boundary conditions that foster professionals to voluntarily restrict their characteristic autonomy within their daily work.

6.3.1 Introduction

When and why do professionals participating in organizational routines enact written rules? Organizational routines are usually defined as repetitive and recognizable interdependent activities involving multiple actors that represent the primary means through which organizations perform and prevail (Cyert & March, 1963; Feldman & Pentland, 2003; Nelson & Winter, 1982). Organizational routines in professional organizations, such as medical treatment routines in hospitals, are characterized by the autonomy of the professionals participating in the organizational routine (Bohmer, 2009; Edmondson et al., 2001; Klein, Ziegert, Knight, & Xiao, 2006). A written rule is enacted in an organizational routine when a knowledgeable observer is unable to detect a frequent and substantial *violation* of a written organizational rule across routine performances (cf. Desai, 2010; Taylor, 1993; Tyler & Blader, 2005). The enactment of written organizational rules, defined as codified ideal-type representations of an organizational routine (March, Schulz, & Zhou, 2000; Pentland & Feldman, 2005; Schulz, 2008), directly conflicts with the professional's autonomy to perform a routine without interference.

Theories on written rules suggest that the enactment of written rules by professionals participating in organizational routines is uncommon. Prior explanations emphasize that routine participants enact written rules because managers monitor and incentivize employees to do so (Kohn, 1999; O'Reilly, 1989; Ouchi & Maguire, 1975), or because enacting written rules is embedded in routine participants' identity (Ouchi, 1979; Tyler & Blader, 2005; Weber, 1922). While these explanations apply to business organizations whose employees act with limited autonomy, they do not explain when and why *professionals* participating in organizational routines enact written rules. First, managers and supervisors usually lack actual control over the daily work of professionals, such as physicians working in a hospital (e.g., Raelin, 1986). Second, professionals are granted considerable degrees of freedom and the core principle of professional identity – the full autonomy over one's own work – is incompatible with enacting written rules (Allen, 2010; Berg, 1997; Scott, 1982). Researchers studying written rules have for the most part failed to theoretically explain when and why professionals participating in organizational routines enact written rules, despite substantial empirical evidence documenting that professionals do enact written rules (e.g., Faraj & Xiao, 2006; Gustafsson et al., 2011; Vanhaecht et al., 2006).

This study addresses this gap between established theory and empirical evidence by turning to the characteristics of the organizational routines in which participants enact written rules. It builds on the organizational routines-as-generative-systems perspective (Feldman & Pentland, 2003; Parmigiani & Howard-Grenville, 2011; Pentland & Feldman, 2005) to conceptualize the enactment of written rules within

organizational routines as effortful accomplishments of routine participants (characterized by a specific level of professional expertise) who perform organizational routines to address tasks (characterized by specific levels of task complexity and frequency). This study conceptually expands the organizational routines-as-generative-systems perspective to a multilevel framework that accounts for the institutional context in which a routine is embedded (level of institutional pressure demanding the enactment of a written rule). It does so because professionals are more embedded in their profession as a field-level institution than in the organization (Pratt et al., 2006).

This study empirically explores what configurations of these four explanatory conditions cause professionals participating in an organizational routine to enact written rules by conducting a comparative case analysis of the enactment of care pathways in the treatment routines of university hospitals. This setting is favourable because university hospitals usually have extensive experience in designing and implementing written rules (Vanhaecht et al., 2006). Focusing on university hospitals therefore allows ruling out explanations of rule enactment that draw on rule design and capability of rule implementation. The empirical analysis relies on qualitative and quantitative data from 19 treatment routines and care pathways in ten internal-medicine departments of university hospitals in Germany. It employs fuzzy-set Qualitative Comparative Analysis (fsQCA) to explore which configurations of institutional, organizational, and task conditions are necessary and/or sufficient for professionals to enact care pathways as part of a hospital department's treatment routines. Furthermore, eight additional interviews with physicians working in internal-medicine departments have been conducted to discuss possible explanations for the findings and to collect additional illustrative evidence.

This study provides two key contributions. First, it identifies three multilevel configurations where professionals enact written rules in an empirical setting characterized by high levels of improvisation and little managerial oversight: when institutional pressure is high, written rules will become enacted in routines addressing tasks of high complexity ("reducing risk"). In this situation, routine participants face strong social norms to conform to specific written organizational rules while also being at particular risk of social and legal repercussions when deviating from established rules, especially those for complex tasks that are more likely to generate unfavorable outcomes. Written rules will further become enacted in routines when institutional pressure is high and routine participants with high expertise execute tasks at high frequency ("securing status"). In this situation, because high task frequency reveals systematic deviations from gold standards, routine participants who do not enact rules are at a particularly high risk of losing status. Finally, when institutional pressure is low, participants will enact written rules when they have low levels of expertise and face high task volumes of low complexity ("surviving

stress”). In this situation, the enactment of written rules effectively supports these actors in guiding and reflecting upon their routine performances, helping them to avoid excessive stress in the early stages of their professional career. As a second contribution, the multilevel framework presented here, highlights that rule enactment depends on conditions of the organizational routine and the external and internal organizational context. While routine participants’ rationale for enacting rules differs in each of the three solutions found in this study, it can be concluded that written rules become enacted when they function as a resource to routine participants and provide routine participants with confirming experience when enacting the written rule. Therefore, theories of organizational routines need to be broadened to include the interplay of multilevel dynamics to explain when and why professionals participating in organizational routines enact written rules.

6.3.2 Theoretical Background

Written Rules and Professional Autonomy

Written rules are commonplace in professional organizations. The diffusion can mainly be attributed to the pressures professional organizations face. These organizations are increasingly expected to provide services efficiently and to be accountable for those services (Leicht & Fennell, 1997; Leicht & Lyman, 2006). The enactment of written rules in organizational routines is critical for professional organizations to function, as failure to do so may lead to economic inefficiency and organizational de-legitimization (Bohmer, 2009; Courpasson, 2000; Powell, Brock, & Hinings, 1999). On an organizational level, written rules contribute to a more efficient service provision, as they may alleviate role ambiguity within the complex environment of professional work (Organ & Greene, 1981: 249) and professionals have been found to employ written rules as instruments to reinforce professional socialization within organizations (Abernethy & Stoelwinder, 1990). As an instrument for external legitimization, enacting written rules effectively conveys the impression that service provision is consistently based on well-proven and objective standards that promote the safety of such things as medical services (Rozich et al., 2004; Timmermans & Almeling, 2009; Timmermans & Berg, 1997, 2003). Hence, it is important to understand when and why professionals participating in organizational routines enact written rules, because the enactment of written rules is crucial for professional organizations to persist and prevail.

While written rules have spread in professional organizations, researchers have not been able to effectively explain when and why professionals enact written rules in the core organizational routines of professional organizations. Research on organizational rules provides two dominant explanations on when and why rules become enacted (Tyler & Blader, 2005). The command-and-control perspective proposes

that rule enactment is a function of external rule enforcement through hierarchical control (e.g., Ouchi, 1979, 1980; Weber, 1922). Organizations engage in formal monitoring activities and incentivize actors to ensure that routine participants adhere to written rules (Adler & Borys, 1996; Kohn, 1999; O'Reilly, 1989). Research from this theoretical perspective focuses on managers' motives to employ rules (e.g., Canales, 2014) and suggests that the enactment of rules depends on their enforceability by external authorities (Eisenhardt, 1985; Lehman & Ramanujam, 2009). While prominent in the economic literature, managerial monitoring and incentivizing have been found to have limited effect in organizations (Gouldner, 1954; Streatfield, 2001). For example, Tyler and Blader (2005), using two empirical studies on employee rule adherence in various types of organizations, show that the influence of incentive- and monitoring-based, command-and-control approaches rarely achieve sustainable rule enactment. Guo and Yuan (2012) provide additional evidence for the limited effect of external control and sanctioning on the enactment of rules. In their study on the violation of written information-security rules, they find that organizational sanctions have no significant direct effect on rule violations, while personal self-sanctions and workgroup sanctions both significantly foster the enactment of rules. The authors attribute this result to the proven short-term effect of punishment and potential resentments towards organizational sanctioning, while self- and workgroup-sanctions appeal to personal accountability and social status within a relevant peer group. This limited effect of external control for the enactment of organizational rules is particularly relevant in the context of professional work. Professional autonomy results in an asymmetry of power between professionals participating in a routine and supervisors, an asymmetry that allows professionals to play a dominant role in enacting or neglecting written organizational rules (Ferlie et al., 2005). Physicians, for example, "[…] traditionally enjoy[s] a collective autonomy over the content and conditions of medical practice" (Doolin, 2002: 373).

In contrast to the command-and-control perspective, the self-regulatory perspective suggests that rule enactment may become part of an actor's identity. From this perspective, routine participants enact written rules because it is the "individual's intrinsic desire to follow organizational rules" (Tyler & Blader, 2005:1144). Son (2011), in his study on the enactment of information-security policies, finds that these rules are more likely to be enacted when they are perceived as legitimate and are congruent with employees' moral values (intrinsic motivation) than when they are enforced through deterrents like impending termination of work contracts (extrinsic motivation). In sum, research from this perspective suggests that rule enactment can be achieved by the socialization of routine participants into organizational culture until individual and organizational goals converge (Hu, Dinev, Hart, & Cooke, 2012).

However, professionals are unlikely to exhibit intrinsic desires to enact written organizational rules, as their work is inherently defined by high levels of individual autonomy that forbids the slavish enactment of organizational rules (Freidson, 2001). Autonomy is the defining characteristic of professional work, shaping both the everyday performances of professionals and their professional identities (Doolin, 2002; Marcus, 1985), because autonomy allows professionals to skilfully apply complex, often tacit, knowledge to solve their clients' specific problems in the best way possible (Greenwood, 1957). In line with these arguments, empirical research has shown that professional socialization inoculating professionals with the norm of autonomy often dominates organizational regulation (e.g., Ferlie et al., 2005; Kellogg, 2009). Accordingly, established theoretical perspectives on rule enactment fail to explain when and why professionals enact written organizational rules because both established rationales (command-and-control and self-regulatory) fail to consider autonomy as the key characteristic of professional work. Professionals' autonomy in routine performances, however, might cause divergence between a prescriptive written rule and the actual routine performance (e.g., Bruns, 2009; Ciborra, 2000; Suchman, 1983).

The following section draws on the organizational-routines literature to identify four multi-level conditions that provide a starting point for explaining when and why professionals participating in organizational routines enact written rules. Against this backdrop, it is argued that the enactment of written rules by professionals in organizational routines depends on a complex interplay between countervailing forces.

Organizational Routines as Generative Systems

Research on organizational routines has recently begun to conceptualize organizational routines as generative systems. Organizational routines function as generative systems because routine participants exert agency (Parmigiani & Howard-Grenville, 2011). To understand how and why routine participants exert agency, research has focused on the interplay of the performative and the ostensive aspect of organizational routines (Feldman & Pentland, 2003; Pentland & Feldman, 2005). The performative aspect captures the "real actions, by real people, in specific times and places" (Feldman & Pentland, 2008: 302), whereas the ostensive aspect captures the "abstract, generalized idea of the routine" (Feldman & Pentland, 2003:101). Contrasting ostensive and performative routine aspects allows routine participants to scrutinize whether and why intended routine outcomes are achieved (e.g., whether and why an established medication provides the appropriate treatment), and whether and why unintended and undesirable outcomes are produced (e.g., patients treated with this medication exhibit an excessive duration of stay). The performative and ostensive aspects of routines have a reciprocal relationship:

the performative aspect creates, maintains, and modifies the ostensive aspect, while the ostensive aspect is employed to guide, account for, and refer to the performative aspect. Routine participants demonstrate their agency when consciously introducing variation in the performative routine aspect (e.g., by treating a patient using a new medication). Routine participants will draw on their ostensive aspects to guide this performative variation, to derive accounts for why the variation was introduced, and to refer to this varied organizational routine. In turn, such performative variation may modify the ostensive aspects of routine participants and thereby influence future performative aspects of the organizational routine (e.g., future treatments of similar patients may eschew the old medication in favor of the new medication).

This mutually constitutive relationship between performative and ostensive aspects provides the foundation for routine participants to exert agency, thereby making organizational routines generative systems capable of drifting away from a once-implemented written rule (Feldman & Pentland, 2003, 2008; Pentland et al., 2012). The exertion of agency with regard to rule-enactment is even more likely in professional routines, as most routine participants are autonomous professionals obliged to follow professional norms rather than formal organizational controls (Freidson, 2001).

Written Rules as Enacted Artefacts in Organizational Routines

While written rules may keep individuals' activities and organizational routines "on track" (Schulz, 2008: 228; see also: Avadikyan et al., 2001), the enactment of written rules is not a deterministic process (Reynaud, 2005; Suchman, 1983; Taylor, 1993). Written rules relate to the ostensive and performative aspect; however, they represent a distinct entity (Pentland & Feldman, 2005): on the one hand, rules articulate how patterns of interaction should form in principle; thus, they shape the routine participant's abstract notion (i.e., the ostensive aspect) of an organizational routine (D'Adderio, 2008). On the other hand, an observer may notice a resemblance between a specific routine performance (i.e., the performative aspect) and a specific rule when routine participants enact that rule. For example, physicians participating in a treatment routine for renal transplant evaluations may have a binder with a printed-out care pathway on renal transplant evaluation on them. While the renal transplant care pathway documents an ideal-type representation of the renal transplant evaluation routine, it is neither identical with the ostensive representations of this treatment routine maintained by individual routine participants, nor is it identical with specific performances of this treatment routine.

Enacting written rules is an effortful accomplishment. Enacting a written rule within a specific routine performance requires routine participants to apply the abstract norms and categories depicted in the written rules to a specific situation (Blau, 1955; Taylor, 1993; Wittgenstein, 1958). Surmounting this gap between the ab-

stract written rule and the specific situation requires routine participants' effort, incorporating the routine participants' ostensive representations of the routine as well as the performative aspects of the task at hand (Anand, Gray, & Siemsen, 2012; Feldman, 2004; Orlikowski, 2000).

In professional organizations, routine participants' ostensive aspect is primarily shaped by their professional expertise. As actors gain professional expertise, their ostensive aspect will develop a fuller repertoire of routine iterations, incorporating also a broader basis to evaluate and rationalize the appropriateness of routine performances (cf. Miller, Pentland, & Choi, 2012; Pentland et al., 2012; Turner & Fern, 2012). For example, senior physicians internalize substantial professional expertise on all relevant treatment routines in their specialty. Their expertise is usually based on many years of thorough training and strict formal evaluations, contributing to the development of a broad and deep ostensive representation of all treatment routines within their specialty. In contrast, most junior physicians, after just having completed medical school, lack such broad and deep ostensive representation of medical treatment routines. Such representations, as captured by the routine participant's professional expertise, contribute to the routine dynamics fostering or forestalling the enactment of written rules. For example, routine participants lacking professional expertise and thus elaborate ostensive representations of a treatment routine they are about to participate in, may enact the written rule to avoid losing sight of the different elements and associations in a task and their significance within the organizational routine performance (Becker, 2005; Lippman & Rumelt, 1982). Written rules may provide useful templates for guiding, accounting for, and referring to performative aspects when actors cannot draw on their own professional expertise for reliable conceptions of appropriate conduct or if personal guidance by professionals with expertise is unavailable (cf. Hutchins, 1995).

Tasks addressed within the performative aspect of a routine performance are commonly characterized by the frequency of task occurrence and task complexity[43] (cf. Miller, Choi, & Pentland, 2014; Pentland et al., 2011; Zollo & Singh, 2004). Comparatively simple tasks that are frequently executed provide feedback more often and exhibit a structure more suitable for drawing inferences regarding the links between action sequences and the attained outcomes than do highly complex tasks that are seldom executed (Zollo & Winter, 2002). In complex but frequent tasks, routine participants may experience ambiguity by losing sight of the different elements and associations in a task and their significance within the organizational routine performance (Becker, 2005; Lippman & Rumelt, 1982). Depending on the routine participants' ostensive representations of the routine, written organizational

[43] The complexity of a task addressed by an organizational routine shall be defined as the number and sequence of actions employed in accomplishing the task as well as how those sequences vary across time (Pentland, Haerem, & Hillison, 2011).

rules may support routine participants in particular when performative experiences are infrequent and complex. However, given that only a limited number of exceptions can be covered by written rules, written rules may also become cumbersome to enact due to the large number of exceptions inherent to complex tasks (Galbraith, 1973; March & Simon, 1958; Milliken, 1987; Thompson, 1967; van de Ven, Delbecq, & Koenig, 1976). In contrast, when tasks are frequent and of little complexity, even routine participants with little professional expertise may quickly develop ostensive aspects that cover all relevant aspects of the routine.

In sum, the enactment of written rules can be assumed to be contingent on the boundary conditions routine participants experience when performing the routine. In the following section, it will be argued that the institutional context in which routine participants are embedded complements task- and organization-based conditions. This institutional embeddedness of routine participants has largely been ignored by prior research on organizational routines. While the institutional pressure originates at a different ontological level, integrating this perspective complements existing explanations on the routine level and may provide explanations of rule enactment.

Institutional Embeddedness of Routine Participants

Actors participating in a routine may enact written rules because they consider them to be reliable guides of appropriate behavior (March, 1994). What is considered appropriate depends on the social expectations that apply to an actor in a given context. Social expectations matter, as "[…] identities and their contentions come all wrapped in larger structures and processes that predate them" (White, 1992: 6). For example, physicians are expected to provide patients with high-quality medical treatment according to current medical standards. These standards are usually developed in collective efforts incorporating medical practitioners and scientists. Students of medicine learn these standards in their training, while senior practitioners are required by law to attend continuing education where current standards are taught. If practitioners fail to meet these standards, they are subject to legal sanctions (Ulsenheimer, 1996).

The social expectations that apply to an actor are captured by the *institutional pressure* that an institutional field exerts. The institutional pressure provides an indication of what is "desirable, proper, or appropriate" (Suchman, 1995: 574) and describes the social context against which routine participants have to account for their performances. Drawing on a written rule legitimized in the institutional field provides an indication of actors' "conformity to a specific standard or model" (Ruef & Scott, 1998, p. 880), thereby securing routine participants' status as legitimate actors in a field (Thomas, Walker, & Zelditch, 1986). In contrast, deviating from written rules legitimized in the institutional field is likely to attract scrutiny and

contempt by other actors embedded in the same field and put routine participants at risk of social sanctions (cf. Meyer & Rowan, 1977). These sanctions may, for instance, include the withdrawal of certificates by accreditation bodies and professional associations or the loss of public endorsement (Deeds, Mang, & Frandsen, 2004:12). Further, routine participants who fail to comply with institutionalized expectations may face social disapproval in their work environment such as "snide comments" and isolation by peers (Kellogg, 2009: 679). To dispel any doubts regarding the appropriateness of their conduct, routine participants are likely to employ a legitimized written organizational rule for a particular routine when accounting for, seeking guidance for, or referring to specific routine performances.

These preceding arguments suggest four explanatory conditions (routine participants' professional expertise, task complexity, task frequency, and institutional pressure) that help explain when professionals participating in a routine will enact written rules in routine performances. However, each explanatory condition influences and is influenced by the other explanatory conditions, so that they eventually coalesce over time into holistic configurations, which in turn influence the enactment of written rules in organizational routines. To identify configurations of the aforementioned conditions that foster the enactment of written organizational rules by professionals in organizational routines, an exploratory comparative case study was conducted. To analyze the data, fsQCA was applied as a method that enables the identification of equifinal and multilevel explanations. In the following section, the empirical setting in which the case studies have been conducted will be introduced.

6.3.3 Sample and Method

Research Approach

Building on the above theory, an investigation was designed to understand when and why professionals participating in organizational routines enact written rules. This study focuses on care pathways as an example of written organizational rules. In hospitals, care pathways are one of the most-common written organizational rules prescribing treatment routines (Timmermans & Almeling, 2009). Care pathways typically define "[…] a number of steps to be taken when specified conditions are met: how general practitioners should proceed when they suspect a new case of diabetes […]," for example (Timmermans & Berg, 2003: 25). Care pathways are designed to provide medical professionals with current and evidence-based medical knowledge that align specific treatment routine with medical standards (Bohmer, 2009). The enactment of care pathways in clinical settings is promoted by international associations such as the *European Pathway Association* and examples on the design, implementation, and effects of care pathways are regularly published in

medical journals such as the *International Journal of Care Coordination.* While medical standards are promoted and evaluated across organizations – on the level of the professional field – the specific care pathways used in hospitals represent local translations and therefore represent organizational rules (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998) that “connect the world of practice with the world of knowledge” (Zander, 2002:107).

The design and application of care pathways are usually subject to extensive scientific scrutiny. Care pathways are based on medical standards and are therefore backed up by clinical evidence based on randomized-control trials demonstrating their medical appropriateness to treat a specified illness (see Rotter et al., 2010; Vanhaecht et al., 2011). Care pathways provide an appropriate baseline for treating the disease they are designed for. Information on specific care pathways is readily available to clinicians, since it is published in numerous medical journals and advanced by institutions such as *The Cochrane Collaboration*. Despite being promoted by the medical profession as a way to ensure consistent application of current medical knowledge in treatment routines, the enactment of care pathways collides with the principle of medical autonomy. For example, Rappolt (1997: 978) points out that care pathways “[…] have a paradoxical relation to professional autonomy, since despite being the quintessence of medical knowledge at the collective level, they diminish the technical autonomy of the individual practitioner.” Accordingly, while care pathways are an accepted means for treatment standardization in the medical community, enacting care pathways is an effortful accomplishment for physicians, as it implies subduing their autonomy. Therefore, the enactment of care pathways within treatment routines can be assumed to be a theoretically adequate and practically relevant research context within which to examine the enactment of written organizational rules by professionals.

Given the lack of an encompassing theoretical framework explaining the enactment of organizational rules, as well as this study’s research interest exploring configurations of conditions that contribute to this phenomenon, a case-based method was used (Morgan & Smircich, 1980). Within a pilot study, 14 chief physicians from a broad spectrum of disciplines working in university and non-university hospitals were interviewed to discuss changes in treatment routines that they supervised after regulatory changes in Germany. These interviews demonstrated a great diversity of terms and associations linked to “care pathways” and their enactment in treatment routines, a situation requiring a more reflective mode of data collection than would have been possible using a large-scale survey. Cases were selected on the basis of a theoretical sampling procedure (Eisenhardt, 1989). To generate insights on how institutional, organizational, and task conditions affect the enactment of organizational rules, hospitals were required to operate under similar economic conditions and regulatory regimes but differed considerably with regard to the explanatory

conditions. University hospitals, as maximum providers of medical care, appeared particularly suited to provide cases relevant to this study's research interest. While university hospitals face competitive pressures similar to those of non-university hospitals, they also represent a clearly defined population that is subject to identical economic challenges and regulatory regimes (Reinhold, Thierfelder, Müller-Riemenschneider, & Willich, 2009). Because of their extensive experience with medical research studies, university hospitals are accustomed to designing, implementing, and updating appropriate care pathways (cf. Vanhaecht et al., 2006; Vanhaecht et al., 2010). Hence, the organizations that constitute the sample of this study are well versed in crafting workable care pathways. Differences across cases in the enactment of written rules are therefore likely due to the boundary conditions professionals face when enacting written rules. By focusing on the university hospitals' internal-medicine departments, which offer a broad but comparable spectrum of treatment routines, variations in the institutional, organizational, and task conditions are likely to account for the enactment of care pathways.

Sample and Data Collection

This research was conducted as part of a larger qualitative study of work organization in hospitals. The nursing directors of all 32 German university hospitals were approached to gain access to their internal-medicine departments. Following this initial approach, 16 hospitals agreed to provide access. The data collection draws on archival data provided by hospitals' mandatory quality reporting, the medical database MedLine (2012), and interview data from the respective departments.[44]

To avoid common-method bias (Podsakoff & Organ, 1986), the interviews were only used to inquire which care pathways implemented in the respective departments had become enacted and which had not. The explanatory conditions were operationalized and measured on the basis of publicly available data on the hospital departments. Most of this data was found in the quality reports issued by the hospitals (G-BA, 2012b). Because these reports belong to the official reporting data de-

[44] While there are potential drawbacks to collecting data via interviews, data collection via participant observation or archival data was not feasible in this study setting. In order to detect the enactment of a care pathway across all explanatory conditions, a large number of observed treatment routine iterations across time would have been required. In order to detect differences between specific treatment actions and written care pathways, these observations would have to be conducted by knowledgeable medical personal. This mode of data collection would have been extremely resource consuming, given the number of actions and cycle times of a single treatment routine execution (Pentland & Feldman, 2008). Furthermore, given the complexity of such an observation, errors or incomplete documentation would have been likely. While relying on archival data would have bypassed many of the problems linked to observations (Pentland et al., 2011), matching the medical documentation of individual patients with written care pathways was not legally feasible due to strict data-protection standards. Against this backdrop, and considering that this inquiry does not intend to study or compare individual treatment routine performances and how these eventually deviate from care pathways, the data collection via interview was judged to be appropriate.

manded by German hospital law (§ 137 Abs. 3 Satz 1 Nr. 4 SGB V), this data can be expected to be valid.

Interviews were arranged with physicians, nurses, and case managers to learn about the enactment of care pathways in their departments. To reduce the possible biases that may have influenced the respondents' assessments, a number of precautions were taken: First, to reduce cognitive biases and errors resulting from faulty memory, the questions focused on past facts and behavior, not their beliefs and intentions (Golden, 1992). Second, to avoid social-desirability response bias, all interviewees were assured of their complete anonymity and communicated that all identifying information was to be removed upon transcription of the interviews. Participation in our interviews was voluntary. Third, wherever possible, at least two people were interviewed – including at least one of each healthcare profession – per department (e.g., nephrology) to ensure reliable statements. In a few cases, the authors were also granted access to the case managers of the respective departments for validation purposes. Interviewees from the same department showed a very high agreement rate. Given that the interviews documented instances in which care pathways had not become enacted, despite university hospitals being experienced designers and users of care pathways, the data-collection method can be assumed to be valid.

In total 48 semi-structured interviews in were conducted, including 22 background interviews with nursing directors and hospital quality-of-care managers, as well as 26 semi-structured interviews with healthcare professionals from internal-medicine departments. Approximately half of these university hospitals' internal-medicine departments either had not attempted to introduce care pathways or employed simpler standard operating procedures and were therefore excluded from further analysis. In one case, an interview partner was able to provide information on two departments, as she had been a member of two medical teams. The interviews were conducted in German – the native language of the interviewers and all interviewees. Because of the work-intensive environment, interview duration ranged between 20 and 104 minutes, with an average of fifty minutes. In nine cases, interviews had to be interrupted because patients required the interviewee's attention. Given that the data collection was part of a larger research project, the interviews focused on care pathways as one of several facets of work organization in hospitals. Following the analysis of the data, eight additional interviews were conducted with junior and senior physicians working in the internal-medicine departments of two university hospitals. These interviewees did not participate in the primary data collection. These additional interviews were used to critically discuss possible explanations for the findings. These additional data not only support the interpretations and conclusions drawn, but also provide additional illustrative evidence that will be presented in the discussion section below.

Measures

Outcome: Enactment of care pathways was measured using interview data. All interviewees were specifically asked which diagnoses/procedures in their department are practiced on the basis of care pathways, as well as from which care pathways practitioners regularly and substantially deviate. They were also asked which diagnoses/procedures are associated with care pathways that have been fully implemented in the past yet are no longer enacted. The interviews sought to identify which care pathways had become an element of daily practice beyond the initial implementation period. With the exception of brief conversations, which were documented with written notes, all interviews were recorded digitally and transcribed for further analysis (Bryman, 2008). Based on the interview data, a list of treatment routines was derived, including which care pathways had been implemented and noting whether or not physicians enacted the care pathway in the respective treatment routines. An example for the enactment of care pathways is provided by Case 1 in the dataset. Here, patients who were about to receive a renal transplant were usually treated according to a written care pathway that was implemented about nine years ago. While the interviewee admitted that exceptional cases required physicians to deviate from the pathway to allow for flexible routine performances to ensure patient safety, he pointed out that the pathway for the evaluation of renal transplant patients was enacted in everyday practice *because "especially in the case of transplantation, it is reasonable to reflect upon the preparation procedures. Also, because [the pathway] coordinates interaction."* Accordingly, in Case 1, care pathways were coded as being enacted. Non-enactment of a care pathway, on the other hand, can be observed in Case 14, where a care pathway for the treatment of arterial hypertension had been implemented but failed to become enacted. As the interviewee put it: *"Hypertension is being [treated] according to the maxim: 'Well, I am pretty familiar with that, I am just going to do that [my way].'"* Case 14 was coded as non-enactment of care pathways.

Institutional pressure. Institutional pressure on the field-level was measured by the number of citations of the most-frequently-cited scientific article on care pathways applicable to the respective treatment routine. While research lacks a commonly accepted measure for institutional pressure (cf. Greenwood, Oliver, Suddaby, & Sahlin-Andersson, 2008; Honig & Karlsson, 2004; Oliver, 1997), the number of citations can be considered a valid proxy, since practitioners draw on this research to inform their practice and are held accountable to this current state of knowledge (Timmermans & Berg, 2003). The more widely disseminated an article that describes and tests a specific care pathway in the professional and scientific community constituting the institutional field, the harder it is for practitioners to justify a treatment that is not aligned with that medical standard (Bohmer, 2009). Furthermore, if the most-cited article on a care pathway for the respective treatment routine

is very frequently referenced in subsequent articles, the prevailing opinion on the use of care pathways can be assumed to be rather homogenous. Random samples of the cited articles were inspected to ensure that findings were largely in favor of the respective care pathway. The more homogenous a field's expectations are, the stronger the pressure towards conformity becomes - in this case the enactment of care pathways (Oliver, 1991). The search for scientific publications was conducted via MedLine (2012) using an array of search terms.[45]

Professional expertise. The level of expertise within the department executing the respective treatment routine was calculated using the ratio of specialist doctors ("Fachärzte") to all other clinicians within the department in question.[46] Specialists have mastered the highest level of medical training available, having undergone five to seven additional years of practical training, and are therefore highly experienced in performing medical-treatment routines (Egan & Jaye, 2009; Maclachlan, 1997). Thus, the ratio of specialists to all other clinicians within a department can be assumed to validly capture the average level of professional expertise present in a department.

Task complexity. Task complexity was calculated using the average complexity of the medical cases treated using the corresponding treatment routine. This information was collected from the so-called G-DRG (German Diagnosis Related Groups) weights that are typically assigned to each treatment routine. These cost weights indicate the relative complexity of a certain diagnosis-related group and are updated annually to provide the basis for health-insurance providers' reimbursement rates for clinical treatments (Pierdzioch, 2008). The weights are determined by InEK, a public organization set up by the German government (Schreyögg et al., 2006: 272). As a first step, the medical procedures constituting the respective routine were matched with the related G-DRG codes. These matches were then validated using expert ratings provided by the head of the accounting department of one of the largest German hospitals. In a second step, the respective G-DRG weights were weighted according to their relative occurrence in the German hospital field to account for the patient composition receiving the respective treatment. The average weight of the respective G-DRG codes per treatment routine was then

[45] As search terms, all synonyms for care pathways described by the European Pathway Organization (2012) were used: "clinical pathway*", "clinical care pathway*", "care pathway*", "critical pathway*", "care path*", "integrated care pathway*", "case management plan*", "care map". Furthermore, the search was restricted to articles published in English or German.

[46] While care pathways usually prescribe all relevant treatment steps for a specific disease and these steps also may include nursing work, the present study focuses on medical doctors as routine participants. This decision naturally excludes nurses and other service personnel from our analysis. However, given that this study intends to explain the enactment of rules in a context where application of rules is not mandated by working contracts—and medical doctors in Germany represent the only participants of a treatment routine who exert legally sanctioned discretion regarding the treatment of patients—excluding nurses and other service personnel from the analysis seems warranted.

calculated. These values constitute the data on task complexity and can be assumed to be a valid measure because G-DRGs are by law designed to capture treatment complexity (KHEntG § 9 Abs. 1).

Task frequency. The frequency of a task was measured by the number of treatments performed by the hospital department within the year 2012.

Table 6.1 depicts the raw data collected for each treatment routine.

Table 6.1: Cases and Raw Data

Case ID	University Hospital	Internal Medicine Department	Treatment Routine
1	I	Nephrology	Renal Transplant Evaluation
2			Renal Dialysis
3		Cardiology	Cardioversion
4	II	Nephrology	Renal Transplant Evaluation
5			Renal Puncture
6			Shunt
7		Cardiology	Angiography
8	III	Oncology	Plasmacytoma
9	IV	Cardiology	Angina Pectoris
10	V	Nephrology	Arterial Hypertension
11			Renal Biopsy
12			Renal Insufficiency
13	VI	Oncology	Bone Marrow Transplantation
14		Nephrology	Arterial Hypertension
15			Renal Biopsy
16	VII	Gastroenterology	Peritoneal Puncture
17			Pleural Punctuation
18			Trans-Arterial Chemo Embolization
19			Mini-Laparoscopy

Table 6.1: Cases and Raw Data (continued)

Case ID	Institutional Pressure	Professional Expertise	Task Complexity	Task Frequency	Care Pathway
1	13	1.25	2.27	10	Enacted
2	11	1.25	1.35	8900	Enacted
3	0	1.21	0.49	164	Enacted
4	13	0.50	2.27	16	Enacted
5	0	0.50	0.91	1	Non-Enacted
6	0	0.50	0.95	85	Enacted
7	1	0.50	0.92	6307	Enacted
8	0	0.63	1.09	228	Non-Enacted
9	76	1.01	0.55	623	Enacted
10	2	0.56	0.53	83	Enacted
11	1	0.56	0.91	218	Enacted
12	11	0.56	1.35	242	Enacted
13	7	1.25	15.70	216	Enacted
14	2	0.86	0.53	56	Non-Enacted
15	1	0.86	0.91	155	Enacted
16	0	0.64	0.76	610	Enacted
17	0	0.64	0.67	101	Enacted
18	11	0.64	1.11	81	Enacted
19	6	0.64	1.06	366	Enacted

Data Analysis

Fuzzy-set Qualitative Comparative Analysis was used to explain the enactment of written organizational rules using the four explanatory conditions derived in the theory section. While researchers have recently begun employing fsQCA to test theory (e.g., Bell, Filatotchev, & Aguilera, 2014; Fiss, 2011), the method was originally developed and applied to smaller data sets to elaborate theory (Greckhamer et al., 2013). FsQCA has a number of advantages for the present study. FsQCA treats each case as a complex configuration of causal factors with a specific outcome and analyzes which set of relations is necessary and sufficient for the outcome to occur (Ragin, 1987, 2000). A conception of causation based on necessary and sufficient conditions is particularly suitable to explore how *conjunctions* of mechanisms are connected to an outcome (e.g., institutionalist and routine-based mechanisms interacting in causing enactment of written rules). Furthermore, fsQCA allows equifinal explanations because this method does not assume only one constellation of features among all observed cases that causes the outcome (Fiss, 2011). Emergent processes, such as the processes causing enactment of written rules in organizational routines, are typically equifinal in form (Crutchfield, 2008). The analytical focus of fsQCA meets this study's objective to explore emergent processes that cause enactment of rules in organizational routines. Finally, fsQCA techniques are suitable for analyzing multilevel data structures (Crilly, 2013; Rohlfing, 2011). Given the multiple ontological levels inherent in the conceptualization of the enactment of rules in routines, fsQCA as a multilevel method represents the appropriate method for the present inquiry.

The fsQCA presented here follows standard procedures of preparing and conducting (e.g., Fiss, Cambré, & Marx, 2013; Ragin, 2000). To ensure transparency, the analysis is based on the standard software package fsQCA version 2.5 (Ragin & Davey, 2009), which proceeds stepwise through each analytical moment. These steps encompass the calibration of raw data to fuzzy-set membership values. The following paragraph will thus elaborate on how the outcome as well as the explanatory conditions were calibrated.

Enactment of Care Pathways. The outcome (enactment of care pathway) was calibrated dichotomously. Set-membership values were assigned to outcomes based on a simple logic: the enactment of care pathways following an initial implementation phase must imply a fuzzy-set membership value of *1* because lower values would falsely indicate qualities of non-enactment. Therefore, all treatment routines exhibiting enactment of care pathways were assigned set-membership values of *1*, whereas treatment routines exhibiting non-enactment of care pathway enactment were assigned set-membership values of *0*.

Institutional Pressure. The calibration of *"high institutional pressure"* draws on exogenous threshold values for full membership, full non-membership, and the crossover point. The full-membership threshold and the crossover point were derived by conducting an additional MedLine search on care pathways limited to the respective specialty area (e.g., nephrology). The search results were analyzed for the most-cited article published in the respective subject area. Given the theoretical assumptions on institutional pressure, this number indicates full set membership for a specific department type. In line with this rationale, the threshold for full non-membership in the set was set to *0.5* citations.[47] The crossover point was derived by inspecting the distribution of the MedLine citation records for a value break among the citation clusters (Crilly et al., 2012).

Professional Expertise. The set *"high professional expertise"* was calibrated using the basic population. More specifically, a measure for actors' professional expertise was calculated (specialist/non-specialist) for all internal-medicine departments in the sample (e.g., nephrology) across all university hospitals in Germany. Threshold values for full membership, full non-membership, and the crossover point were derived for each department type by visually inspecting the data for value breaks between clusters (Crilly et al., 2012).

Task Complexity. Calibration of the set *"high task complexity"* was based on the German hospital reimbursement system. This system assigns the DRG value *1* to treatments of average complexity (InEK, 2012). Accordingly, a measured routine complexity of *1* provides a highly appropriate qualitative anchor for the set's crossover point. Lacking theoretical criteria indicating threshold values for full membership and full non-membership, these anchors were derived by inspecting the distribution of the average DRG values reported by all German hospitals for obvious value breaks (Crilly et al., 2012).

Task Frequency. The set *"high task frequency"* was calibrated using basic population information. Again, the official quality reports of all German university hospitals were used. First, data on the number of treatment-routine executions (e.g., renal biopsy) in the respective departments per report year were gathered. To derive threshold values for full membership, full non-membership, and the crossover point, these distributions were inspected for value breaks (Crilly et al., 2012). These breaks supposedly indicate qualitative differences in the levels of treatment frequencies (Crilly et al., 2012).

[47] Setting the threshold to 0 was not possible, as the sample includes cases exhibiting no citations on care pathways. Thresholds cannot be placed on values covered by empirical data (Ragin, 2000).

Table 6.2 provides an overview of the thresholds used for calibrating the raw data. The four explanatory conditions and the outcome of each case were calibrated to fuzzy-set membership values accordingly (see Table 6.3).

Table 6.2: Thresholds of the Explanatory Conditions

Condition		Full Membership	Crossover Point	Full Non-Membership
Institutional Pressure				
	Cardiology	76	15	0.5
	Gastroenterology	27	5.5	0.5
	Nephrology	13	6.5	0.5
	Oncology	26	3.5	0.5
Professional Expertise				
	Cardiology	1.3	0.8	0.37
	Gastroenterology	1.8	1.2	0.71
	Nephrology	1.3	0.95	0.6
	Oncology	1.4	0.9	0.45
Task Complexity		1.8	1	0.7
Task Frequency				
	Angina Pectoris	650	400	216
	Angiography	6935	3780	875
	Arterial Hypertension	143	66	43
	Bone Marrow Transplantation	185	144	50
	Cardioversion	325	132	70
	Mini-Laparoscopy	240	70	20
	Peritoneal Puncture	487	281	83
	Plasmacytoma	178	130	30
	Pleural Punctuation	77	38	22
	Renal Biopsy	195	116	50
	Renal Dialysis	6300	3700	900
	Renal Insufficiency	157	85	18
	Renal Puncture	50	18	5
	Renal Transplant Evaluation	51	32	9
	Shunt	30	16	4
	Trans-Arterial Chemo Embolization	40	19	3

Table 6.3: Fuzzy-set Data Matrix

ID	High Institutional Pressure	High Professional Expertise	High Task Complexity	High Task Frequency	Enactment of Care Pathway
1	0.95	0.93	0.99	0.05	1
2	0.89	0.93	0.79	1.00	1
3	0.04	0.92	0.01	0.62	1
4	0.95	0.02	0.99	0.11	1
5	0.04	0.02	0.29	0.00	0
6	0.04	0.02	0.38	1.00	1
7	0.05	0.11	0.31	0.92	1
8	0.03	0.14	0.58	1.00	0
9	0.95	0.78	0.01	0.94	1
10	0.10	0.03	0.01	0.66	1
11	0.06	0.03	0.29	0.98	1
12	0.89	0.03	0.79	1.00	1
13	0.61	0.89	1.00	0.99	1
14	0.10	0.32	0.01	0.21	0
15	0.06	0.32	0.29	0.81	1
16	0.04	0.03	0.08	0.99	1
17	0.04	0.03	0.04	0.99	1
18	0.68	0.03	0.60	1.00	1
19	0.52	0.03	0.57	0.99	1

Causal analysis in fsQCA builds on the notion of necessary and sufficient conditions. Since procedures uncovering sufficient conditions cannot be relied on to uncover necessary conditions, necessary and sufficient conditions were analyzed separately, beginning with the necessary conditions (Schneider & Wagemann, 2010). Logically, *necessary conditions* are always present if the outcome is present, and there must not be an instance in which the outcome is present and the condition absent (Schneider & Wagemann, 2007). By convention, a consistency value of at least 0.9 is required for indicating necessary conditions (Goertz, 2006). To test for necessary conditions, the "necessary conditions" procedure provided by fsQCA 2.5 was applied. In scrutinizing the results of the analysis, the consistency values of all conditions (as well as their negations) were found to be well below 0.9, suggesting that fuzzy-set membership values of the explanatory conditions across all cases are lower than outcome-membership values (Ragin, 2006). Therefore, none of the conditions was considered necessary for the enactment of care pathways in treatment routines. The analysis was continued by testing for sufficient conditions.

For a *sufficient condition*, the outcome is always present if the condition is present; and there must not be an instance in which the condition is present and the outcome absent (Schneider & Wagemann, 2007). The Quine-McClusky algorithm provided by the fsQCA 2.5 software package was used to uncover sufficient conditions causing rule enactment by professionals, applying a consistency threshold (0.90) that is stricter than the consistency threshold (0.75) suggested by Ragin (2006). In the course of the minimization procedure, the fsQCA 2.5 software allows for three types of solutions. Whereas the parsimonious and intermediate solutions incorporate logical remainders to varying extents, the complex solution incorporates only statements about situations that occur empirically (Ragin, 2000) and therefore represents the most-conservative approach (Vis, 2012). Accordingly, this analysis relies on the complex solution. The findings are presented below.

6.3.4 Findings

Table 6.4 presents the configurations of conditions associated with the enactment of care pathways. The presentation of these results relies on the established notation style suggested by Ragin and Fiss (2008). Black circles indicate the presence of a condition, while crossed circles indicate the absence of a condition. Blank spaces indicate a "don't care" situation in which the condition may be either absent or present.

Table 6.4: Complex Solution of Sufficient Conditions for Outcome[48]

		Solution	
Condition	**1**	**2**	**3**
High Institutional Pressure	●	●	⊗
High Professional Expertise		●	⊗
High Task Complexity	●		⊗
High Task Frequency		●	●
Consistency	.99	.95	.91
Raw Coverage	.35	.17	.40
Unique Coverage	.18	.05	.31
Cases Covered	1, 2, 4, 12, 13, 18, 19	2, 9, 13	6, 7, 10, 11, 15, 16, 17
Overall Solution Consistency		**.94**	
Overall Solution Coverage		**.71**	

The complex solution (Table 6.4) indicates three sufficient equifinal solutions explaining the outcome of care-pathway enactment. Solution 1 states that the presence of high institutional pressure and high task complexity are sufficient for the enactment of care pathways to occur, whereas Solution 2 states that the presence of high institutional pressure in conjunction with both high levels of professional expertise and high task frequency are sufficient for this outcome. Solution 3 states that the absence of high institutional pressure in conjunction with the absence of high levels of professional expertise, the absence of high task complexity, and the presence of high task frequency, are sufficient for care pathways to become enacted. The overall solution consistency (0.94) and individual solution consistency terms (0.99, 0.95 and 0.91) are well above the minimum consistency (0.80) recommended by Ragin (2008). This result indicates that there is an appropriate correspondence between the empirical data and the set-theoretic relationships captured in the solution terms (Fiss et al., 2013). The relevance of the different solution terms is expressed by the coverage scores, which are calculated from the percentage of cases that represent a given solution term within the outcome (Ragin, 2006). As indicated by the solution coverage, all three solutions together account for approximately 71 percent of the fuzzy-set membership values in the outcome. While this result implies that most of the outcome is explained by the solution terms, it also indicates some degree of unexplained idiosyncrasy. As indicated by the unique coverage measures, which are lower than the solution coverage, some cases are explained by all three solution terms. This result indicates that equifinality is present in this phenomenon.

[48] Cases 8, 3, 5, 14 were excluded from the analysis because the truth table rows containing these cases failed to meet the consistency threshold (0.90).

6.3.5 Discussion

This study provides a foundation for understanding when and why professionals participating in organizational routines enact written rules. Previous research on organizational routines has provided evidence that routines and rules frequently drift apart (Anand et al., 2012; Bruns, 2009; Ciborra, 2000). The present analysis uncovered organizational rules that were implemented within the very same hospital department and had become enacted in one instance (Case 15) but not in the other (Case 14). Interestingly, the written rule not enacted in this department was enacted in another hospital department (Case 10). With these patterns in mind, attributing the varying outcomes to differences in designing, implementing, and updating care pathways across departments seems implausible. Instead, the following discussion focuses on the interaction between organizational rules, routines participants, and organizational context.

Exploring Rule Enactment by Professionals in Organizational Routines

The analysis found no necessary condition explaining written rule enactment in routines. Accordingly, enactment of written rules does not depend on a single, key mechanism driving routine participants' behavior (cf. Dionysiou & Tsoukas, 2013; Tsoukas & Chia, 2002). However, the analysis revealed three equifinally sufficient explanations for the occurrence of rule enactment. The following section will demonstrate how and why these configurations of conditions foster rule enactment. To clarify and illustrate the central mechanism of each configuration fostering rule enactment, interview quotations from the expert discussions will be provided.

Situation 1: Reducing Risk

Solution 1 suggests that high institutional pressure and high task complexity cause enactment of care pathways, irrespective of task frequency and professional expertise of routine participants. The expert discussions revealed that in this situation, routine participants may enact organizational rules to reduce sanctioning risks. Care pathways covered by high institutional pressure are organizational rules that are based on widely accepted treatment standards. Failure to enact written rules based on such standards will raise contempt by peers and, given that undesired treatment outcomes may result, legal prosecution. At the same time, Situation 1 encompasses treatment routines that address highly complex tasks. Complex tasks (e.g., bone marrow transplantation) require substantial coordination between routine participants and are frequently considered risky. Treatment routines addressing such tasks usually incorporate a larger number of routine participants performing interdependent routine steps. Without care pathway enactment, *"coordination between the physicians involved would not work at all, because [the different specialists participating in the treatment routine] work completely differently" (Interviewee 1)*. In this situation, routine participants are not only confronted with high institutional pres-

sure to conform to specific written organizational rules but also risk social and legal repercussions when deviating from these rules.

Enacting written rules allows routine participants to both facilitate coordination, thereby reducing the risk of causing objectionable routine performance outcomes, as well as to visibly conform to written rules based on accepted standards. A senior physician provided illustrative evidence for this risk-reducing mechanism: *"Bone marrow transplants are delicate, and you have to be very careful to avoid the patient slipping away – the patient may very easily die" (Interviewee 3).* Against this background, he pointed out that institutional pressure causes *"peer pressure from fellow physicians to perform according to the care pathway; performing according to your private preferences would simply demonstrate professional incapacity"* and added that *"you want to avoid exposing yourself as someone not able to measure up to this high [treatment routine] complexity and not being able to comply with the standard" (Interviewee 3).* Taken together, *"[...] under these conditions, it's just easier and safer for the individual actors to draw on a pathway than to decide on their own" (Interviewee 8).*

In summary, while written rules may represent a comparatively inefficient coordination device for highly complex tasks, prior research has rarely considered the interaction between task characteristics and institutional pressure when explaining why routine participants adhere to specific organizational rules. High institutional pressure creates strong social expectations for actors to account appropriately for their routine performances. In such situations, written rules protect routine participants from accusations of inappropriate conduct when failing at a complex task. Participants who fail to live up to social expectations risk sanctions from institutional stakeholders (e.g., loss of certifications) as well as disapproval by peers. In this configuration, written rules are likely to become enacted across routine iterations, as they support routine participants in reducing their risk of failure in a situation in which failure is likely to be caused by high task complexity and linked to severe social sanctions resulting from high institutional pressures. Written rules reduce routine participants' risk by continuously guiding present routine performances while also providing reliable means of accounting for past routine performances.

Situation 2: Securing Status

Solution 2 suggests that high institutional pressure in conjunction with high levels of routine participants' professional expertise and high task frequency are sufficient for the enactment of care pathways, irrespective of task complexity. The expert discussions revealed that the enactment of written organizational rules in this situation follows from routine participant's impetus to secure their status as knowledgeable and experienced professionals. Highly experienced routine participants frequently

"[…] not only experience this institutional pressure, but also contribute to its development" (Interviewee 3). In this situation, routine participants are confronted with high institutional pressure to conform to specific written organizational rules. More importantly, high task frequency allows experienced peers to uncover systematic deviations from well-established standards. Thus, participants have a strong incentive to enact the rule.

The findings suggest that securing status becomes particularly apparent when executing frequent treatment routines that involve experienced professionals guiding a small number of junior physicians in a department through routine performances. Due to the high institutional pressure associated with the care pathway, senior physicians are held accountable by their peers for guiding junior physicians during routine executions. While infrequent deviations from written rules based on highly institutionalized standards may be accounted for by patient requirements, frequent deviations from written rules based on highly institutionalized standards will raise contempt by fellow senior physicians In the expert discussion, a senior physician provided evidence for this mechanism: *"Consider this example: There are people [junior physicians] that are new to the […] department. Accordingly, they have little knowledge of the current […] literature. Due to this lack of knowledge, I think that they [junior physicians] do not really experience this pressure coming from citations. What really matters here is how the leadership team [senior physicians], like myself, decides on care pathways and standards, demonstrates their application and uses them on their own" (Interviewee 6).* In assuming a guiding role, senior physicians have to ensure that junior physicians are being trained and socialized according to established standards. Junior physicians, because they lack professional expertise, are unable to take into consideration prevailing institutional pressure when performing treatment routines. This mediating function of senior physicians between the field-level and the organizational routine is illustrated by the same experienced physician: *"Well, I am fully aware of this filter function – it is highly relevant. […] Considering the larger context, there certainly is considerable pressure [to enact a highly institutionalized care pathway]. However, this does not really affect the junior physicians directly. It's more like we [senior physicians] mediate this [pressure], and only then will junior physicians experience it as well" (Interviewee 6).*

Taken together, three different levels of explanatory conditions jointly foster the enactment of care pathways: Experienced routine participants are most susceptible to institutional pressures due to their exposed position as role models and task characteristics allow peers to easily identify systematic deviations from a pathway. In this configuration, rules are likely to become enacted across routine iterations, as they support routine participants in securing their professional status in a situation in which their high professional expertise puts them under particular pressure to

continuously respond to the strong social expectations prescribing the enactment of written rules as appropriate behavior, while high task frequency increases the chances that deviant behavior will be detected. Written rules help to secure routine participants' status by providing a means to guide routine performances, thereby visibly complying with the institutional pressures that weigh particularly strong on highly experienced routine participants who are expected to translate established standards for junior professionals. Further, the enactment of written rules secures routine participants' status by supporting them when accounting for their routine performances.

Situation 3: Surviving Stress

Solution 3 suggests that low levels of professional expertise in conjunction with low institutional pressure, low task complexity, and high task frequency are sufficient for the enactment of care pathways. The expert discussions revealed that in these situations, surviving stress is a dominant mechanism driving the enactment of written organizational rules. Departments employing mostly unexperienced routine participants can hardly provide constant close supervision by experienced routine participants. When reflecting on this situation one junior physician stated: *"When I first started working here, someone plunked down a ring binder next to me, telling me to get going. The folder contained all basic care pathways I needed to know when working here; however, it still was a 5 cm folder! […] You had to work that thing through in order to know how to accomplish your first shift on your own" (Interviewee 1).* Another junior physician reiterated: *"[…] such a guideline is the best thing that can happen to you; in particular when you're an inexperienced newbie, you're in constant need of guidance. However, the problem is that you won't receive constant guidance by senior physicians […]" (Interviewee 4*). Despite their lack of expertise, junior physicians are expected to address non-complex but frequent tasks in a professional and efficient manner. As a junior physician from the expert discussions pointed out, inability to address such tasks independently commonly leads to uncomfortable situations – both by demonstrating medical incapacity and by delaying interdependent treatment routines: *"[It's] not necessarily embarrassing, but annoying to yourself if you constantly have to ask someone: 'Listen, I don't know this stuff – can you help me out one more time?'. That becomes really tedious after some time" (Interviewee 4).*

In this situation, routine dynamics are likely to foster rule enactment, as routine participants with limited professional expertise can draw on written rules for guidance and reflection on their experiences. Low levels of professional expertise in a department imply that most routine participants have not yet developed elaborate ostensive aspects to guide their routine performance. A senior physician illustrated: *"As a junior physician, you're extremely happy if you can draw on standard oper-*

ating procedures (e.g., care pathways, the authors) - because then you have something you can stick to. You're not in a situation where you have to decide completely on your own. Instead, you have a standard operating procedure which tells you exactly what to do under which circumstances" (Interviewee 8). The low task complexity in this situation places routine participants under the pressure of completing tasks without seeking constant guidance by senior physicians, as tasks of this kind are easily comprehensible and highly analyzable. While failing at low complexity tasks hardly threatens patient life, lacking thoroughly developed ostensive aspects may cause stress in departments primarily staffed with junior physicians. Without institutionalized standards available on the field-level, such local demands for guidance are addressed by highly idiosyncratic care pathways. Such written organizational rules may represent an adequate substitute for incomplete ostensive aspects and lack of personal guidance by seniors.

In summary, the findings suggest that under conditions of high task frequency, inexperienced actors are more likely to inappropriately execute treatment routines and, as a consequence, must justify their routine performances more often. Having performed a routine in accordance with a locally developed written rule will aid inexperienced routine participants in accounting for the actions taken. The enactment of rules will minimize sanctions for failing at relatively easy tasks, as adhering to written rules implies that routine participants performed a routine not only to the best of their knowledge but also to the best of general knowledge within the department. In this configuration, rules are likely to become enacted across routine iterations, as they support routine participants in surviving stress. The enactment of rules serves as a resource to routine participants that allows them to survive stress, because rules guide inexperienced routine participants with weakly developed ostensive aspects while at the same time supporting inexperienced actors in accounting for their performance whenever undesired outcomes arise in these frequent routine performances.

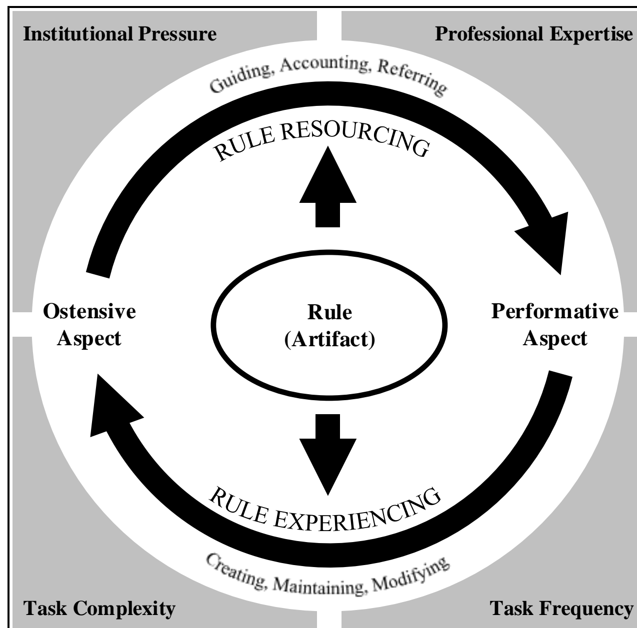
A Configurational Model of Rule Enactment

Across the three sufficient conditions of care-pathway enactment, this study finds that professionals enact written rules when routine participants face conditions where written rules serve as resources. Written rules become resources when they enable routine participants to perform an organizational routine. To perform an organizational routine, participants have to successfully coordinate their individual actions (Dionysiou & Tsoukas, 2013; Jarzabkowski, Lê, & Feldman, 2012). Furthermore, routine performances must be considered legitimate by peers. To achieve both coordination and legitimization, routine participants can draw on written rules. Written rules can serve as guides to coordinate routine performances, as sources to account for routine performances, and as labels when referring to routine perfor-

mances. Written rules therefore may serve as resources for routine participants when engaging in the processes that link the ostensive to the performative aspect of an organizational routine. Conversely, written rules may also serve as resources in linking the performative to the ostensive aspects of organizational routines.

The findings of this study demonstrate that written rules are only invoked when specific situations challenge routine participants in guiding, referring to, and accounting for routine performances, because of increased coordination needs or strict behavioral expectations reflected by the institutional environment. For example, in Solution 3 ("surviving stress") routine participants are likely to quickly integrate the enactment of a written rule into their representation of the routine (i.e., the ostensive aspect), as they frequently execute a routine that addresses a treatment of little complexity. In this situation, the rule will most likely work as an efficient coordination device while also compensating for the routine participant's lack of professional expertise. Given this configuration of conditions, routine participants are likely to experience frequent and positive feedback from enacting a care pathway, a result that contributes to the enactment of the written rule in future performances of the organizational routine. Figure 6.1 depicts a configurational model of rule enactment.

Figure 6.1: Configurational Model of Rule Enactment



This model shows how the interplay between the ostensive and performative aspect of a routine fosters rule enactment. Based on the empirical analysis, this model distinguishes between rule resourcing and rule experiencing as antecedents to rule enactment. Rule resourcing takes place whenever routine participants find themselves in a situation in which they enact a written rule, as it provides a resource in guiding,

accounting for, and referring to routine performances. Depending on the experiences that follow from each routine performance incorporating the written rule, the performative aspect (which includes the enactment of a written rule) creates and maintains an ostensive aspect that includes rule enactment as an important element of routine participants' shared representation of the routine.

Going back to the empirical data, the interview data suggests that in Solutions 1 and 2, routine participants find themselves in a situation in which they face social pressures to conform to what is deemed appropriate conduct in the eyes of field-level stakeholders (e.g., professional associations or federal bodies) as well as peers, while at the same time are confronted with task characteristics that increase the risk associated with failure to do so. In Solution 3, routine participants find themselves under high pressure to perform routines appropriately and efficiently without expertise to guide their performance.

In all three configurations, the way in which routine participants' ostensive aspect guides, accounts for, and refers to their performance needs to satisfy multilevel demands encompassing institutional, organizational, and task conditions to ensure appropriate conduct and efficient coordination. The analysis therefore underscores that the dynamics of organizational routines not only depend on internal organizational contexts (Howard-Grenville, 2005) but also on external institutional contexts. Furthermore, the finding of three equifinal solutions supports the notion established by some researchers that organizational routine dynamics are subject to equifinal processes. Only a few single-case studies have indicated that multiple ontological levels influence routine dynamics (e.g., Howard-Grenville, 2005; Rerup & Feldman, 2011). Equifinality in routine dynamics has been mostly implied by existing research but rarely studied empirically (Pentland, Hærem, & Hillison, 2010: 933).

6.3.6 Limitations and Conclusion

The enactment of written rules by professionals can be explained by their function as a resource linking the ostensive to the performative routine aspect and the experiences derived from the routine performances incorporating the written rule. The present analysis substantiates but also extends the generative-systems perspective on organizational routines. It substantiates the generative-systems perspective in demonstrating that both conditions influencing rule resourcing (related to processes of guiding, accounting for, and referring to performative aspects) as well as conditions influencing rule experience (related to creating, maintaining, and modifying ostensive aspects) interact in fostering the enactment of written rules. The analysis also extends previous research in the generative-systems tradition. It does so by demonstrating that the enactment of written rules is not only subject to specific per-

formances by specific actors in specific situations, but also follows from the interaction of conditions incorporating the institutional, organizational, and task level. This finding should remind researchers theorizing about routines as generative systems to consider the different contexts in which routines are performed. Failure to do so might result in incomplete descriptions and interpretations of phenomena. This study suggests that theories of organizational routines need to be broadened to include multilevel dynamics in order to explain the enactment of written rules in organizational routines in professional organizations. Based on the empirical analysis of rule enactment, this study proposes a configurational model of rule enactment that incorporates external and internal organizational context. Accordingly, it expands the generative-systems perspective on routines by contributing theory and data that explicitly address context as an oftentimes neglected influence (Parmigiani & Howard-Grenville, 2011). In conclusion, this study proposes a "routines-in-situations perspective" to explain routine dynamics and rule enactment.

This study aims to explain an empirical phenomenon – the enactment of written organizational rules by professionals – for which the relevance for organizational survival and performance has been extensively documented by research on professional organizations (cf., Heugens & Lander, 2009). However, we still lack research that examines the enactment of written organizational rules by professionals in organizational routines. While this inquiry addresses this research gap, the sample of this study includes a relatively small number of organizational routines. Although other qualitative studies on organizational routines incorporate a comparable or smaller number of routines (e.g., Feldman, 2000; Howard-Grenville, 2005), any generalizations drawn from the present study should consider this limitation. For example, it cannot be claimed that the sufficient solutions apply to every type of written rule enacted for every routine in every form of organization. Another potential limitation is that all organizational routines in the sample are executed within internal-medicine departments at German university hospitals. However, the calibration procedure included in the fsQCA mitigates this shortcoming, since the set-membership values were not defined according to the sample's means, but rather according to exogenous standards (e.g., population means). This design reduces the necessity of employing a representative sample for generalization (Fiss, 2011). Therefore, this study's findings should also apply to treatment routines in other hospital departments or non-university hospitals.

Since hospitals are an extreme in terms of knowledge-intensive and competitive professional organizations, they offer substantial learning opportunities for comparable professional organizations (cf., Adler, 2003). That said, this study's findings cannot be generalized to organizational routines that are executed within non-professional organizations – settings which provide an interesting area for further research. Furthermore, the present study draws on data aggregated across individual

routine participants. Given that organizational routines are usually performed within a social context constituted by more or less experienced actors, the measure appears appropriate for the present study. Future research could expand on these findings and employ ethnographic methods to study more closely the interaction of multiple actors and their interaction processes causing the enactment of rules in routines. Such research seems particularly promising when considering the impact of prior ethnographic work on hospitals (Kellogg, 2009) and the initial implementation of written rules in routines (Lazaric & Denis, 2005; Reynaud, 2005).

7 Discussion and Conclusion

This dissertation started out with the question on professionals' role in processes of institutional change and stability. If nothing else, the preceding chapters have shown that the different contexts in which professionals operate have to be taken into account to explain, when, why, and how professionals exert institutional work. In the course of this last chapter I will elaborate in more detail on how institutional research could profit from a more contextualized conceptualization of professionals' institutional work that takes into account that the archetypical 'professional' simply does not exist. First, I will discuss how the conceptual idea of professionals as contextually embedded boundary workers is reflected in each of the empirical studies presented above. Further, I will elaborate on how the studies presented above relate to extant research and how they contribute to the study of professionals' role in institutional dynamics. Second, I will discuss the limitations of this thesis before closing with a concise summary of its main findings and implications.

7.1 The Context-Dependency of Professionals' Institutional Work

This dissertation contributes to research on professionals' role in institutional dynamics by suggesting a more nuanced view on professionals as contextually embedded actors who are more heterogeneous than current research suggests (e.g. Suddaby & Viale, 2011).

Recent institutional research has focused its attention on the professional as a special kind of social actor that often critically influences whether and how institutions change (Currie et al., 2012; DiMaggio, 1991; Greenwood et al., 2002; Kitchener & Mertz, 2012; Leicht & Fennell, 2008; Muzio et al., 2013; Scott, 2008b; Suddaby & Viale, 2011). Yet, reflecting the heritage of trait-based approaches to the professions (Carr-Saunders & Wilson, 1964; Etzioni, 1969) and early neo-institutionalists' interest in sources of structural stability (Zucker, 1977), professionals have often been conceptualized as homogenous group of actors (DiMaggio & Powell, 1983) and powerful defenders and promoters of their professional logic (e.g. Ackroyd, 1996; Currie et al., 2012; Currie & Suhomlinova, 2006; Micelotta & Washington, 2013).

While both sociologists and institutionalists have proposed that there may be considerable differences within and between different professions with regard to their basis of authority and their status (Abbott, 1981; Scott, 2008b), this insight has yet to fully translate into the study of professionals' institutional work. For example, Scott (2008a: 227-228) differentiates between creative, carrier, and clinical profes-

sionals. According to him, creative professionals establish the institutional framework along which their profession is structured and are mostly to be found in research and teaching facilities (ibd.: 227). These professionals, as Scott (2008a: 227) points out, enjoy the highest status within a profession. Carrier professionals, in turn, diffuse these professional frameworks into organizations in their roles as educators (e.g. lawyers or consultants) while clinical professionals – the largest subgroup of a profession – "apply professional principles to the solution of problems presented by individual clients" (ibd.: 228). Yet, despite identifying these multiple sub-groups within a profession, Scott's (2008a: 219) idea of professionals as "lords of the dance" and "most influential, contemporary crafters of institutions" (ibd.: 223) leave little room for the conceptualization of professionals as heterogeneous groups of actors whose potential to shape institutional arrangements may differ considerably.

Each empirical study of this thesis provides insights that shed a critical light on the concept of '*the* professionals' as a specific, largely homogenous group of institutional agents. In particular, study 1 of this thesis suggests that professionals' institutional work is strongly affected by their relative status within a field. While both physicians and nurses have been conceptualized as profession of some sort (Abbott & Meerabeau, 1998: 3), study 1 shows that they differ considerably with regard to their access to discursive means as important – if not most important – tools of institutional work on the field-level. In effect, the findings of this critical discourse study suggest that the professional project of low-status professionals does not only occur *at* their regulatory and task boundaries with adjacent (high-status) professions (Abbott, 1988, 1995) but *within* the meaning systems provided by the high-status actors of a field. For the study of professionals' role in institutional dynamics, this insight is important insofar as it illustrates how professionals may add to both institutional change and stability at the same time. While nurses actively challenged the paradigm of medical dominance in German health care, they reinforced the medical professions' right to define the objects around which the field-level discourse revolved. Further, study 1 underlines the need to differentiate between different kinds of professionals who, for example, differ in their relative field-status and hence their access to discursive means of agency.

Tightly linked to this first insight that professionals are generally heterogeneous with regard to their inherent ability to create, maintain, and disrupt institutions is the second and – arguably – major contribution of this thesis, that is, the conceptual and empirical advancement of our understanding of how professionals' contextual embeddedness affects when, why, and how they exert agency.

Recent conceptual work has emphasized that professionals' embeddedness in different field- and organizational contexts may critically affect whether and how they

engage in institutional dynamics and may even bring about different "forms of professionalism" (Muzio et al., 2013: 703). Adding to the growing number of research that studies professionals' institutional work in context (Currie et al., 2012; McCann et al., 2013; Reay et al., 2006; Smets & Jarzabkowski, 2013; Smets et al., 2012), this thesis has tried to provide a more systematic view on professionals as *embedded* institutional agents. On the conceptual level, it advances current research by integrating sociologists' idea of professionals as 'boundary workers' (Abbott, 1988, 1995; Chreim et al., 2013; Fournier, 2000; Gieryn, 1983; Kilpatrick et al., 2012) with institutionalists' conceptualization of institutional dynamics as shifts in logic constellations (Zilber, 2013). Specifically, I suggested that professionals' institutional work can be described as boundary work to in- or exclude logics. This conceptual model of professionals' institutional work as boundary work between multiple logics stands in explicit contrast to earlier research that implied that professionals mostly engage in agency to promote and defend their professional logic. Accommodating the reality of many professionals, this model acknowledges that professionals are often exposed to several logics at the same time and that the mere maintenance and defense of their professional logics is often neither feasible nor desirable against the contextual boundary conditions of their work (Goodrick & Reay, 2011; Harris et al., 2014; Kitchener & Mertz, 2012; Reay & Hinings, 2009). Professionals may selectively in- and exclude logics while fulfilling their organizational and professional roles and while exerting their routines. This kind of institutional work – while leading to the maintenance or change of logic constellations in routines, organizations, and eventually fields – is often driven by pragmatic considerations as professionals, like most employees in organizations, are interested in 'getting the job done' (see e.g. Smets & Jarzabkowksi, 2013: 1304). However, the inclusion of non-professional logics in their routines and roles is not always owed to the fact that efficiency considerations override professionals' political interests. As shown by extant research, professionals may even purposefully enact non-professional logics to advance their professional project (e.g. Greenwood et al., 2002; Salhani & Coulter, 2009). A particularly illustrative example for this is probably the enactment of managerial logics by low-status professionals to gain influence and status through the organizational hierarchy (Kirkpatrick et al., 2011).

While the conceptual model of professionals' institutional work as boundary work suggests that whether and how professionals combine (specific elements of) different logics is dependent on the contexts in which they are embedded, the empirical studies of this thesis – study 2 and 3 in particular – systematically examine how configurations of contextual conditions affect professionals' institutional agency. These studies advance institutional research by transcending the level of individual, in-depth case studies on professionals' institutional work while maintaining the richness of qualitative research. In doing so, they answer explicit calls to employ

comparative qualitative analysis to gain more insights into the antecedents and processes of institutional agency (Battilana et al., 2009: 95).

These two papers illustrate well why it is so important to account for professionals' contextual embeddedness to explain when, why, and how they exert institutional work. Specifically, the studies in sections 5.3 and 6.3 provide insights on how configurations of contextual conditions may add to the development of what Muzio et al. (2013: 703) identify as different "forms of professionalism". Both studies show that professionals' contextual embeddedness may effectively lead to a divergence of the highly political professional project on the field-level and the more pragmatic and implicit professional projects on the organization- and routine-level.

Study 2 illustrates that even when new task-spheres and corresponding role changes are promoted as an important step towards nursing professionalization by field-level actors, these changes only translate to the organizational level when specific boundary conditions are met. Examining when and why nursing professionals in German university hospitals are open to changes in institutionalized task-divisions between nurses and physicians, I found three different configurations of boundary conditions which were summarized as 'Pragmatic Progress' (high functional and low institutional pressure), 'Authorized Professionalism' (high institutional pressure and involvement of a high-status change agent in a change project with low divergence), and 'Guided Professionalization' (low institutional pressure and involvement of a high-status change agent in a change project with high divergence). These types of configurations all have in common that they provided nurses with both normative and pragmatic rationales that jointly fostered nurses' openness towards changes in their task responsibilities. While tentative, this finding implies that within organizations, professionals simultaneously enact elements of their professional logic and the corporate logic of efficiency and – under specific circumstances – even primarily base their reaction towards change on its implications for process efficiency (for more detail see 6.3.4).

I would like to specifically focus on the configurations of 'Pragmatic Progress' (high functional and low institutional pressure) and 'Authorized Professionalism' as these offer additional insights on when and why professional projects on the field-level may be misaligned with professionals' institutional agency within their organization. The situation that I called 'Pragmatic Progress' is characterized by high functional and low institutional pressure, leading nurses to primarily focus on how new task-divisions could increase process efficiency. Additionally, the lack of advanced nursing training in the respective departments made the logic of 'nursing professionalism' far less salient than on the field-level. This resulted in an interesting combination of visible structural progress and conservatism in the underlying rationales. While nurses were open towards new task responsibilities, they provided

legitimization accounts that were at cross with the professional project on the field-level as it promoted typical elements of the traditional nursing logic of "unconditional care" (Kirpal, 2004: 217). Specifically, nurses emphasized their interest in putting the patients' needs first while disregarding the implications of new task responsibilities for the development of nursing as a profession. In sum, this solution provides insights on how professionals' embeddedness in a specific organizational situation may detach them from their professional project on the field-level: It shows how strong functional pressures together with a local absence (or at least underrepresentation) of the field-level 'professional logic' may lead to the development of a conservative professional project that only appears to be in line with the progressive professional project on the field-level but indeed follows different rationales.

Solution 2 of this study, that is, 'Authorized Professionalism' (high institutional pressure and involvement of a high-status change agent in a change project with low divergence), in turn, illustrates that even if professionals reproduce the professional project on the field-level by viewing new task responsibilities as an adequate reflection of nurses' growing professional expertise, their openness towards change may be fragile. Interestingly, the enactment of confident nursing professionalism which was strongly promoted by nursing representatives on the field-level (see also study 1) did not only translate into the confident assumption of new tasks but also in the confident demarcation of nursing from medical work that became especially relevant when nurses felt that physicians could benefit from new modes of task division at nurses' expense. Accordingly, nurses' generally open stance towards new task responsibilities was owed to the specific interaction of the given boundary conditions. The involvement of high-status change agents was important for the change project to become an official acknowledgement of nurses' high qualification in these departments while the low divergence of the project itself implied that the changes in task responsibilities were small enough to not be considered much additional work strain and thus be tolerated. This solution underlines particularly well that scholars should not only generally account for the contexts in which professionals are embedded but also employ comparative methods that allow for a holistic evaluation of their institutional work in context as it may be the idiosyncratic interaction of conditions that critically informs when, why, and how professionals engage in institutional dynamics.

How professionals' contextual embeddedness shapes their institutional agency in a way that creates an explicit contrast between field-level professional projects and the behavior of clinical professionals is further illustrated by study 3 of this thesis. Specifically, this study accounted for the multi-level embeddedness of professionals' routines in fields, organizations, and immediate task environments when trying to answer the question of when and why medical professionals enact rules in their

routines. As elaborated on in chapter 6.3, German health care is characterized by pressures towards increased efficiency and accountability while representatives of the medical profession openly spoke out against the standardization of medical practice and the enactment of care pathways in particular. With the enactment of care pathways physicians integrate the "logic of efficiency and accountability" into their routines, thus laying the foundation to change in the medical profession from the bottom-up (Adler and Kwon, 2013: 954). At the same time – at least in the specific case of the German medical profession – the enactment of care pathways in medical routines constitutes a contradiction with the recommendations of the professional associations on the field-level. The findings of this study suggest that physicians enact care pathways in their routines when they perceive them to be 'resources' to support coordination and/or legitimization of their routine performances.

Interestingly, the findings do not only support the idea that professionals' subtle institutional work within their routines is driven by the practical necessities of their daily tasks and occurs along the way of staying on top of one's work (see specifically Solution 3 'Surviving Stress'). Instead, the findings also suggest that professionals include care pathways (and thus the logic of efficiency that these rules convey) into their daily work in an attempt to secure their professional status. Solution 2, which was named 'Securing Status', exhibits a mechanism behind rule enactment that illustrates well how institutional and functional pressures interact to detach professionals from the political agenda of their profession on the field not in spite of but because of their goal to secure their status as legitimate professional.

In the case of German health care this paradox situation could occur as the field-level pressures on medical professionals were complex and did not prescribe a dominant set of behavioral expectations for clinical professionals. On the one side, the enactment of pathways has been publicly decried by as "cookbook medicine" (Sturm, 2013: 223) undermining professional autonomy and the sacred relationship between a physician and his patient (see section 6.1). On the other side, representatives of the medical profession spoke out for the application of evidence-based medicine in the medical profession's tradition of applying scientifically proven, state-of-the-art knowledge. Against the background that the routine participants in Solution 2 were physicians with high levels of expertise facing frequently occurring tasks, the enactment of professional autonomy was obviously less important to them than the demonstration of state-of-the-art medicine. As further interview evidence suggested, physicians tried to secure their status as knowledgeable and experienced professionals because of their function as teachers and role models to young physicians. Interestingly, they saw themselves as both translators and creators of institutional expectations according to which young professionals should be socialized. Accordingly, the enactment of care pathways at the expense of fully autono-

mous conduct was not merely a performative pattern of physicians with high levels of expertise who sought to consistently demonstrate their ability to keep their treatments in line with the latest scientific findings. Rather, as senior physicians are local providers of professional socialization and high-status peers to junior physicians, their enactment of pathways also promoted the reliance on formal rules as an appropriate element of medical treatment routines. Accordingly, this situation illustrates well how professionals' response to practical problems in idiosyncratic contexts paves the way for bottom-up institutional change (see also: Adler & Kwon, 2013; Smets et al., 2012): The enactment of care pathways by physicians with high expertise stands not only in explicit contrast to the promotion of medical autonomy by field-level representatives but – as these professionals are perceived as legitimate mediators of field-level expectations – also leads to a socialization of junior physicians into professional roles that are incommensurable with these top-down pressures. These socialization processes by frontline practitioners can be conceptualized as disruptive institutional work since they promote the normative appropriateness of standardizing medical practice und thus contribute to the diffusion of new views on medical professionalism.

Overall, both the conceptual and the empirical parts of this thesis have contributed to a more systematic understanding of how professionals' contextual embeddedness in systems of meaning and tangible structures affects when, why, and how they exert institutional work. Specifically, this thesis shows that scholars should remain cautious when speaking of 'professionals' or 'the professions' as these are not necessarily homogenous groups of social actors. The contextual embeddedness of professionals in fields, organizations, and routines may even – as specifically illustrated in study 2 and 3 of this thesis – lead to a divergence of a profession's professional project and the institutional work of individual and collective professional agents. This is because their boundary work between different logics may in itself be bounded, either when the arenas of institutional agency are being discursively dominated by other actors (study 1) or when real-life working environments make the unadulterated enactment of their ideal-type professional logic impossible, inappropriate, or inefficient (studies 2 and 3).

These insights resonate well with Ackroyd's (1996: 604) idea of "double closure" as a precondition for successful professionalization. Double closure refers to the combination of a profession's regulatory closure in the labor market and professionals' control of dominant positions within their organizations to maintain and reinforce a profession's status and power (Ackroyd, 1996: 604-605). As already pointed out by McCann et al. (2013: 754), institutional work "on the frontline" is thus equally important as professionals' grand political strategies on the field-level. Accordingly, the rise and fall of professions needs to be studied as a multi-level phenomenon with specific attention to the different contexts in which professionals

operate (see also section 3.2). The insight of this thesis that professionals' embeddedness in ideological and structural contexts may explain the (mis)alignment of field-level professional projects and the local enactment of professional logics may advance our understanding on why some professions successfully shape their institutional environment according to their preferences while other professions fail to do so. Additionally, scholars should take into account that the conceptualization of professionals as being generally interested in the consequent enactment of their professional logic which brought about almost paradigmatic dichotomies, such as 'professionals versus managers' (Dent, 2003; Raelin, 1986) and 'professions versus the state and the market' (Freidson, 2001; Relman, 2007), is too simplistic against the complex contexts in which professionals are currently embedded and the multiple roles they hold (Bode & Maerker, 2014; Doolin, 2001; Kirkpatrick et al., 2011; Kuhlmann et al., 2013; Llewellyn, 2001; Thorne, 2002). As the conceptual sections of this thesis suggested and the empirical studies illustrated, professionals may even actively promote logic constellations that lie at cross with their profession's overall political goals as contextual conditions 'activate' clinical professionals' own concepts of appropriate behavior which are informed but not determined by their membership in a profession.

In sum, this thesis contributes to institutional research by challenging both old and more recent conceptualizations of professions and professionals in institutional literature. Early conceptualizations of professionals have emphasized their homogeneity and their function as sources of structural stability in organizational fields (DiMaggio & Powell, 1983; Levitt & Nass, 1989; Slack & Hinings, 1994) while later work on the professions has added that professionals also serve as powerful agents who bring about institutional change as their professional projects "reverberate throughout the field" (Suddaby and Viale, 2011: 426). This dissertation has provided insights on the contextual forces that promote the enactment of different concepts of professionalism even within the same profession, thereby challenging early conceptualizations of professionals as "interchangeable" actors (DiMaggio & Powell, 1983: 152) who solely adhere to their professional norms and thus become sources of isomorphism in a field. The effect of contextual embeddedness on professionals' preferences and behavior also challenges more recent ideas of professionals as powerful agents in institutional change. Professionals are and will always be agents of their profession, endowed with certain privileges and deeply concerned about the maintenance of professionalism as societal logic from which they derive their special status in fields like health care and law (Child & Fulk, 1982; Currie et al., 2012; Micelotta & Washington, 2013; Savage & Robertson, 1999). Yet, while professionals are, without a doubt, influential actors in socially important fields like health care, both the conceptual and the empirical sections of this thesis should have provided a case for a cautionary view on professionals as a new kind of insti-

tutional 'super-agents' who single-handedly create and shape institutional contexts. While professions are a constitutive pillar of the institutional pressures that characterize a field, professionals as the "inhabitants" (Delbridge & Edwards, 2013; Everitt, 2013; Hallett & Ventresca, 2006) of professions are embedded in diverse institutional and practical contexts that both enable and constrain agency. Since professions cannot exist apart from and beyond their enactment through professionals, they emerge, change, and perish in dependence from the contexts in which their members operate. Thus, as much as professions shape contexts, contexts shape professions.

To account for the diversity of professionals, future research should consider distinguishing professionals according to their access to and the relevance of the concept of professionalism to their work (see also: Adler & Kwon, 2013). On the field-level, different professions may be more or less associated with the societal logic of professionalism as study 1 of this thesis underlines: While physicians – as members of one of the most traditional professions – casually depicted non-medical healthcare professionals as 'non-professional', nurses struggled to discursively link nursing to the status of a profession. On the organization- and the routine-level, professionals may be partially detached from their field-level professional logic due to specific role expectations and practical pressures as illustrated by the studies 2 and 3 of this thesis. Consequently, both a profession's history and the immediate contextual embeddedness of professionals may affect professionals' reaction to and their involvement in institutional dynamics. As elaborated on in the course of this thesis, the mere distinction of professionals and non-professionals as different kinds of institutional actors provides a very narrow view on professionals' role in institutional change and maintenance. Differentiating institutional workers according to how accessible and relevant professional logics are to them, would, in turn, allow researchers to account for professionals' different professional backgrounds as well as their embeddedness in organizations and routines while not neglecting the effects of professionalism on institutional work.

The insight that professions and professionals are just as much shaped by context as they shape their institutional contexts also holds managerial implications. Most importantly, it puts the notorious 'non-manageability' of professionals (Raelin, 1986, 1989) into perspective. While professionals are endowed with high degrees of autonomy due to their professional regulation and normally remain in control over the operational core of their work (Marcus, 1985), this thesis has shown that (i) professionals' openness to changes in their task responsibilities depends on specific constellations of boundary conditions (study 2) and that (ii) the contextual conditions in which their routines are embedded may explain whether professionals will enact formal rules (study 3). While not all of the contextual conditions that shape professionals' susceptibility to managerially motivated change and their motivation to

align their work with bureaucratic modes of control can be easily manipulated (e.g. institutional pressure from the field), managers might want to consider the specific situations into which they try to implement change. Increased awareness of the joint effect of different boundary conditions of professionals' work may facilitate the choice of departments when trying to design pilot projects and may support managers in preparing adequate strategies to overcome resistance to change. This thesis highlights such specific boundary conditions (see specifically study 2 and 3). Consequently, while the contributions of this thesis are clearly more theoretical, the insights gained from the empirical studies may help managers to guide their attention and raise their understanding of why professionals react to managerial interventions the way they do.

7.2 Limitations and Conclusion

This dissertation sought to provide a balanced perspective on professionals' role in institutional dynamics that – while acknowledging professionals' important role in fields like health care – examines professionals' institutional work as embedded agency that is critically influenced by context.

Limitations

Focusing on German health care and employing qualitative research methods, the findings of this thesis are naturally of limited generalizability. While German health care is currently characterized by similar changes as most Western health care systems, that is, marketization and liberalization (see section 2.2), the hierarchical relations between the different health care professions differ when compared to other European countries. Specifically, the traditional dominance of the medical profession in health care is still very noticeable in Germany and reflected in the medical professions' involvement in the central regulatory bodies of German health care (see section 2.1). Accordingly, the findings that pertain to the professional projects of the medical and the nursing profession (specifically study 1) may not apply to other health care systems.

Due to its qualitative orientation and its selective focus on specific precursors and forms of professionals' institutional agency, this thesis' contribution to institutional theory must be viewed as only a small piece towards the resolution of a greater theoretical puzzle. Specifically, future research should focus more on comparative studies between different professions to provide a deeper understanding of how similar contextual embeddedness affects the institutional work of different professions differently. More comparative research appears particularly important since more and more occupations make the claim of being recognized as a profession and exert practical and political institutional work to promote their professionalization

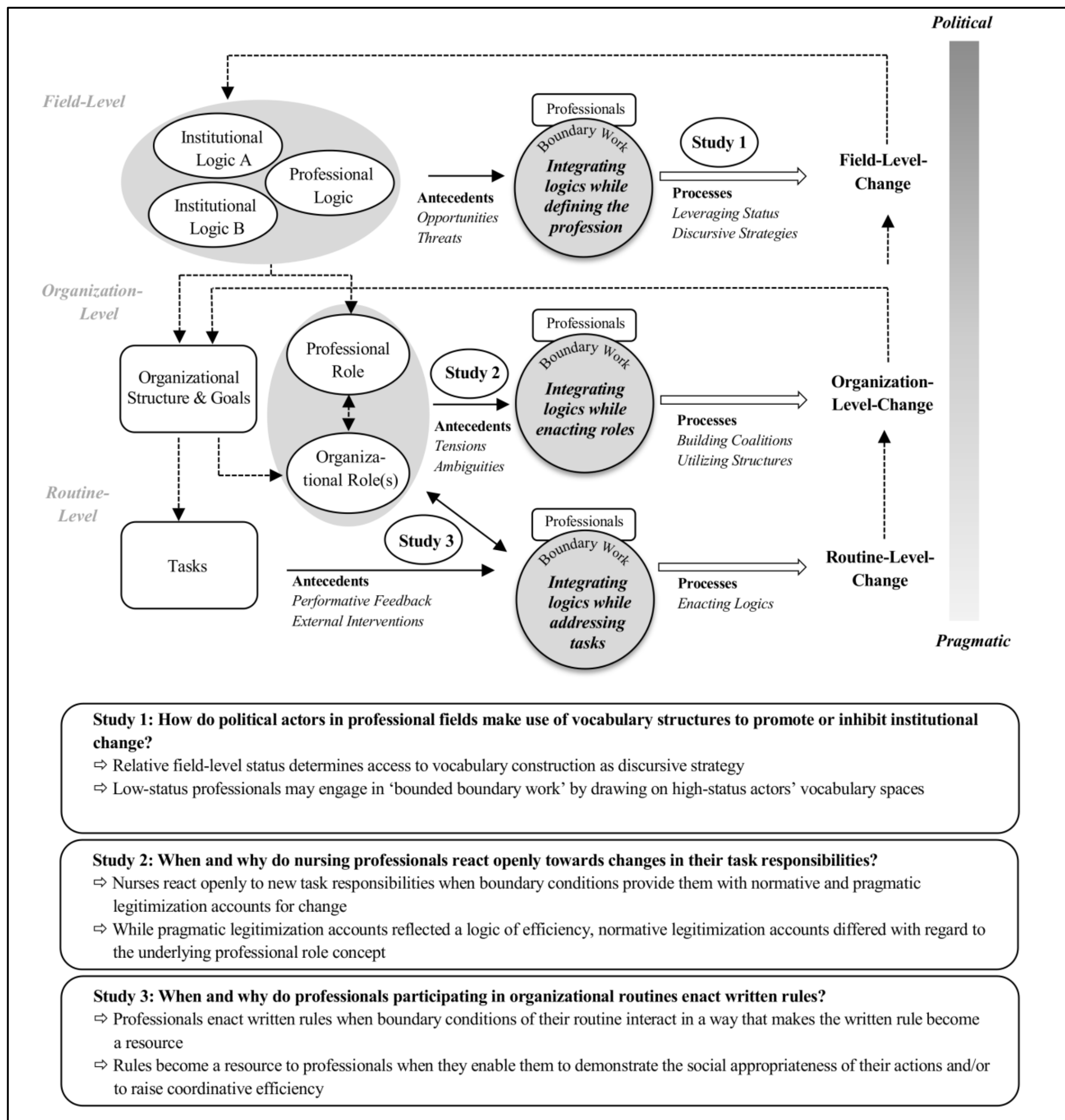
(Cooper & Robson, 2006; Kirkpatrick et al., 2011; Kitchener & Mertz, 2012; Neal & Morgan, 2000). While study 1 of this thesis has already provided first insights on how a professions' status within a field may affect professionals' access to discursive means as tools in institutional work, there is still much need to compare professions on other dimensions such as age or dependency on organizational contexts (e.g. managers, in opposite to lawyers or physicians are inherently dependent on their organizational embeddedness to exert their 'craft'). A potential starting point for a more systematic comparison of different professions' institutional work is provided by Adler and Kwon (2013: 934-941), who propose that professions can be differentiated according to their degree of autonomy, their distinctive field of expertise, their values, their degree of shared identities, and their ties to critical roles in organizations.

Another potential avenue for further research is the interaction of professionals' institutional work on different levels. While I have pointed towards a potential divergence between professional projects on the routine-, the organization-, and the field-level in the preceding discussion, more research is needed to uncover how professionals' agency on these different levels of their work is mutually interdependent. For example, we still know little about how the realities of professional practice may undermine political arguments or how practical improvisations may escalate to changes in professional regulation and other field-level structures (for a notable exception see: Smets et al., 2012).

Conclusion

This dissertation sought to add to institutionalists' understanding on when, why, and how professionals engage in the dynamics of institutional change and stability. Figure 6.1 provides an overview of the main insights of this thesis, focusing on how the three main chapters (4, 5 and 6) complement the conceptual model on professionals' institutional work in context (see also figure 3.2).

Figure 6.1: Professionals' Institutional Work as Boundary Work in Context – Findings



My thesis started out with an overview on German health care as the empirical setting in which I studied when, why, and how professionals are involved in institutional dynamics (*Chapter 2*). Given the recent changes in German health care and the central importance of professions to this field, German health care proved to be a suitable setting for more in-depth analyses on professionals' institutional work. Before theoretically elaborating and empirically examining when, why, and how (health care) professionals contribute to institutional change and stability on different levels of their work, I provided the conceptual foundation to this thesis (*Chapter 3*). Specifically, I elaborated on how conceptualizations of professionals moved from trait-based approaches (Greenwood, 1957) to an interactionist perspective (Abbott, 1988; Freidson, 1988a) that laid the foundation for institutionalists' current

idea of professions and professionals as institutional agents (Scott, 2008b; Suddaby & Viale, 2011). Given that today, most professionals are employed in large organizations and exert their work as participants in organizational routines, I discussed how the different contexts in which professionals operate (i.e. fields, organizations, and routines) may enable and constrain their institutional agency. Challenging the idea that professionals are primarily enacting and defending their professional logic, I developed an integrated model that conceptualized professionals' institutional work as boundary work between different logics that allowed a more nuanced view on professionals' agency as embedded in different contexts which promote the enactment of diverse logic constellations.

Chapters 4, 5, and 6 – as the three main parts of this thesis – each provided an in-depth analysis of professionals' institutional agency on the different levels of their work in the empirical setting of German health care. All three chapters exhibit the same structure by first elaborating on the relevant developments of German health care as empirical background and then providing a literature review that identifies major gaps in research before presenting a qualitative empirical study that focuses on a selected aspect of professionals' role in the institutional dynamics of German health care.

Chapter 4 focused on professionals' role in institutional change on the field-level. The main changes in the field of German health care can be described as marketization and economic rationalization and provided an opportunity for nurses – as low-status actors in German health care – to promote their professional project since the ever-increasing efficiency pressures led to a general re-evaluation of regulatory and task-boundaries between the different health care professions. The literature review in the theoretical section of this chapter uncovered that professionals engage in institutional work when they perceive opportunities or threats to their profession. While the existence of opportunities and threats to the status of a profession often stems from developments in the larger institutional environment – such as the marketization of German health care – a professions' status can also be threatened from within as different subgroups promote diverging logic constellations (Dunn & Jones, 2010; Ramirez, 2013). The strategies and instruments through which professionals promote change or stability in a field often rely on leveraging their central position in fields and societies as a whole, which gives them the chance to articulate their opinion on institutional developments. As institutional dynamics on the field-level are mainly driven by political processes that include negotiation, professionals' institutional work on this level often occurs through the discursive (de-)legitimization of new institutional arrangements. Accordingly, the empirical study in chapter 4.3 focused on how different professionals used discursive means to promote or prevent change in German health care. Specifically, this study raised the question 'How do political actors in professional fields make use of vocabulary

structures to promote or inhibit institutional change?'. Its findings suggest that professionals' relative status within a field explains how they are enabled and constrained by the construction of specific vocabularies. Specifically, nurses appeared to be 'caught up' in the vocabulary structures provided by federal actors and physicians. This study expands extant literature on professionals' institutional work on the field-level by drawing attention to vocabulary construction as a subtle discursive strategy while finding that the reproduction of high-status-actors' vocabularies may lead to 'bounded boundary work'.

Chapter 5 provided theoretical and empirical insights on professionals' institutional agency on the organization-level. German health care organizations, under pressure by regulatory demands for more efficiency and accountability, have recently established new administrative roles such as quality managers which provide new opportunities for professionals to exert influence in their organization and buffer their work against the ever-increasing managerial control. Additionally, the strive for efficiency promoted the re-evaluation of task-divisions between medical and nursing professionals that translated into the proliferation of medical task delegation projects. The theoretical section of this chapter showed that within organizations, professionals are incentivized to exert institutional work when it promises to alleviate the tensions that result from the integration of different cognitive schemes in multi-professional organizations and the ambiguities that professionals experience due to conflicts between their organizational roles (e.g. as managers) and their professional roles. The strategies and instruments through which professionals foster institutional change and stability within their organization differ from those on the field-level as organizations provide a unique environment to build inter-professional alliances since organizational hierarchies comprise an additional dimension along which groups can form. Further, professionals may utilize organizational structures like information systems as unobtrusive pathways to promote new normative and cognitive frameworks, thereby implementing institutional change while borrowing the legitimacy of extant structures. As research on professionals' institutional agency within their organization has been much concerned with resistance and the maintenance of professional logics against managerial intervention, the empirical study presented in section 5.3 focused on the conditions under which professionals are open to changes in institutionalized task-divisions that affect their professional roles. Specifically, this study examined the question of when and why nursing professionals react openly towards changes in their task responsibilities. The findings suggest that boundary conditions of change need to provide nursing professionals with both pragmatic and normative legitimization accounts. It added to institutional research on the professions by showing that boundary conditions of institutional change critically influence how professionals rationalize these changes. Specifically, this study illustrated that due to their embeddedness in idiosyncratic

constellations of boundary conditions, including both institutional and functional pressures, members of the same profession who work in similar organizations and express similar reactions to similar changes may, in fact, be guided by different rationales that imply different role identities.

Chapter 6 dealt with the most micro-level of professionals' institutional work, integrating institutional and routine-theoretical perspectives to provide theoretical and empirical insights on when, why, and how professionals' work towards the reproduction or disruption of logic constellations within their daily routines.

This chapter started out with an overview of how German health care professionals' routines have recently been pushed towards standardization, pointing towards a conflict between care pathways as an instrument to secure treatment quality and efficiency and care pathways as 'cookbook medicine' that undermines medical autonomy. The theoretical section of this chapter showed that professionals' institutional work on the routine-level may be induced by both the mundane feedback they draw from their daily routine performances and external interventions that may disrupt extant routines. In stark contrast to their political work on the field-level and their less dramatic but still noticeable institutional work on the organization-level, professionals exert institutional agency on the routine-level along the way of simply 'doing their job' – selectively enacting and rejecting logics in their routine performances. Given that bureaucratic means of coordination such as formal rules and professional conduct are generally perceived as incommensurable, yet one can increasingly observe the enactment of formal rules in professionals' routines, the empirical study of this chapter raised the question 'When and why do professionals participating in organizational routines enact written rules?'. Specifically, this study explored which configurations of a routines' boundary conditions (participants' expertise, addressed tasks, and institutional context) cause physicians in university hospitals to enact care pathways in their treatment routines. The findings suggest that boundary conditions must interact in a way that makes the written rule become resource for routine participants. Rules may become a resource for professionals when they enable them to demonstrate the social appropriateness of their actions and/or to raise coordinative efficiency against the specific work situations in which they find themselves.

In the discussion in the preceding section of this thesis, I argued that despite the different foci of each study of this thesis, they are united in their conclusion that professionals' institutional agency needs to be studied in context to fully understand when, why, and how professionals engage in institutional dynamics. The consideration of not only the social but also the practical boundary conditions of professionals' institutional work may help to foster a more nuanced view on professionals who – while being powerful institutional agents in such important fields as health

care – are not a new kind of 'institutional super-hero'. Specifically, scholars should remain cautious to acknowledge that different professional groups may differ considerably with regard to their ability to shape their institutional environment. Even professionals within the same profession may enact diverging logic constellations since their professional membership, while strongly affecting their identity, does not – unlike early (neo-)institutionalists suggested – make them interchangeable actors. Against their multiple embeddedness in fields, organizations, and routines, actors within the same profession are often neither interested in promoting the same institutional structures and practices nor are they equally able to exert agency. Consequently, while this thesis could provide first insights on when, why, and how professionals engage in institutional change and stability, it would be presumptuous to articulate a definite answer to any of these questions.

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