

**Individual level dynamics and organizational responses to institutional complexity.
An ethnographic study in a neurological rehabilitation unit**

Giulia Cappellaro

University of Cambridge
Cambridge Judge Business School
Trumpington Street
Cambridge, CB2 1AG
Tel: +44 1223 760471
Fax: +44 1223 339701
e-mail: gc400@cam.ac.uk

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INTRODUCTION

Understanding organizational responses to institutional complexity has become a central theme in institutional theory (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011). Notably, there is an increasing interest in how institutional complexity is handled within the organization by individuals at the front line (Reay, Golden-Biddle, & Germann, 2006). To date, explanations have tended to give relative attention to either the individuals' 'doing', i.e. a practice perspective, or the individuals' 'being', i.e. an identity perspective. However, the study of the 'mutual interplay of practices and identities remains an underdeveloped yet promising area of research'(Thornton, Ocasio, & Lounsbury, 2012:134).

Drawing upon this call, in the paper we seek to investigate how work practices and social identities, through their emotional and affective components, recursively interact in organizations experiencing institutional complexity and how this interaction affects organizational responses. We present an ethnographic study of an Italian neurological rehabilitation unit in a hospital into which new governance and organizational arrangements were recently introduced to incorporate a more commercial orientation in the traditional, public and highly professional hospital system. We show how the adaptation of the organizational response from a 'blended' to a 'structurally differentiated' hybrid (Simsek, 2009) derived from the cumulative effects of practice and identity reactions of the professionals working in the unit. Emerging findings reveal two stages, namely, drift and reassessment, and five micro dynamics: practice accumulation and reduction, identity articulation and revalidation, and boundary re-creation. This explanation differs from existing approaches and provides three contributions to the study of organizational responses to institutional complexity.

First, we advance the understanding of the temporal aspect of organizational responses to institutional complexity. Specifically, we find that successful hybridization solutions create novel complexity in the medium term, thereby requiring organizations to flexibly adapt their structures and strategies to accommodate ever evolving pressures. Second, we demonstrate that the adaptation of the organizational response is generated by the mutually supportive relationship between individuals' practices and social identities, which triggers a rhythmic trajectory characterized by a stage of larger drift followed by a stage of partial reassessment. The misalignment between the realized equilibrium and the original organizational response prompts an adaptation of the response. Within this perspective, the study provides a more nuanced, realistic account of the temporal path through which individuals cope with and resolve institutional contradictions in the everyday professional life.

Finally, the study contributes to emerging literature emphasizing how institutional contradictions are not simply cognitively experienced, but rather "embodied, lived and often highly

emotionally charged” (Creed, Dejordy, & Lok, 2010). On the one hand, we show that the active management of the emotional component of social identity (Tajfel, 1978) is a critical constituent of the identity response to institutional complexity. Furthermore, in accordance with social identity theory (Bergami & Bagozzi, 2000; Ellemers, Kortekaas, & Ouwerkerk, 1999), we show that the (un)successful management of the emotional component of identity affects individuals’ attachment and belonging to the workplace, thus redefining group membership and boundaries.

THEORETICAL FRAMEWORK

Institutional complexity and organizational responses

Epistemologically founded in the Aristotelian science of inference, the metatheoretical construct of logic has become a powerful and recurrent construct in institutional research, in that it has enabled conceptualization of the beliefs and material practices that underpin institutions (Friedland & Alford, 1991; Thornton & Ocasio, 2008; Thornton et al., 2012). Early accounts of the cross-level linkages between institutional logics and focal organizations emphasize how higher order systems of beliefs and practices provide a basis for predictability and order in organizational action (Thornton, 2004). Recent literature, in contrast, highlights how organizations are not mere script-following actors, but construct ‘repertoires of responses’ (Greenwood et al., 2011) in their strategies, practices and structures (Kraatz & Block, 2008; Oliver, 1991; Thornton & Ocasio, 2008).

Nevertheless, current understanding of how organizations respond to institutional complexity remains selective because of the primary level of analysis employed. Indeed, most empirical work frames the organization as a unified interpreter of institutional demands and offers few details of how institutional complexity is handled within the organization, i.e., at the “coalface” (Barley, 2008). Powell and Colyvas (2008:279) emphasize this point, by recommending the need to study how “organizational participants maintain or transform the institutional forces that guide daily practice”(Powell & Colyvas, 2008). Similarly, Barley (2008) urges the exploration of how “institutions and actors meet in the throes of everyday life” and echoes previous work cautioning that we should confer more attention on individuals (Zilber, 2002), especially those ‘at the front line’ (Reay et al., 2006).

Indeed, studying everyday processes and the role of individuality is particularly salient in the context of institutional complexity. While traditional accounts emphasize that dominant logics shape individuals by providing systems of incentives (Rao, Monin, & Durand, 2003), modeling individual preferences (Luo, 2007), and more broadly, providing the context for decisions and outcomes (Goodrick & Reay, forthcoming), in settings where multiple competing logics coexist actors are given more discretion, yet also less guidance, on how to act in ambiguous and contradictory situations. To better understand organizational responses to institutional complexity

we thus need to investigate how individuals within organizations experience the conflicting logics and how members' reactions influence organizational dynamics.

Individuality and organizational responses to institutional complexity

To date, two lines of scholarship have emerged, each emphasizing differences in the mechanism, unfolding and cumulative effects of individual actions on organizational responses to institutional complexity. In particular, these perspectives differ in the relative attention given to 'doing' as opposed to 'being'. The first, more established, perspective 'holds on to individuality by asserting people's actual activity in practice' (Whittington, 2006:615). Practices are defined as patterns of human activities centrally organized around shared practical understanding (Schatzki, 2001). As such, practices are the material enactment of field-level logics (Lounsbury, 2007) and it is in their collision that institutional contradictions are educed and problematized (Smets, Morris, & Greenwood, 2011). Within this perspective, institutional complexity is experienced and resolved as part of the 'ordinary, everyday nature of work' (Jarzabkowski, Matthiesen, & Van De Ven, 2009:289), and provides an impulse for change when 'paired with the urgency and consequence of accomplishing specific tasks' (Smets et al., 2011).

The second, and more emerging perspective holds on to individuality by prioritizing organizational members' social identities and, specifically, their affective component. Social identity is defined as the "individual's knowledge that he belongs to certain social groups together with some emotional and value significance to him of this group membership" (Tajfel, 1978). Identity is an element of "situated, bounded, intentionality guiding social members' actions and social interactions" (Thornton et al., 2012). Scholars have traditionally documented how members' social, especially professional, identities influence behavior in organizations, promoting (Lounsbury, 2001) or resisting change (Townley, 1997). Underlying these early studies was the assumption that individuals are able to critically disentangle the properties of the social identity category from the characteristics of the contingent institutional demand, evaluate the fit between the two, and react if a mismatch is recognized.

Recently, a few studies provide a more fine-grained and nuanced theorization of identity-based responses, by theorizing the possibility for the individual to undergo emotional shifts, that can trigger behavioral changes and ultimately yield institutional consequences. Kellogg (forthcoming), for example, emphasizes that emerging demands might not be immediately and unambiguously perceived as identity-threatening and, therefore, actors may delay their reaction. In her analysis, high status organizational members shifted from supporting to resisting a reform implementation after having experienced concerns – an emotional shock – about loss of high status due to the planned change. As a consequence, organizational responses to institutional pressures are not

necessarily consistent over time, as these individual behavioral shifts might ultimately alter and reverse the original response. Moreover, other studies unveil and emphasize that identity can itself be triggered by institutional contradictions (Creed et al., 2010; Gutierrez, Howard-Grenville, & Scully, 2010; Lok, 2010). That is, individual behavioral responses are the outcome of a cognitive and emotional process of internalization of institutional contradictions and identity reconciliation; this process can be prolonged and not always positively resolved (Creed et al., 2010).

Taken together, the literatures on intra-organizational practice and identity have provided important, very different, explanations for the timing and the cumulative effects of individuals' responses to institutional complexity. Nevertheless, our understanding of how individual level processes contribute to framing organizational responses will remain limited until we distinguish people's *doing*, as highlighted by the practice perspective, and people's *being*, as emphasized by the identity perspective. Indeed, Nag, Corley and Gioia (2007:824) urge scholars to "account for identity's relationship with the collective practices that characterize how organization members conduct their daily work". Similarly, Pratt, Rockmann, & Kaufmann (2006:255) showed how, when faced with a violation between their work and professional identities, physicians rectified this violation by 'customizing who they were to match what they did'.

In summary, examining the relationship between practice and social identity in everyday organizational life is central to understanding organizational responses to institutional complexity. Indeed, through an unwitting focus on either the timescale of the organization and the pressure 'to get the job done', *or* the timescale of individual and her reflexive stances, research risks providing an overly simplified scrutiny of the temporal path of practice and identity responses and their cumulative effect. For example, when and how do identity-based affective and emotional reactions emerge in organizations where individuals experience the urgency to accomplish daily tasks as a result of increasing and self reinforcing institutional pressures? Our focal research questions are therefore: How do practice and social identity, through its emotional and affective component, recursively interact in organizations that experience institutional complexity? How does this interaction affect organizational responses?

METHODS

Empirical Context

The study was initially guided by an interest in the emergence of a hybrid public-private organizational form in the Italian health care service (*Sistema Sanitario Nazionale*), as a response to the novel complexity deriving from the introduction of private commercial principles in a sector traditionally informed by a strong public bureaucratic and professional tradition.

We pursued an induction-driven research design suitable for elaborating theory about complex and weakly understood processes (Locke, 2001). Specifically, we conducted a single site realist ethnography (Hammerseley & Atkinson, 2007; Van Maanen, 1979) for three reasons. First, the prolonged presence in the field and the participation in multiple organizational levels are needed to unveil covert tensions and struggles as well as document more overt activities and results. Second, familiarizing with the research context and being accepted by the community is essential to acquire an emic perspective of how logics are ‘inhabited’ (Hallett & Ventresca, 2006) in the organization. Third, affective and emotional expressions at the base of micro dynamics need to be elicited in time (Gross & Thompson, 2007).

We based the selection of the research site, R-Hospital, on three criteria that helped explain the phenomenon. R-hospital was a representative case of ‘blended hybrid’ that had successfully combined the state bureaucratic, private corporate, and the professional logics. Thus unveiling the rationale and the process by which a successful hybridization case came to modify its response as a result of intra-organizational dynamics would shed light also on other less extreme cases. Furthermore, R-hospital performed rehabilitation services, which, as previous work has shown (Pratt & Rafaeli, 1997), are by nature particularly open to field-level interactions. Finally, R-hospital focused on a highly intensive sub-specialty niche, namely severe acquired brain injuries rehabilitation; physicians working in this sub-specialty would thus be more likely to show stronger social identity traits compared to other, less complex, rehabilitation services.

Data collection

Observational, interview and archival data were collected over 10 months between September 2010 and May 2011. During the first 6 months period, we accessed the site on a daily basis for 8 hours on average; during the remaining 4 months on a weekly basis. Table 1 lists the data sources and their use in the analysis.

 Insert Table 1 here

Observations. The R-Hospital data include participant observation at multiple organizational levels. The main level of analysis was the ward, i.e. the severe acquired brain injury unit. Ward-level observations included 20 weekly planning meetings, 15 interdisciplinary team first visits and 5 interdisciplinary team follow-up visits for a total of 140 patients followed over 6 months. We acted as a ‘human camera’ (Barley, 1990), jotting notes verbatim in a notebook with the support of an observation sheet and typing notes within the following 24 hours (Emerson, Fretz, & Shaw, 1995). Besides ward-level observations, we observed strategy making at bi-monthly board meetings,

monthly clinical governance meetings, sporadic internal meetings for budget negotiation, procurement activities monitoring, hiring practices and negotiations with trade unions, and external communication events.

Ethnographic interviews. Guided by the initial weeks of observation, we developed a list of open-ended interview questions to elicit how the public-bureaucratic, private-corporate and the professional logics were inhabited in the hospital (Hallett & Ventresca, 2006). A total of 100 organizational members, 33 of which in the unit, were selected on the basis of disproportionate stratified sampling, with employees' occupations serving as the stratification factor. Interviews lasted approximately 45 minutes, were conducted in person, and were tape-recorded, except for 4 interviews for which extensive notes were taken. A total of 2,300 pages of interview transcripts were created. Interviews were conducted in Italian by the author who is a native speaker, tape recorded, transcribed and, where necessary, translated into English.

Archival data. We had access to public and confidential organization-level documents that allowed us to validate impressions and to triangulate the individual- and organization-level accounts with field-level linkages. Data included minutes of all hospital board meetings (2002–2010), documents related to budget negotiation, procurement activities, agreements with trade unions, internal procedures on patient management and ward activity planning, press releases and newspaper articles (September 2010–November 2011).

Data analysis

Data analysis followed the principles of naturalistic inquiry (Lincoln & Guba, 1985), including constant comparison and theoretical sampling (Glaser & Strauss, 1967). It draws specifically upon the action condition paradigm within the grounded approach (Locke, 2001) and distinguishes contextual and internal dynamics (Harrison & Corley, 2011). We constructed a chronological account list of key events, activities and interpretations composed of primary data, namely, field notes, documents, interviews pertaining to the organization and its field linkages. Subsequently, we focused more analytically on the ward, and performed the analysis in 3 stages.

Stage 1. The first stage entailed the synchronic and diachronic analysis of practices and identity-related raw data. First, we combined preliminary interviews and archival data to develop a categorization scheme based on the three major dimensions that defined the core principles of the professional work, the set of related practices and identity traits. Next, we rearranged the field notes in a longitudinal perspective by unit of work, the *patient*, and built a chronicle of each of the 140 patients' rehabilitation paths. we employed attribute coding procedures (Saldana, 2009) to categorize the type of patient, his or her length of stay, and the primary physician responsible for

the patient's rehabilitation path.¹ we read the entire corpus of ward-level field notes related to coding *critical encounters*. Adapting Owen-Smith's (2001) definition of skeptical encounter, we defined a critical encounter as any conversational exchange in the group in which directive or critical comments and decisions were made about a specific aspect of the rehabilitation path of a patient. we noted the content of the exchange, the author of the comment, the answer provided by clinical director of the ward, and the reaction of the person who raised the issue. Encounters were then sorted in chronological order by the major dimensions previously identified and clustered into 5 categories that reflected the deviations from the professional principles. The 5 categories were later grouped into 2 higher-order themes, low-deviant and high-deviant practices, on the basis of the extent that they challenged the core of the professional work and were ultimately reassessed by the group. Finally, we performed a diachronic analysis, tallying each encounter's frequency over time, to analyze whether there were differences in the distribution of deviant practices in the pre and post identity reaction phases.

Stage 2. Following data preparation, we adopted open coding procedures to identify initial concepts and group them into first-order categories. we then engaged in axial coding searching for the relationship between the first-order categories. The 2nd order themes (7) were ultimately grouped into 2 overarching dimensions that created the basis of the grounded theoretical framework.

Stage 3. Finally, we integrated all of the previous rounds into a temporal explanation of how individual dynamics affected organizational responses to institutional complexity in R-Hospital.

Figure 1 describes the data structure that emerged from the analysis. On the right hand side, the figure depicts the contextual conditions that, according to informants, influenced members' dynamics over time. On the left hand side, the figure unpacks members' responses and outcomes in each stage. The dotted lines indicate the transition triggers from one stage to the other. Table 2 reports the coding through a number of examples from the text.

 Insert Figure 1 and Table 2 about here

¹ The *Type of patient* attribute was divided into 3 categories: Type I (orthopedics), Type II (neurological patients) and Type III (post-anoxia coma patients). These categories were meaningful from both a clinical perspective – they overlapped with the codes of the international classification for diseases (MDC-DRG) – and a financial perspective – for types 1 and 2 the reimbursement system set a maximum length of stay after which reimbursements decreased, whereas for type 3, a higher fee with no reduction was given. The *Primary physician* attribute was divided into 2 categories: new entry and senior physicians. We considered a physician as a new entry in the first 6 weeks of the work in the ward. We were told by organizational members that this period was usually regarded as appropriate for recently enrolled physicians to become familiar with the context and get acquainted with the group.

To ensure trustworthiness, we began data analysis during the observational phase and conducted an internal member validation on the emerging themes during fieldwork. Analyses were conducted with the support of a qualitative management software, namely, Atlas Ti.

FINDINGS

Context

R-Hospital was a small, publicly owned, acute care facility. In early 2000', in a context of rationalization of the health delivery network and public deficit reduction, the local health unit (LHU) converted the public facility into a public private stock company, with the majority of shares owned by the LHU and the local municipality, and the minority of shares owned by a private health clinic. The focus of medical activities shifted from acute to rehabilitation care. Guiding the new hybrid organization were three institutional logics: the state bureaucratic logic, the corporate commercial logic and the professional logic.

In the state bureaucratic logic, the hospital had the primary function of serving the health needs of the local population. In this ideal type, work practices followed impartial rules and norms defined at the central level by different tiers, namely the State for the essential levels of care to be provided, the Region for the global financial allocations and the general guidance on the services delivered, and the Local Health Unit for the detailed annual activity and budgetary planning. In the private corporate logic, the hospital had to operate as independent actor on the market. While the actual content of the work practices was defined autonomously by professionals, activities as a whole should contribute to the principles of organization's self-sufficiency, activity turnover maximization, and market share increase. The clinical work performed was indirectly subject to managerial procedures and routines that governed the hospital 'as a firm'. Finally, in the professional logic the hospital had to maximize the relational position of the medical sub-specialty in the professional network by acting as the reference center for the discipline. Professional rules and norms reflected the affiliation to the disciplinary school and centered around a set of three principles, namely the inter-disciplinary and outcome-based approach to rehabilitation, the preservation of the bio-psycho-social unity of the patient and the priority-based planning², which

² According to the inter-disciplinary and outcome-based approach each patient's rehabilitation is performed collectively by a team comprised of different professional figures who compile an 'individual rehabilitation project' and agree on the patient's rehabilitation global outcome and intermediate goals; the preservation of the bio-psycho-social unity of the patient states that the individual rehabilitation project has to be carried out in a single rehabilitation setting to maximize the synergies among the components of the inter-disciplinary team; finally, the priority-based planning principle implies that patients are classified into different levels of priority based on both the seriousness of the disease and the potential for rehabilitation. Preference has to be given to patients coming from the LHU-owned acute hospital with higher rehabilitation potential.

guided the content of daily work. Control on work processes was made through profession determined standards (Goodrick & Reay, forthcoming), which clinicians contributed to develop by taking part in standing working groups at the national and regional regulatory level.

The three logics – state bureaucratic, private corporate and professional – were blended in the hospital and in its main ward – the neurological rehabilitation unit – in three aspects, namely the governance model, the operational model and the revenue model (Kivleniece & Quelin, 2012). From a governance perspective, the shared ownership rights between public and private partners and the mixed hiring mechanisms – according to which all professionals were employed by the new organization except for the senior medical staff who were transferred from the LHU and a minority of public servants already operating in the facility prior to its conversion – guaranteed dispersed sources of authority and control. From an operational perspective, public and private partners jointly shared the responsibility for the delivery of rehabilitation services. Professionals working in the ward undertook the majority of the operational tasks regarding inpatient and outpatient care treatments, while the public actor complemented those tasks for which there was little convenience for an in house production, e.g. diagnostic tests. Internal procedures, such as procurement and hiring systems, followed the private civil law jurisdiction, which allowed the hospital to acquire resources with greater flexibility and discretion without undergoing public competition. Finally, from the revenue perspective, the unit derived returns from the public partner under the form of fee for service payments (DRG) for inpatient services and ex ante negotiated payments for outpatient services. While revenues were partially capped and dependent on public sector allocations, the inclusion of the unit in the local public network reduced environmental uncertainty and lessened market risks, by guarantying a constant flux of patients.

By virtue of its blended structure, in the early years the hospital increased the activity turnover and revenues and obtained high media endorsement. Specifically, the unit came to be increasingly cited by the media as ‘the optimal organizational model for delivering rehabilitation services’. Regional policy makers acknowledged the success of the ward in public speeches. In early 2010, the representatives of the LHU and the top management of the hospital agreed to further leverage their synergy, signing a new agreement that would increase the number of beds dedicated to the most severe type of patients, thus solidifying the role of the unit as a reference center for the treatment of neurological patients.

The analysis reveals that the process of how individual dynamics affected the adaptation of organizational responses to institutional complexity involved two stages: drift and reassessment. First, the achieved positive performance triggered a period of drift. New mutually reinforcing pressures from the partners attempting to capture the positive payoffs of the hybrid induced

physicians to operate in a context of institutional ambiguity and professional isolation. Pressed with the urgency to comply with the competing demands and endeavoring to adapt their professional identity to the environmental and task novelty, professionals came to accumulate deviant practices. Next, the cumulative effect of practice variations induced a process of reassessment. The recognition of an alteration in the nature and the quality of the job performed breached the perception of identity-work integrity and triggered a phase of identity revalidation, which entailed the recalibration of the emotional component of members' social identities. Later, professionals undertook a process of behavioral regulation where practice variety was explicitly assessed. Ultimately, members came to consolidate emotional and cognitive boundaries and reached a point of temporary equilibrium between the observance of professional claims and the compliance with institutional demands. The misalignment between the internal members' equilibrium and the initial organizational response to institutional complexity triggered the adaptation of the latter. Below, we describe the findings in greater detail.

Micro Stage 1. Drift

Institutional theory suggests that hybrid organizations reach positive performance (Tracey, Phillips, & Jarvis, 2011) and legitimacy in the field (Purdy & Gray, 2009) in the short term. However, the initial common benefits can be eroded because the involved parties' individual efforts to capture higher payoffs from the originally created value might generate new pressures and ultimately undermine the socially optimal outcome (Kivleniece & Quelin, 2012). Consistently with these predictions, our analysis suggests that new institutional demands emerged from the gains produced by the hybrid and triggered a resurgence of complexity and ambiguity. To meet the contingent demands of all social referents, professionals repeatedly enacted clinical decisions that gradually lead to the accumulation of deviant practices. The need to familiarize with new roles and careers in the hybrid context undermined the immediate receptivity of these deviances as identity threatening.

Institutional ambiguity and uncertainty. Two sources of institutional ambiguity and uncertainty nurtured the period of drift. First, self-reinforcing demands from the public and private partners gradually emerged. The private sector partner had required physicians to comply with three rules of action in their daily work, namely do not exceed the length of stay defined for each patient's reimbursement category, maximize the number of more 'remunerative patients', and fill the ward to full capacity. The compliance with these corporate logic's demands rendered the ward more efficient than the public facilities in the network; the LHU, as a consequence, started to adopt public sector opportunistic behaviors, claiming higher shares than originally expected by virtue of its governmental powers (Spiller, 2008). For example, it increasingly required physicians to

hospitalize more ‘complex’ patients, e.g., patients with lower rehabilitation potential but higher need for care assistance, as in the case of patients in a vegetative state. Similarly, aware that the existing facilities were insufficiently equipped to absorb the sustained flux of patients coming out of the unit, it expected physicians to take care of patients’ post-discharge aspects. Lastly, it tightened the steering function by imposing the mix of activities to be delivered by the ward, with specific regard to outpatient services, on the basis of the contingent needs. As the director of the LHU explained:

This hospital is like our young kid who’s now growing up. During his first years of life, we left him free to experiment with the new reality. But now we cannot have children walking at different paces. I mean, it would be extremely hard to justify why this hospital makes profit, while the LHU as a whole is in deficit. The hospital must help the other public facilities, as elder brothers would do (Director of the LHU, informal exchange).

Second, physicians came to perceive an increasing uncertainty on the actors entitled to perform functions pertaining to the state bureaucratic sphere, once univocally guaranteed by the LHU. Indeed, as a result of the positive performance achieved, the CEO of the hospital started to overtly and publicly affirm that the real defender of public functions, i.e., public service delivery, protection of public finances, and safeguarding the principle of patients’ free choice, was the hybrid organization, as opposed to the public partner. During a board meeting, for instance, he complained:

“There is also another fundamental issue that I think the public partner overlooks. The LHU is currently purchasing services from this hospital at a reduced rate. If the LHU decides to decrease the amount of outpatient services in this hospital, it will be forced to buy them from the private accredited facilities at higher rates. We are safeguarding public finances. (Board Meeting, 15/10/2010)”

Together, the mutually reinforcing demands and the perceived discrepancy between logic-specific functions and those designated to perform them nurtured an environment of ambiguity and uncertainty. First, physicians came to perceive fulfillment of the corporate and state contingent pressures to be more important and desirable in the short term than compliance with professional guidelines. This perception interfered with their ability to interpret the certainty of the situation and act accordingly:

Physician 6: “Patient #78 is going nowhere in terms of rehab...you know, he came here only because they [LHU] asked for it.”

Clinical Director of the Ward: “I totally understand what you are saying. However, if we hadn’t taken this patient, they would have forced us to do so anyhow. We would have then had the pressure of the local politicians, and in the end, all of our efforts would have turned out to be useless. I am the first to be annoyed by this situation, but let’s roll up our sleeves and tolerate this case for now.” (Observation journal, planning meeting 8)

Similarly, the sense of mistrust regarding the role of public sector actors as legitimate carriers of the principles governing the health care sector undermined members’ ties with their field-level

intermediaries, who were fully embedded in the public network. Over time, this created a sense of professional supremacy, yet also of isolation. As this physician recalled:

“I am totally in favor of a public health service. Public means free and universal coverage. But...you know, often in the public realm, individuals think they are allowed to become lazy. Take the example of the medical staff working in the nearby hospitals. (Interview, Physician SABI Unit 12/04/2010)”

“I was reading the local newspaper today, and there was an article on the average waiting lists for outpatient services in this area that stated: “385 days on average for a mammogram in the LHU”. 385 days...? That’s enough to die! If you call our centralized booking office today, you can set up a visit for the 1st May at the latest!” (EI 4).

Accumulation of deviant practices. In a context of institutional ambiguity and professional isolation, physicians came to experience the urgency to meet all of the contingent demands of the public and private partners. Uncertainty over the issues to be prioritized in one’s daily professional life exerted a greater pressure ‘to get all the tasks performed’ and resulted in an increased individual workload. Indeed, physicians would frequently recall staying extra hours in the ward or skipping lunch breaks to complete the duties. The following conversation captured the issue:

Physician 1: Can we start the meeting now? I need to finish in 30 minutes, do the MDT visit with a new patient, run downstairs to the outpatient clinic and come back to make a phone call to the hospice for patient #13. I will give you 50 Euros for a bite of your sandwich...(laugh)!

Physician 2: (ironic) Why are you complaining? You should know that high-specialty rehab physicians eat only once a day. I’ve heard that they will soon give us a catheter, so that we will not need to go to the bathroom and ‘lose time’ in the toilets. (Observation journal, planning meeting 7)

To speed up the process of replying to day-to-day requests, physicians started to occasionally make decisions in their daily work that were in contrast with their professional logic. Initially justified as pragmatic solutions to manage the contingent situation and ‘move forward to the next medical issue’, these decisions were only marginally contested. Furthermore, they were not perceived as openly illegitimate, being initially sponsored by the clinical director of the ward, who, by means of his overlapping membership of the different groups (i.e., LHU-employed physician transferred to the hospital as unit head), acted as an intermediary for the compliance with the diverse demands.

He [Clinical Director of the Ward] acts like a “pad”. He is a public servant working here as head of the group, he is definitely the one who suffers the most these types of pressures. He convey these pressures to us in a much smoother way. (Ethnographic interview, ID12)

Over time, professionals began to think that the deviant decision was ‘in the end, what [they] had also performed last time’. By making the contingent justifications routine, physicians came to

enact, reinforce and accumulate over four months five major practices that deviated from the professional logic's principles (Table 4).

 Insert Table 4 here

First, contrary to the outcome-based approach principle, physicians would frequently indicate in the individual rehabilitation projects the best achievable outcome in the temporal period defined for each patient's reimbursement category (n=20) and postpone the discharge of a number of cases even though the rehabilitation path was completed to ensure full capacity saturation (n=9).

Physician 1: "What is the maximum length of stay for type-1 patients, the orthopedics?"

Clinical Director of the Ward: "25 days."

Physician 1: "Is this a 'must' when I have to fill in the rehab project?"

Clinical Director of the Ward: "Well, it would be better."

Second, contrary to the principle of the bio-psycho-social unity of the patient, they would defer some of the tasks pertaining to the patients' rehabilitation to another facility or to the outpatient clinic or hospitalize the patients in two subsequent periods whenever the maximum hospitalization length had been reached (n=16):

Clinical Director of the Ward: "Any news on patient #4?"

Physician 7: "Still taking the vancomycin."

Clinical Director of the Ward: "I suggest that the first day he feels better, you discharge him and send him to hospital alpha."

Physician 7: "But with which rehabilitation goals?"

Clinical Director of the Ward: "None. However, at least he will go back to his local health unit."

Physician 7: "Well, hospital alpha would then reply that this patient has no rehabilitation goals."

Clinical Director of the Ward: "Hospital alpha is in his local health unit. It's their responsibility to find a place for this patient, not ours."

Finally, contrary to the priority-based principle, physicians would hospitalize an increasing number of patients with low rehabilitation potential, generally linked by family and political ties (n=5). This ultimately yielded difficulties in handling the rehabilitation process and the discharge procedures and triggered a procrastinating attitude among the physicians (n=21).

Clinical Director of the Ward: "Patient #7! Any news? Are we 'passively' waiting for a bed in hospital beta?"

Physician 2: "What do you mean by 'passively'?"

Clinical Director of the Ward: "That we are waiting for hospital beta to call us and tell us that they have a free bed?"

Physician 2: “Hey ... do you remember? ... We tried to call them last week and told them that it would be their responsibility to take the patient ... but then, to be honest, I was overwhelmed by other tasks and did not think about the issue anymore.”

Clinical Director of the Ward: “Alright, let’s wait a few more days.”

Whilst some of the deviant practices might have originated in the previous phases, they manifested themselves systematically as contingent responses to the resurging constraining dynamics, and their effects emerged later in the process.

Identity articulation. Physicians did not immediately perceive these practice deviations as threatening their professional identities, as these were themselves subject to articulation in the new context. Indeed, to secure a sustainable blended hybrid structure, the employment procedures of the hospital favored hiring young professionals with little or no experience in neither the public nor the private sector, and filling key hierarchical positions with physicians temporarily transferred from the LHU. As a result, most professionals were experiencing a role or career transition (Pratt et al., 2006). Institutional pressures therefore emerged in a working context where professionals were partially struggling with the task of assimilating new skills or social behaviors and were less likely to disentangle, in the short term, the deviant aspect of the practice variations.

On the one hand, young physicians, who tended to come straight from their medical residency, were advancing in their professional careers from being interns to being ‘proper doctors’. Their young ‘identity age’ (Petriglieri, 2011: 649) formed their view of what it was meant to be a physician by emphasizing ideal as opposed to lived, experienced traits. For example, in the interviews they emphasized the idea of being ‘complete doctors with a holistic view of the patient’ and an interest in ‘curing the person, as opposed to the disease’, which they regarded as being distinctive, instead, of the surgical specialty. Similarly, they underscored the importance of ‘being team leaders’, supporting the fastest conclusion of the rehabilitation project. Finally, they accentuated their therapeutic function; in their view, ‘[they] do not just prescribe pills, but actually work with the patient’. Although they expressed strong ‘generalized medical professional identities’ (Conrad, 1988), they indirectly admitted they knew little with regard to how to translate these skills into practice. As one physician explained:

I decided I wanted to become a doctor when I was 6. When I graduated, I thought I was at the end of the path – that I had succeeded. However, when I left medical residency, I soon realized that I had to start *doing* the profession. Before entering here I knew what my profession was ‘on paper’ – I had very clear ideas on what being a doctor meant to me – but I was completely inexperienced on how to actually translate it into practice. (Interview, Physician)

On the other hand, the public servants appointed as senior medical staff were learning a new hierarchical role, which entailed not only a medical professional dimension but also a managerial and trust-based dimension that led them to feel the ‘need to be accountable’ to both partners:

I have now learned that a physician is like a chair with three legs: the first is the clinical-technical leg, the second is the relational-communicational leg and the third is the managerial leg. I used to seeing my profession primarily in terms of the first leg, but now I see it through all three lenses. Indeed, I feel that the clinical side is becoming less and less predominant (interview, Clinical Director of the Ward)

Both young and senior physicians operating in the unit were thus experiencing upward shifts in discretion, either within their professional domain or by expanding to other domains, in a context of higher environmental and task novelty (Nicholson, 1984). Thus, the identity reaction was postponed as they were familiarizing with the aspects relevant to the particular social roles (Hall, 1968:447).

In sum, our first finding is that the positive performance achieved by hybrid organizations nurtures new institutional complexity as each constituent attempts to retain the payoffs of the synergy. Given the integrated nature of the collaboration, organizational members are more likely to respond with localized efforts to act in accordance with all emerging demands. The day-by-day compliance with the contingent pressures, coupled with the adaptation of the identities to the new roles, justifies why what begins as contingent response is replicated in a relatively unopposed manner.

Micro Stage 2. Reassessment

It was when the cumulative effect of practice variations outlined in the previous stage was conveyed as ‘objectified external reality’ that physicians came to realize the potential disruptive nature of the change they had unwittingly nurtured. The perception of an identity-practice integrity violation (Pratt et al., 2006) triggered a phase of identity revalidation, which entailed the rebalance of the emotional component of the members’ social identity (Tajfel, 1978). Later, professionals undertook a process of cognitive and behavioral regulation where practice variety was explicitly assessed. Ultimately, members came to consolidate emotional and cognitive boundaries and reached a point of temporary equilibrium between the observance of professional logic’s claims and the compliance with the state and the corporate demands. The misalignment between the internal members’ equilibrium and the initial organizational response triggered the adaptation of the latter to institutional complexity.

Perceived external identity threats. The turning point in the professionals’ perception of the consequences of the accumulation of deviant practices happened a few months later, when the hospital underwent a formal assessment procedure. Data on clinical activity collected as part of the procedure showed that, on average, during the second half of the year, physicians had hospitalized patients with lower rehabilitation potential, and that these patients would stay in the ward longer without achieving proper rehabilitation goals. In fact, a few indicators measuring the resumption of

the activities of daily living scored lower than the first semester and far below the target that was originally set.

In addition to the change in the patient mix, an increasing number of episodes was reported where patients and their relatives started to complain about the quality of care provided. Whilst cases of users' dissatisfaction are by no means infrequent in care settings, observational data show that these were indeed perceived by members as being unexpected:

“Patient #74 has a decubitus ulcer and is complaining about the way he is treated by the nurses. I know that our nurses have less time per patient now; it wasn't like this in the past. However, the patient is right: I visited him this morning, and he had reddened skin” (weekly planning meeting #18, February 15, 2011).

Increasingly aware of the decrease in performance and, most notably, of the perceived variation in the nature of their job, physicians began to express signs of destabilization of the emotional and evaluative component of their professional identity. That is, while they did not cognitively question their identities as physicians, they started to feel a decline in the affective commitment and self-esteem as a result of an internal assessment between their daily work practices and their identity components. For example, some questioned their role as successful team leaders:

“I do not know how to motivate my team. It is so disappointing. (Physician, planning meeting, 2010/01/30)

while others devalued their essence of being ‘complete doctors’:

“I am so frustrated. I mean, treating 1 or 100 type-3 patients does not make a difference to them (pointing to the administrative team dining in the hall). However, for me...I need to get some gratification from the activities I carry out. I should be able to start and conclude a rehab path...”

“Rehabilitating patients is a luxury currently. I feel I am doing social worker's stuff.” (researcher field notes, lunch time, observation journal, February 2011)

In sum, the negative outcomes of the accumulation of the day-to-day relatively uncontested practice variations were conveyed to individuals as external statistics. Professionals started to recognize that their assumptions about who they were, and what they were doing, were being violated (Pratt et al., 2006).

Identity revalidation. A shared sense of frustration was recognized and triggered an identity reaction. Sensitized by the clinical director's attempt to regulate the negative emotional impact of the situation, individuals came to revalidate their professional identities by employing alternative ways of restoring the emotional and affective components of these identities.

Aware that the consequences of the practice deviations could be a source of professional demotivation, the clinical director held an internal ward meeting with the purpose of sharing and collectively reflecting on the information collected. During the meeting he employed two strategies

aimed at regulating the potentially negative valence of the situation and encouraging professionals to ‘move forward’. First, he changed a situation’s meaning in a way that positively altered its emotional impact. When introducing the results of the assessment process, for instance, he framed them as an opportunity for learning:

These data are drawn from the accreditation process. Now that the process has come to an end, we should make a decision: either file it as any other bureaucratic activity we carried out in the past or use it as a way to improve our work. I suggest we go for the latter and collect indicators both on the clinical and on the organizational side.” (excerpt from ward meeting, February 2011)

Similarly, he anticipated physicians’ negative reactions by providing immediate justifications for negative outcomes that were a result of the deviant practices:

We kept this class of patients longer. Why? Three reasons. First, we hospitalized more complex patients. Second, if you [pointing to physicians and therapists] have more complex patients to treat all together, it is harder for you to manage efficiently and promptly the issues related to the hospitalization: visits, technical aids, and establishment of contacts within the other settings. Third, because we had more beds for type III patients, we gave less attention to whom we were actually hospitalizing with the risk of being dependent on the waiting list”. (excerpt from ward meeting, February 2011)

Second, he directed the attention from the negative aspects of a situation to different, positive features of the same situation to influence the emotions (Gross & Thompson, 2007). For example, he emphasized clinical indicators that had shown an increase compared to others, similar in nature, that reflected a different trend. Together, the emotion regulation strategies of cognitive change and attention deployment (Gross & Thompson, 2007) gave physicians a framework for affectively and cognitively interpreting the practice accumulation that had occurred.

Members employed alternative strategies to restore the emotional and affective components of their identities. The majority expressed active and positive feelings of alertness and care, which reinforced their commitment to their professional identity. These physicians came to show a renewed professional engagement, which was evident, for example, in the promotion of new educational activities.

“I know things aren’t going well now. There are times when I ask myself why I do all of this. The answer is always the same: neither money nor glory – only the will to cure people. The Clinical Director is right: we have to move forward”.

Others expressed passive and negative feelings of fatigue and tiredness, which partially undermined the salience of the professional identity as compared to other social group classifications, namely gender/family group and local community affiliation:

“If you work here, you just get used to thinking in terms of profession, but is this really fair? I am not just a doctor; I am a woman, and a mother soon.” Physician, interview, February 2011

“I am the coach of a rugby team. You see, my life does not end at the hospital gates. I do not want to give up that side of my life.” (Physician, interview, January 2011)

Finally, a few members expressed active and negative feelings of stress and tension, which were conveyed publicly using expressions such as ‘the violin has become untuned’, or ‘I cannot put up with this anymore’. These physicians started to recognize an inconsistency between their perceived professional identity and their ‘would be’ identity, in terms of aspects not adequately represented in their current identity, but worthy of being achieved. When these temporal professional identity discrepancies (Corley & Gioia, 2004) were coupled with the perception that the ward could not support them in achieving the desired outcome, these individuals ultimately left the hospital.

“I am a public doctor, and I have always wanted to be a public doctor. However, my idea of serving the public good through the profession entails a sense of security and stability that I feel I do not currently possess here.” Physician, interview, February 2011

Together, the aggregate of individuals’ reactions redefined the membership of the unit and aligned professionals to the same level of affective involvement. The identity reaction triggered a reassessment in practice variation.

Reduction of Practice Variation. The strong feeling of alertness prompted defensive behaviors by physicians who began to reflect and schematize the practice variation to restore the alignment with their professional identity. This cognitive and behavioral regulation manifested itself in two ways. First, members confirmed the legitimacy of ‘low deviant’ practices, i.e., those practices that enabled physicians to comply with specific demands and were justifiable in professional terms as cause-effect accounts. These were the compliance with the demand not to exceed the maximum length of stay defined by each patient’s reimbursement category and the tendency to slightly postpone patients’ discharge despite the completion of the rehabilitation path in order to fill the ward to full capacity::

You have frequently heard that patients “expire,” as if they were a type of mozzarella cheese. Well, this is not true. It simply means that there is a tariff reduction, but we are not forced to discharge them. We do that because we deem it clinically appropriate to complete the rehabilitation project in this time span. (clinical director of the ward, planning meeting #13)

Second, physicians came to discredit ‘high deviant’ practices, i.e. those practices that were considered in open contrast with the professional principles, and to develop, whenever possible, alternative solutions to these. Among the others, for example, they questioned the hospitalization of patients through non-priority based criteria:

From now onwards, we should select patients more carefully in terms of classes of priority. Try not to hospitalize patients in a vegetative state, even though we might have

pressure to do so. Be sure that patients have some type of rehabilitation potential.
(clinical director of the ward, planning meeting #13)

The result was a gradual, partial reversal of the deviant practices back to the ideal ones with the contextual sedimentation of those micro-discrepancies that did not radically challenge the professional core principles (Table 4).

Boundary re-creation. As members attempted to revalidate their professional identity and reassess their working practices, they also came to emotionally distance themselves from the sources of the pressures by remarking the ‘power to counteract’ whenever the new equilibrium could be threatened. The creation of emotional and cognitive boundaries was manifested in three social arenas. First, members frequently commented their distinctiveness internally in the ward by sharing with colleagues the assumption that ‘[they] are the ones who actually treat the patients and deserve the merits for it’. These conclusions were reinforced by symbolic cues, such as hiding patients’ gifts from the administration:

Patient #103 has gifted me a painting in thanks for the work performed. I suggest we do not show the painting to the administration; I am sure they would immediately issue a press release and embezzle all the merits, as usual. Let’s keep the gift here and hang it on the corridor. (physician, March 2011)

Second, senior medical staff started to remark both with the public and the private partners that the compliance with their requests would be linked to the resources provided and that no extra burden would be tolerated:

Clinical director of the ward talking to the Administrative director: “Now I have a panel of data to monitor my activities, and whenever you ask me to increase the activity or to provide an additional service, I can reply to you that with the resources I have, this is the maximum I can do.” (clinical governance meeting, 3/2011)

“With these data we can now go to the LHU and say that they cannot change the rules of the game while we are playing because this is what we have now” (Clinical Director of the Ward, Ward meeting, February 2011)

Third, professionals in a few occasions unveiled also publicly the misalignment between their and the partners’ position, so that outsiders started to question the positive performance of the organization:

[referring to a previous conversation] “the son of the patient was furious. He said that his mum was discharged despite the fact that the rehab project with the speech therapist was not concluded. Matthew [clinical director of the ward] replied that unfortunately the speech therapist’s job contract had expired and the administrative office had not renewed it. (...) The Administrative Director stepped into the conversation apologizing for the inconvenience, but the son didn’t seem to be persuaded. He replied loudly that he didn’t care about the internal problems of the hospital, he just wanted his mum to get

the treatment. When the son went out of the office, Matthew said that he had no intention to take the responsibility for negative consequences not linked to professionals' actions" (informal exchange, head of the marketing department, April 1, 2011)

In summary, the perceived external professional identity threats triggered members' response that started with a process of identity revalidation and ultimately generated a reduction of practice variation by discrediting deviant practices. These dynamics, coupled with the creation of emotional and cognitive boundaries, enabled organizational members to reach a point of temporary equilibrium between the fulfilment of professional principles and the compliance with public and corporate demands.

Exit point: Adaptation of organizational response

Thus far we have argued that the resurgence in institutional complexity stemming from the success of the original blending response yielded two micro processes at the individual level. First, a process of drift where individuals in their attempt to comply with public and private partners' demands came to accumulate deviant practices. Second, a process of reassessment that started with a process of identity revalidation and brought to a reduction of practice variation and boundary creation. Most notably, however, we also found that these micro processes had in turn a sway on the initial organizational response, yielding its adaptation.

Specifically, the organization shifted from a solution where the public bureaucratic logic, the private corporate logic and professional logic were blended in one integrated unit, to a solution where they were compartmentalized in two sub-units, each dealing with a particular combination of logics: the inpatient clinic operating under the public and professional logics, and the outpatient clinic under the private corporate and professional logics. We briefly summarize these events following field exit.

Physicians' partial resistance to partners' demands, with specific reference to quantity increases, potentially challenged the hospital growth strategy, as, from a private corporate perspective, it would potentially slow down activity turnover, and, from a public sector perspective, it would question unit's role as safety valve for the health needs of the local area. In anticipation of new year's budget negotiation with the LHU, hospital managers started to frame the unit as 'a problem'. During an internal meeting, for example, they presented the data of the previous year and advanced 'the question of whether the integrated structure of the unit would still be the most appropriate manage all of the services'. By showing the decrease in performance and suggesting the need to 'achieve more flexibility in replying to the LHU requests in terms of mix of outpatient activities', senior managers convinced the partners of the need to separate the unit into sub-units, thus reducing the power of that group of physicians.

According to the new organizational configurations, physicians once managing the entire unit would now be in charge of the inpatient service only. By contrast, the outpatient clinic came to embrace a more commercial orientation. From a governance perspective, it was managed by a newly hired, full-time employee physician, and no longer by a public servant transferred by the LHU. Thus, with the senior medical staff primarily subject to the firm's incentive systems, the sources of power and control came to be concentrated in the top management's hands. From an operational perspective, informal exchanges occurred several months following the exit from the field showed that the outpatient clinic quickly began to promote services under a private practice scheme, outside of the national health care system. Finally, from a revenue perspective, the sub-unit increasingly derived returns from end users, as opposed to public partner only, requiring patients to pay, or co-pay, the full charge for the service.

DISCUSSION AND CONCLUSION

Our objective in this article was to understand how work practices and social identity recursively interact in organizations that experience institutional complexity and how this interaction affects organizational responses. We studied how rehabilitation physicians experienced and reacted to novel institutional complexity by employing a mix of practice and identity reactions over the course of 10 months, and show how the restorative work triggered a adaptation of the original organizational configuration. Emerging findings reveal two micro phases, i.e., drift and reassessment, and five dynamics: practice accumulation and reduction, identity articulation and revalidation and boundary re-creation. Figures 2 summarizes and generalizes the process.

 Insert Figure 2 about here

Our findings started from the observation that hybridization solutions create novel complexity in the medium term, as logics' social referents attempt to capture the value created by the blended structure. As new multiple pressures emerge, individuals primarily react by triggering an incremental process of practice accumulation that, in the urgency of the organizational life, ensure contingent compliance with institutional prescriptions. During this stage, we contend that the contribution of social identity as mediator of deviant practice accumulation depends on the extent to which it is performed in a known role and enacted in a familiar setting. Specifically, the younger the identity age and the greater the perceived discrepancy in role/career transitions, the later the identity reaction will emerge.

Deviant professional practices become socially recognized as problematic when they produce tangible negative outcomes that infringe the work-identity integrity (Pratt et al., 2006). Individuals,

who start recognizing an objective discrepancy between their being and doing, feel a weakening of the affective commitment and self esteem and undertake a process of identity revalidation. The resolution of members' internal contradictions ultimately redefines group membership, by either renewing professional engagement and commitment in the workplace, or by resolving temporal identity discrepancies leaving the workplace. Identity revalidation informs a behavioral reassessment process on the part of organizational members, who revise practice variation by rejecting those practices that challenge professional principles and by incorporating those that enable to comply with parts of the demands without abdicating the professional principles. In the end, members re-create cognitive and emotional boundaries by distancing from the sources of pressures. If the equilibrium reached by the reassessment is no longer aligned with the original response, organizations are likely to readapt their initial strategies to avoid paralysis or break up (Pache & Santos, 2010).

The analysis makes three contributions to institutional theory. First, the study advances the understanding of the temporal aspect of organizational responses to institutional complexity (Greenwood et al., 2011; Tilcsik, 2010). Contrary to most empirical studies which assume that 'organizations enact single and sustainable responses' (Greenwood et al., 2011:351), the analysis shows that strategies are altered and gradually adapted over time. Specifically, while current literature has reached the 'common conclusion that hybridization, as a response, can successfully secure endorsement by field-level actors and, at the same time, achieve effective performance' (Greenwood et al 2011: 352), our analysis reveals that the gains achieved by the hybrid configuration contain the seeds for novel complexity in the field and thus entail an adaptation of the response at the organizational level. Thus, sustaining institutional complexity necessitates a degree of 'plasticity' (Lok & De Rond, forthcoming) whereby organizational responses are adapted to accommodate ever evolving pressures emerging from the first successful solution.

Second, we explain the temporal process by which organizational participants experience and react to complexity, by responding to recent calls for a deeper investigation of the interplay of practice and identities within organizations (Thornton et al., 2012). Indeed, prior research has tended to present practice and identity as distinct mechanisms for action, and emphasized different temporal and cumulative dynamics. The practice-based approach, on the one hand, emphasizes that individual reactions to institutional pressures emerge rather immediately, as the temporal properties of organizational life require actors to develop contingent and pragmatic solutions in the short term. Moreover, the effects of these actions manifest themselves through a slow and 'hardly conscious' (Vaara & Whittington, forthcoming), yet steady and incremental pattern which results in an 'apparently uncoordinated and uncontested' accumulation and sedimentation (Smets et al., 2011).

The identity-based approaches to institutional complexity, on the other hand, emphasize the time perspective of individuals and their reflexive awareness (Creed et al., 2010). The cumulative effect of individual actions is fuzzier and more uncertain, as behaviors are affected by the reflexive shifts in actors' consciousness deriving from their 'identity work' (Watson, 2008).

In contrast, we show that the mutually supportive relationship between practice and identity reactions triggers a rhythmic trajectory characterized by a period of larger deviation followed by a period of partial reversal. Practice-oriented agency is the primary reaction to the immediate situation of institutional pressures. Deviant professional practices accumulate until they manifestly become identity-threatening. The violation of work-identity integrity (Pratt et al., 2006) triggers identity-oriented agency which induces the attempt to revert back to the original condition. The net effect is a smaller, yet cognitively acknowledged, incremental variation in members' behaviors. Thus the study by providing a more nuanced, realistic perspective, of the temporal path through which individuals cope with and resolve institutional contradictions in the everyday professional life.

In a similar, yet complementary vein, attending to the interplay between practice and identity advances the understanding of identity as 'filter' to complexity (Greenwood et al., 2011). While previous research has emphasized the *valence* and the *strength* of the identity, we contend that an additional predictor is the extent to which it is enacted in the role and setting where institutional complexity is at play. Thus, the study complements previous research which emphasized, by contrast, the need to avoid the creation of subgroup identities (Battilana & Dorado, 2010) to ensure long term sustainability of hybrid organizations.

Third, the study contributes to emerging literature emphasizing how institutional contradictions are not simply cognitively experienced, but rather 'embodied, lived and often highly emotionally charged' (Creed et al., 2010). On the one hand, we show that the active management of the emotional component of identity (Tajfel, 1978) is a critical constituent of the identity response to institutional complexity. Whilst current literature contends that emotional experiences are managed individually by dispersed actors (Creed et al., 2010), we show that in organizational contexts leaders who recognize the emergence of identity-threats enact strategies of emotion regulation in the group (Gross & Thompson, 2007). As such, we emphasize that the creation of a collective response to institutional complexity involves the preservation of a tolerable level of shared 'emotional investment' (Voronov & Vince, 2012).

Furthermore, in accordance with social identity theory (Bergami & Bagozzi, 2000; Ellemers, Kortekaas, & Ouwerkerk, 1999), we show that the (un)successful management of the emotional component of identity affects individuals' attachment and belonging to the workplace, thus

redefining membership and boundaries. Specifically, high degrees of arousal (Seitz, Lord, & Taylor, 2007; Seo, Barrett, & Bartunek, 2004), are linked to action, either reinforcing the commitment in the workplace, if with a positive valence, or triggering the need to move, if with a negative valence.

Table 1 Data sources and use in the analysis

Data source (micro to macro)	Observations (71 meetings, 1,050 pages, double spaced)	Interviews (111 interviews, 2,205 pages, double spaced)	Supporting documents	Use in the analysis
Individual	<ul style="list-style-type: none"> • (Through the below levels) 	<ul style="list-style-type: none"> ▪ Ethnographic interviews with employees (100) ▪ Informal exchanges on a daily basis 	<ul style="list-style-type: none"> ▪ Graphic Rating Scales 	<ul style="list-style-type: none"> ▪ Investigate identity traits ▪ Acquire an emic perspective of the organization, and of members' understanding of how logics are inhabited in the organization ▪ (Reflexivity: acceptance by members)
Ward/Unit	<ul style="list-style-type: none"> ▪ Weekly planning Meeting (20), MDT -First visit(15), MDT-Follow up meetings (5) for a total of 140 patients over 6 months ▪ Daily informal exchanges 	<ul style="list-style-type: none"> ▪ Follow-up interviews with senior medical staff (3) (indirectly through the individual level) 	<ul style="list-style-type: none"> ▪ Internal Procedures on patient management and on ward activity planning 	<ul style="list-style-type: none"> ▪ Reconstruction of the set of practices and principles governing the activities of the ward ▪ Track record of the cognitive, affective and behavioral expressions, ▪ Link work practices with job outcomes
Organization	<ul style="list-style-type: none"> ▪ Board Meetings (6) ▪ Meetings for the Accreditation Process (10) ▪ Meetings for Monitoring of Procurement Activities, Budget and Trade Unions (5) negotiations 	<ul style="list-style-type: none"> ▪ Semi-structured interviews with partners (4) ▪ Preliminary interviews with senior managers (4) ▪ Informal conversations 	<ul style="list-style-type: none"> ▪ Archive of the minutes of all Board meetings (2004-2010) ▪ All Documents related to budget negotiation, code for procurement, agreements with trade unions 	<ul style="list-style-type: none"> ▪ Observe strategy making and field-level linkages ▪ Familiarize with the organizational history ▪ investigate interaction between groups ▪ Investigate organizational filters of institutional complexity
Media endorsement	<ul style="list-style-type: none"> ▪ Public events (11) 	<ul style="list-style-type: none"> (indirectly through the individual level) 	<ul style="list-style-type: none"> ▪ Press releases (September 2010-November 2011) ▪ Archival Data (newspaper articles since 2002) 	<ul style="list-style-type: none"> ▪ Track record of media perception of the organization and link with intra-organizational dynamics

Figure 1 Data structure

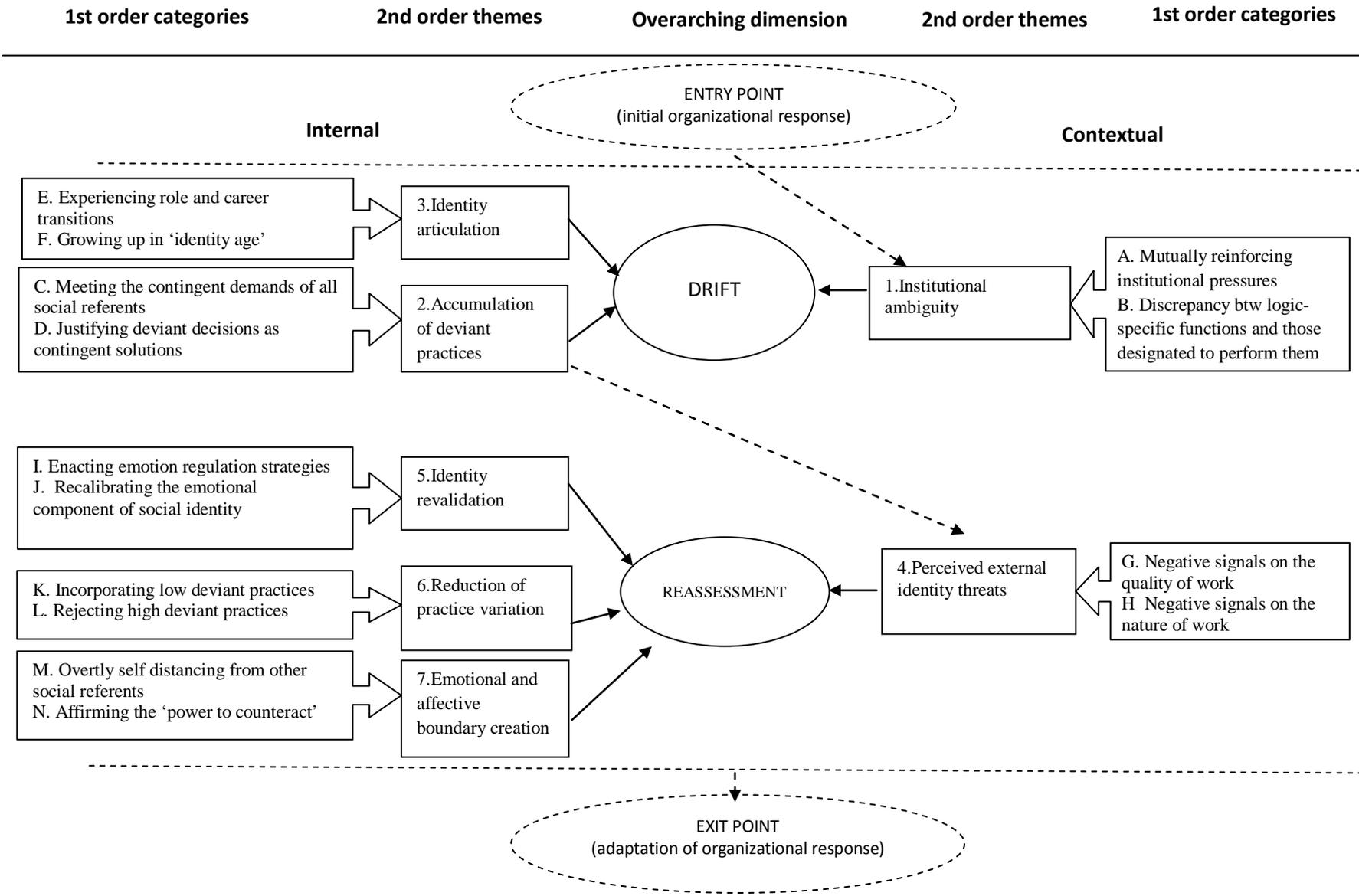


Table 2 Categories and illustrative quotes

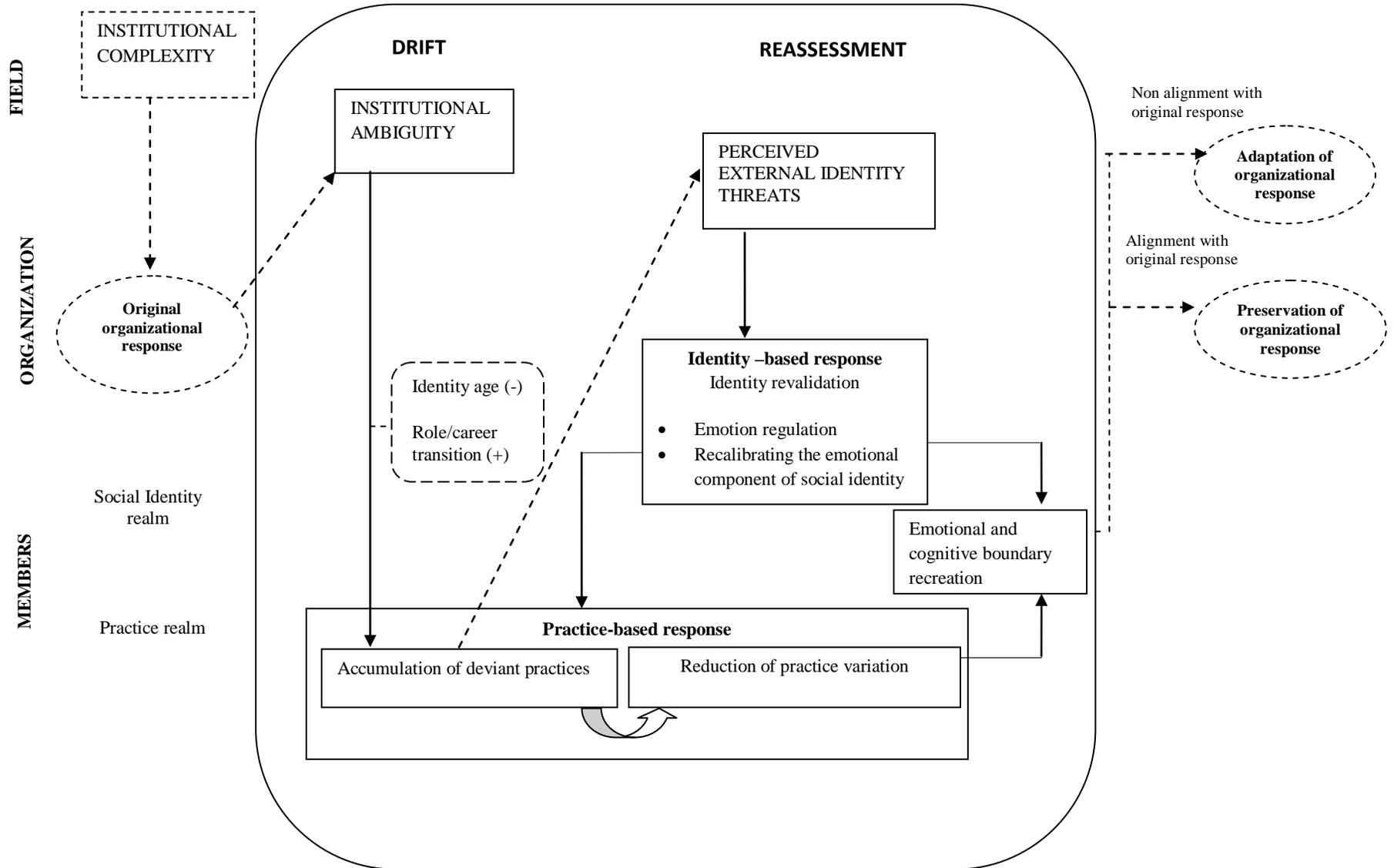
Theme	Illustrative quotations
Drift	
Institutional ambiguity	<p>I want to emphasize that we have a public service role to fulfill. If I were the manager of a private hospital and told in July that a new budget would be applied to all the NHS services delivered, I would immediately implement complementary strategies in the remaining part of the year, such as promoting out-of-pocket services. But I won't carry out these strategies here, we perform a public function. (Director General talking to public partners, Board Meeting, 15/10/2010)</p> <p>“The ward is open 24/7 the whole year. Public hospitals usually close their wards for 2 or 3 weeks, even the whole summer. I know for instance that the neurology department of hospital Beta [nearby public hospital] closes from 1st to 21st August. On the contrary, here we keep 47 beds on 31st December, 47 beds on 15th August, 47 beds on 25th December..always 47 beds!”(Ethnographic interview, ID31)</p> <p>You know, I can't understand why, in the public sector, one cannot preserve the same rigor in the long term. It is like playing poker with someone else's money. I'm not like that, although I feel myself being a career of public value principles. (Ethnographic interview, ID06)</p>
Cumulating deviant practices	<p>Clinical Director of the Ward: “Physician 5, could you tell us something about patient #3?”</p> <p>Physician 5: Well ... I will try to contact the daughter of the patient today. She was supposed to come on Sunday, but I haven't seen her. To be honest, I had so many other problems to solve yesterday. I don't know when to find the time to do these bureaucratic activities. I don't have time to actually treat my patients! I'll think about it this afternoon.” (physician, weekly planning meeting #5)</p> <p>He [Clinical Director of the Ward] acts like a “pad”. He is a public servant working here as head of the group, he is definitely the one who suffers the most these types of pressures. He convey these pressures to us in a much smoother way. (Ethnographic interview, ID12)</p>
Identity articulation	<p>I am a public servant, but I feel that I am managing the ward as if it were mine. You can't imagine how often colleagues tell me: “it seems that profits go directly in your pocket!”. They are right...I manage the ward as if I could share the profit earned at the end of the month (Ethnographic interview, Clinical Director of the ward)</p> <p>“The first day I arrived in the hospital, I was sent to the tailor's to have 4 white coats, 4 uniforms, and clogs manufactured. I mean, I know it is our right to have our own locker or white coat...but in five years of medical residency I had never seen such an availability of resources for my personal use! I remember bringing my own white coat from home, sharing the locker with the other colleagues...Whereas here, who knows how many other things I will get to learn”. (Ethnographic interview, ID 30)</p>
Reassessment	
Perceived external identity threats	<p>“This morning I intercepted a phone call of patient's #120 relatives . They wanted to talk to the external relations office to complain for the quality of care provided . I managed to calm them down. But we should be careful next time” (physician, weekly planning meeting #19, February 22, 2011)</p>

	<p>[Lunchtime in the dining hall. Physician 1 sits for lunch at the table where I am eating with the other physicians.] Physician 2: “Hi, Paul. Have you finished the MDT for Patient #3?” Physician 1: “Yeah. So frustrating ... I don’t know how to motivate the team ... that patient is literally “warming” the bed ... no rehabilitative potential at all. We are like social service workers, aren’t we?”</p>
<p>Identity revalidation</p>	<p>Director of the ward: “Well, there’s only one issue: I have noticed that for type III, the average hospitalization length has increased.” Vice-director: “It shouldn’t be a problem, though.” Director of the ward: “I am not sure—I’ve got to reflect about it. [silence] Hmmm ... well ... looking back ... we admitted a few patients in a vegetative state with no rehab potential [silence] ... and I guess this is not the only reason. I suspect that because we had increased the number of beds for this type of patient, in the end, we implicitly found it more convenient to keep them here longer, despite the rehab goals ... We now have to be careful. We should talk to the group at large.” (observation journal, January 2011)</p>
	<p>“As of today, I feel that I am “private” because I work here and I contribute to this system. But in the future I want to be there [pointing to public sector realm]. I start feeling uncomfortable about this split. I guess I should figure out quite soon who I really want to be.” Physician, interview, January 2011</p>
<p>Reduction of practice variation</p>	<p>Physician 1: “What is the maximum length of stay for type-1 patients, the orthopedics?” Clinical Director of the Ward: “25 days.” Physician 1: “Is this a ‘must’ when I have to fill in the rehab project?” Clinical Director of the Ward: “Yes, but it is absolutely enough. Lengths of stay have been defined at the national level by a team of experts, and they reflect the national average.” Physician 1: “Oh, I see ... I didn’t know that.”</p>
	<p>Physician 3: “I’d like to work more with Patient #56. I am sure that she can recover fully from the aphasia.” Clinical Director of the Ward: “Send her to the outpatient clinic then.” Physician 3: “The outpatient clinic?” Clinical Director of the Ward: “Yes, she’s granted up to 10 daily entries. She doesn’t need full-time assistance any longer. We can try that.” Physician 3: “OK, let’s hope it is as effective as the inpatient service.”</p>
<p>Emotional and affective boundary recreation</p>	<p>‘From time to time private partners ask me to ‘crack the whip’ on you because they have ‘the feeling’ that physiotherapists do not work enough in the outpatient clinic. It is time to stop discussing about feelings and start discussing about numbers. Let’s collect our own data. Shoud they complain with our performance and ask for more, we shall then reply that they had set up a goal of 11 and they cannot ask for 15 now’ (clinical director, weekly planning meeting #19)</p>
	<p>AD: “Matthew is very well-informed. I wonder how he knows all this.” [laughs] Clinical director of the ward (rather angry): “Well, very simply, I have taken an Excel spreadsheet and asked my physicians to write down, every time they hospitalize and discharge a patient, some basic clinical indicators. It is clear to all of you that this process is costly in the sense that the time physicians spend in filling in this sheet is less time spent for the patient. But the result is that now I have a panel of data to monitor my activities. And whenever you ask me to increase the activity or to provide an additional service, I can reply that, given this amount of resources, this is the maximum I can do. The same applies to the LHU.” (clinical governance meeting, 3/2011)</p>

TABLE 3
Type and occurrence of deviant practices

	Low deviant practices		High deviant practices		
	<i>Link with DRG</i>	<i>Setting fragmentation</i>	<i>Task deferment</i>	<i>Non priority-based hospitalization</i>	<i>Procrastination</i>
Professional principle and associated original practice	Principle and associated original practice: Outcome-based approach: define the “individual rehabilitation project” for each patient and set the rehabilitation global outcome	Principle and associated original practice: bio-psycho-social unity of patient: carry out the rehabilitation project in a single setting to maximize the synergies among the components of the inter-disciplinary team	Principle and associated original practice: Outcome-based approach: define the “individual rehabilitation project” for each patient and set the rehabilitation global outcome	Principle and associated original practice: Priority-based planning. Classify patients into different priority classes of on the basis of both the seriousness of the disease and the potential for rehabilitation. Preference should be given to patients with higher rehabilitation potential.	Principle and associated original practice: Priority-based planning. The role of the physician is to support the fastest conclusion of the rehabilitation project
Associated deviant practice	Associated deviant practice: Set the best achievable rehabilitation outcome in the temporal period defined for each patient’s reimbursement category	Associated deviant practice: Postpone patients’ discharge despite the completion of the rehabilitation path	Associated deviant practice: Defer some of the tasks pertaining to the patients’ rehabilitation to another facility or to the outpatient clinic. Hospitalize patients in subsequent rounds	Associated deviant practice: Hospitalize patients with low rehabilitation potential, imposed by the LHU or other facilities (family or political ties or complex patients)	Associated deviant practice: Physician’s procrastinating attitude
Micro-stage 1: Drift (September-mid January)	20	5	16	9	21
Micro-stage 2: Reassessment (mid January – April)	17	3	8	3	6

Figure 3 Emerging grounded model of the interplay of social identity and practice in response to institutional complexity



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