Constellations of Multiple Institutional Logics at Micro Level: Investigating the Practices of Physicians in the Turkish Healthcare Field

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Abstract
This retrospective grounded theory study aimed to help unveil micro-level incarnations of logics pertaining to both before and after a government-led health transformation initiative, which was introduced to an already-established Turkish healthcare field by drawing attention to the institutional logics aspect of change over time. Focusing on the day-to-day activities and practices of the ground level actors, this study mainly seeks to explore the impacts of these change initiatives on the logical orientations of the micro-level actors who translate these changes into action while getting the work done. This study allowed the researchers to identify the catalog and associated characteristics of logics that are available to the ground-level actors, and the great deal of professional autonomy and discretion they use in the selection of which logic(s) to employ under which circumstances. The results of the study reflect that professional actors with an absolute control over their professional domain can shed existing institutional templates to a great degree, and set on out on their own account to create and follow a deviant logic, which is tactfully crafted to satisfy their immediate private needs. Unraveling the micro-level practices of ground level actors as they pertain to different logical orientations substantially advances our understanding of how and under what conditions certain or various combinations of institutional logics are employed during day-to-day activities.

Keywords:
Institutional logics, Turkish healthcare field, change initiative, ground-level practices

Introduction
In institutional theory literature, a relatively recent approach has focused on micro-level processes as sources for institutional continuity and change (McPherson & Sauder, 2013; Reay, Goodrick, Waldorff, & Casebeer, 2016; Smets & Jarzabkowski, 2013; Smets, Jarzabkowski, Burke, & Spee, 2014; Smets, Morris, & Greenwood, 2012). In this new stream of research, “the focus is ... on the effects of differentiated institutional logics on organizations and individuals (Thornton & Ocasio, 2008, p. 100).

Using the useful lens of institutional logics perspective, research in this tradition has concentrated on how and under which conditions actors “manage an organizational environment at the intersection of multiple institutional fields, with distinct sets of expectations” (McPherson & Sauder, 2013, p. 166), how interdependent actors in a professionalized context interpret co-occurrence of multifarious institutional templates, and manage the resulting power relationships and politics (Currie & Spyridonitis, 2016; Reay & Hinings, 2005, 2009) identity change processes (Reay et al., 2016), and enact various balancing mechanisms (Smets et al., 2014) with relation to the institutional complexity experienced within organizations. Toward unraveling these institutional dynamics, the lion’s share of existing scholarship has either chosen healthcare as their research context (Broek, Boselie, & Paauwe; Currie, Lockett, Finn, Martin, & Waring, 2012; Currie & Spyridonitis, 2016; Dunn & Jones, 2010; Kitchener, 2002; Özseven, Danişman, & Bingöl, 2014; Reay & Hinings, 2005, 2009; Reay et al., 2016; Scott, Ruef, Mendell, & Caronna, 2000), or suggested that it should be the focus of the future institutional logics’ studies (e.g., Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011; Pache & Santos, 2013; Smets,
Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012), as healthcare organizations typically encompass institutional complexity characterized by multiple belief systems and associated practices (Currie & Spyridonitis, 2016; Greenwood et al., 2011; Scott et al., 2000) mainly occasioned by reform initiatives catalyzed by the government (Currie & Spyridonitis, 2016; Reay & Hinings, 2005, 2009) that places organizational actors in a situation in which they need to continuously combine, reconfigure and manipulate logics (McPherson & Sauder, 2013).

However, although these studies provide valuable insights, there is still a lack of clear explanation for “how institutions operate through the influence and agency of individuals” (Suddaby, 2010, p. 17) and how logics are actually manifested on the ground (Thornton, Ocasio, & Lounsbury, 2012); that is, how “organizational actors translate logics into action as they engage in everyday organizational work” while under the concomitant influence of multifarious institutional prescriptions. Notably, our understanding is even more limited in terms of the role of professional actors’ discretionary power in mediating the “institutional demands and the requirements of day-to-day activity” (McPherson & Sauder, 2013, p. 166). In this manner, more research “illuminating the relationship between agency and logics when multiple logics exist and hold potential to influence professional work … is certainly warranted” (Goodrick & Reay, 2011, pp. 405-406).

Additionally, studies conducted to date are limited in scope in terms of fully depicting individual level belief systems and associated practices (Friedland & Alford, 1991; Scott, 2001; Thornton et al., 2012) in doing or performing daily activities (Smets et al., 2012) “in the throes of everyday life,” and do not provide a fine level of granularity in terms of micro-level manifestations of institutional logics and their sub-characteristics as they apply to “institutional theory’s coalface” (Barley, 2008, p. 510). The coalface has long lain largely idle and, as a result, there is still a plenty of coal left to mine (Smets et al., 2012). Thus, there is indeed a dire need for more miners (Smets et al., 2012) to investigate how “individual actors translate logics into action and practices as they engage in everyday organizational work” (McPherson and Sauder, 2013, 166).

Informed by these voids, we aimed to make a contribution to the existing literature by exploring the reflections of institutional logics on the micro-level practices of physicians in the government healthcare organizations in Turkey. In line with the increased “corporatization” of public healthcare throughout the world (Goodrick & Reay, 2011, p. 403; Light, 2000; Salmon, 1987), in 2003, the Turkish Republic of Ministry of Health announced the implementation of a new initiative, named ‘Healthcare Transformation Program (HTP) in Turkey,’ which entailed, effectively as of 2005, enforcement of a ‘Performance-based Supplementary Payment System (PBSPS),’ all of which were primarily geared toward injection of a “business-like healthcare logic” into a healthcare field believed to have long characterized by a deep-rooted “public service logic” (Özseven et al., 2014). Thus, Turkish healthcare organizations represent a setting characterized by sustained intrusion of business principles, public service principles and increased regulatory control, resulting in heterogeneity of prescriptions healthcare professionals continually experience, confront and manage in their daily operations (Aksoy, 2007; Özseven et al., 2014). In this new era, physicians who are intensely socialized within certain professional norms, principles and values are as well required by government to operate within business-like and government principles and thus are presumed to be situated between a rock and a hard place in feeling, interpreting and managing the incompatibilities arising from the multiplicities of logics.

In this study, we aimed to understand and identify the nature and characteristics of “socially-constructed sets of material practices, assumptions, values and beliefs” (Thornton et al., 2012) in physicians’ daily performance of work; whether “new sets of material activities across actors” have emerged leading to “establishment of a new practice via institutionalization” (Lounsbury & Crumley, 2007, pp. 995-996); or whether their enactments of practice patterns or logics have witnessed any change over a period of institutional change processes (Thornton, Jones, & Kury, 2005; Thornton et al., 2012). Specifically, we sought to address the following interlinked research questions: (1) how do logics become manifest and take on tangible qualities at the individual level of analysis? In other words, how are logics enacted or actualized in day-to-day organizational activity? (2) what types of practice patterns emerge in the day-to-day activities of physicians and how might they be related to macro-level institutional orders? and (3) Do government policy initiatives or interventions implemented in an institutional context change or influence ground level actors’ logical orientations? In other words, do ground level actors’ logical
orientations change over a period of institutional change processes? By addressing with these objectives, our study proves to be rather distinctive in that it aims to provide a high level of granularity in terms of the degree and strength of which logics and their sub-elements are ‘in action’ at the coalface of physicians’ daily work experiences.

**Institutional logics perspective**

Institutional logics are commonly described as “macro-level belief systems” (McPherson & Sauder, 2013, p. 167) or “taken-for-granted social prescriptions” (Battilana & Dorado, 2010, p. 1420) that “structure cognition and fundamentally shape decision making” (Marquis & Lounsbury, 2007, p. 799). Logics “furnish the guidelines for practical action” (Rao et al., 2003, p. 796) that “predominate in an organizational field” (Scott et al., 2000, p. 170). These belief systems greatly influence individuals' cognitive schemas related their way of doing businesses, and in a way, provide meaning to their activities.

It can be stated that institutional logics perspective emerged as a response to the disconnects identified between the institutions and the actual ground level processes, activities and work. Institutional logics perspective can thus be viewed as “providing a link between institutions and action” (Thornton & Ocasio, 2008, p. 100) by offering explanations regarding the interactions between individuals and the institutions and how and in what way they impact each other. By providing a cognitive framework guiding individual behavior, institutional logics thus help explain and justify why specific means are chosen to achieve certain ends; in other words, it enables individuals to rationalize their actions to themselves and others (Bacharach, Bamberger, & Sonnenstuhl, 1996).

The main assumption of the institutional logics approach is that “the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics” (Thornton & Ocasio, 2008, p. 103). This embeddedness is reflected in a two-way ongoing mutual relationship between the logics individuals generate, and are also bound by (Besharov & Smith, 2014). Institutions, in this view, are produced and reproduced by human action, which are reflected in organizational activities, practices and procedures, which in turn shape society’s broader institutions (Smets et al., 2012). Thus, it is a very important “mediating” (Friedland & Alford, 1991, p. 242) mechanism explaining the relationship between human action and higher institutions established at the societal level.

This study explores these mediating mechanisms as they pertain to healthcare via delving into the micro-level manifestations of institutional logics in healthcare organizations as enacted by physicians, based on their “lived experience[s]” (Lawrence, Suddaby, & Leca, 2011, p. 52) during performance of their daily routines, by means of adopting a practice lens approach. In order to investigate these issues from the useful lens of institutional logics, this study first attempts to theoretically embed its arguments in literature and then proceeds to evaluate the healthcare context in which this research was carried out, and then elaborates upon the methods, findings, discussion and concluding remarks.

**Institutional logics and their enactments at micro level**

Macro-level belief systems or logics are often embodied in organizational structures and practices (Greenwood et al., 2011; Thornton, 2004), by means of permeating through the organizational field level (i.e., meso-level) down to the intra-organizational level (i.e., micro-level) where they are actively translated into action by the ground-level social actors (Goodrick & Reay, 2011; McPherson & Sauder, 2013; Pache & Santos, 2010; Reay & Hinings, 2009). In this transformation process, the effects of macro-level belief systems are echoed at the practice level, just as they do at the meso-level, thereby bringing the tensions or contradictions of those logics down to the ground level where the actual daily activities of the organization are carried out (Pache & Santos, 2013).

The ground level practices or activities are where the roots of the organizational activities reside, and
therefore they may be viewed as the ground level representation of collective organization activity or vice versa (Powell & Colyvas, 2008). In this manner, logics structure or restructure individual and/or work practices (Goodrick & Reay, 2011), which may in turn influence collective organizational activity (Smets et al., 2012). Hence, in cases where organizations are faced with logic plurality when attempting to satisfy multiple demands, so are their internal activities and practices at the ground level (McPherson & Sauder, 2013).

Scholars have attempted to explore how social actors at the ground level cope with multiplicity of logics and their associated complexities in two separate lines of companion research streams: institutional work (Bechky, 2011; Lawrence et al., 2011; Smets & Jarzabkowski, 2013; Zietsma & Lawrence, 2010) and practice lens approach (Currie & Spyridonitis, 2016; Goodrick & Reay, 2011; McPherson & Sauder, 2013; Reay et al., 2016; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012), which yielded considerable emphasis on agency used by actors in their endeavors to tactfully manage those contradictory institutional prescriptions. In these studies, however, it can clearly be discerned that the actors’ enactment of agency is not solely triggered by actors’ experience of complex institutional environments, but is due to their experiment of a specific situation with certain practical exigencies favoring adaptation of some practices over others (Smets & Jarzabkowski, 2013), or in some cases, to actors’ motivation to pursue their interests (Currie & Spyridonitis, 2015; McPherson & Sauder, 2013). According to this line of research, while interpreting and enacting a wide array of logics (Jones & Livne-Tarandach, 2008; McPherson & Sauder, 2013; Pache & Santos, 2013), actors inevitably may prioritize some interests at the expense of others (McPherson & Sauder, 2013).

During actors’ accomplishment of daily tasks, which entail ongoing ‘decision and subsequent action’ points, “the agency used by organizational and individual actors contributes to variation in how multiple logics become instantiated within organizations” (Besharov & Smith, 2014, p. 366). At the intersection of certain institutional templates, conflicts arise in terms of which logics to adopt or which logics to shed in accomplishing daily tasks, and these conflicts become the heart of the source empowering certain interest groups, thereby creating “a capacity for action” (Kitchener, 2002, p. 410). Actors encountering these problematic situations, which, at times, require a great deal of imagination and judgement in choosing the appropriate course of action, may indeed distance themselves from the expected or appropriate behaviors (i.e., the default logic), and exercise choice and pursue desirable institutional arrangements ultimately suiting their own interests (DiMaggio, 1988).

As previous institutional logics scholarship attests to (Barley, 2008; Hallett, 2010; Powell & Colyvas, 2008; Smets et al., 2012; Thornton et al., 2012), in order to understand these institutional dynamics as they apply to individual level analysis, more institutional logics research should “get closer to people and action” (Hallett & Ventresca, 2006, p. 222) as there is a “lack of attention to individual-level, practical responses to institutional complexity” (Smets & Jarzabkowski, 2013, p. 1283). The bi-directional relationship between logics and the actor instantiating them can only be informatively clarified through studying manifestations of those ground level practices in daily real-life work, which is what this study aims to accomplish. In what follows, this study “delves deeper into the dynamic patterns of complexity” currently experienced in the Turkish healthcare context, arising from multiple institutional logics, each with distinct set of institutional prescriptions (Greenwood et al., 2011).

**Institutional logics and the healthcare setting**

Interpenetration of interinstitutional contradictions into the day-to-day practices subjects organizations and organizational actors to being “increasingly exposed to multiple, and yet interconnected, institutional arrangements and prescriptions” (Seo & Creed, 2002, s. 228). Sudden changes in government regulation may be a catalyst for interinstitutional incompatibilities (Marquis & Lounsbury, 2007; Raaijmakers, Vermeulen, Meeus, & Zietsma, 2015; Reay & Hinings, 2005, 2009; Schneiberg & Bartley, 2001).

Healthcare facilities are prime examples of where such complexities are confronted by the social actors
in their daily activities and practices (Greenwood et al., 2011), following policy-driven radical revolutionary changes (Currie & Spyridonitis, 2016; Reay & Hinings, 2005, 2009; Reay et al., 2016). Recent research performed in different healthcare contexts, post government-led policy-driven initiatives, shows that healthcare facilities are characterized by institutional complexity emanating from existence of multiple, yet contradictory, logics (Currie & Spyridonitis, 2016; Dunn & Jones, 2010; Goodrick & Reay, 2011; Kitchener, 2002; Reay & Hinings, 2005, 2009; Reay et al., 2016; Scott et al., 2000).

As in the other contexts previously studied, the Turkish healthcare context, institutional evolution of which will be discussed in detail below, recently underwent a policy-driven change which brought with it its associated contradictions and tensions for the field and its organizational level referents (i.e., physicians) (Aksoy, 2007; Özseven et al., 2014).

The Turkish healthcare system has had a long and challenging journey since the establishment of the Turkish Ministry of Health (MoH) in 1920. As years passed, the goals, mission and applications of the MoH in Turkey has also changed in line with the social, cultural, technological, financial, political and environmental changes affecting the strategies, policies and provision of healthcare. Until the 1960s, the MoH reflected dedicated orientations toward principles of state policy in terms of healthcare, and its mission was to fight the communicable diseases the wars in the earlier periods caused, and also to restructure and improve the healthcare system, which was in an extremely poor state, across the nation. With enactment of the 1961 Constitution, the government strengthened and solidified its role in terms of ensuring individuals’ healthy state physically and spiritually by delineating healthcare as a non-transferrable and indispensable basic right for individuals.

In the later parts of 1970s and the beginning of 1980s, during which neoliberal views and policies gained accelerated momentum in the world, the Turkish MoH’s perspective in terms of how Turkish healthcare should be managed started to change progressively toward adoption of those neoliberal views (Elbek & Adaş, 2009; Karasu, 2011). In this new trend, the governments started adopting strategies to gradually open the (until then) government-managed and -owned field of healthcare to private sector by means of commercialization of public healthcare. The beginning of the single-party rule period of the Republic of Turkey in 2002 brought with it political stability, which facilitated policymaking and enforcement regarding healthcare reforms the previous governments failed to implement through completion. The years spanning 2002 to present witnessed that with the consistent political power the government possessed, as well as the financial aids received from the universal actors, the reform stages were implemented one after another without any hiccups, under the name of a ‘health transformation program’ (Bulut, 2007). These years also witnessed a significant growth in the number of private healthcare facilities trickling into the system. For instance, while the proportion of private hospitals in the total number of hospitals was 23 percent in 2001, it progressively increased through the years and reached 37% in 2013.

With the adoption of the HTP in 2003, and subsequently PBSPS in 2005, healthcare system was completely redesigned and it was converted from a government-managed field to a field dominated by business principles, whose characteristics in the Turkish healthcare context include, but are not limited to: employment of personnel under contracts with stipulations relating to certain performance criteria (versus employment under government employee status), outsourcing (ancillary services being outsourced to private sector), public-private partnerships (in which government assumes responsibility only in clinical services and the construction of health facilities, delivery of ancillary services and non-clinical services, and operation of commercial spaces are transferred to private sector in return for lease of those buildings and services to government for a period of up to 49 years on a yearly payment), autonomization, corporatization and privatization of public hospitals (public hospitals being converted to business enterprises with annual budgets and performance goals), and finally, establishment of a “payment and rewarding system to encourage health workers to perform efficient and qualified healthcare services” (Turkish Republic Ministry of Health, 2008, p. 7).

In sum, various different orientations were reflected by the Turkish MoH during the challenging journey of healthcare policies and programs devised and implemented in Turkey. In the initial stages of the Republic of Turkey, individuals were regarded as “social citizens” (Kartal, 2009, p. 23) and priorities and interests of the entire society were guaranteed to be protected by the Republic of Turkey. Thus, the years spanning 1920-1980 were heavily characterized by state principles. Business principles were not at
all characterizing the healthcare system in this period. In the period spanning 1980 to 2002, however, the
government laid the groundwork for commercialization of public healthcare through the legislations
enacted, but without proper implementation due to political instability and financial difficulties. In these
years, healthcare system was under very little influence (only subtle shades) of business principles, but
very strong influence of state principles remained effective. Following 2002, however, the one-party rule
dominated the political arena and further legislations were steadfastly enacted toward commercialization
and corporatization of the public healthcare system with prompt and decisive implementation stages.
Specifically after implementation of the HTP followed by the PBSPS, from the perspective of the
government, individuals began to be viewed as “consumers” (Kartal, 2009, p. 40) in their relationships
with the government (just as market principles dictate), and thus the years spanning 2002 to present, when
viewed from the government’s perspective, were predominantly characterized by business principles
(very strong influence) with relatively lower influence by state principles.

As can be seen, the Turkish healthcare context is a perfect fit for the study of institutional logics from
a practice level perspective, since it has experienced considerable policy-driven changes, resulting in
variations in institutional logics, yielding contradictions and tensions experienced by physicians in their
daily practices (Aksoy, 2007; Özseven et al., 2014). Physicians, who are presumed to hold strong ties to
their home group logics (i.e., medical professionalism) by means of their socialization, orientation and
education (Currie & Spyridonitis, 2015; Reay & Hinings, 2005, 2009; Reay et al., 2016), are challenged
with conforming to business principles (i.e., effectiveness, efficiency and customer service) while under
the concomitant influences of public service considerations in accomplishing their daily tasks (Özseven
et al., 2014). Within such a context, it is important to understand and explicate whether physicians
exercise agency in reconciling multiple institutional prescriptions or prioritize some interests at the
expense of the others, and if so, what type of practice patterns may be associated with these logic
(re)combinations or interest-seeking endeavors, which logic(s) could these practice patterns be
representative of, when viewed collectively and have any logic shift(s) or transformations in relation to
physicians’ interpretation and enactment of various institutional frame(s) materialized during their
performance of daily routine tasks over a period of time (i.e., before and after 2005, henceforth referred
to as Era 1 and Era 2, which is our historical marker for policy change initiatives).

Research Method

We attempted to craft a research design that best suited to most appropriately explore the research
questions posed in this paper and to ultimately facilitate achievement of the goals of this study. The fact
that the first author is well-versed and has been professionally involved in the Turkish healthcare system
for the past twenty years has proved extremely beneficial not only in the development stages of the
research design, but in the entire research process as well. The first author not only possessed
an extensive prior insight in terms of the dynamics of the Turkish healthcare field, but he also had prior expertise in
professional medical coding (the author gained his certified professional coder diploma from the
American Academy of Professional Coders, UT, USA, in 2004), which also facilitated accomplishment
of the qualitative data analysis stages. The first author’s involvement in and constant interactions with the
ground level actors of the healthcare field allowed him to gain extensive insight into the institutional
complexities experienced in the research setting and the dynamics of the healthcare system as a whole.

We investigated both the historical evolution of Turkish healthcare leading to the HTP and
subsequently PBPS by analyzing the steps the Turkish government has taken to put into effect the
initiatives required for enactment of these programs from 1920 to present and the interaction or clash of
logics ground level actors operate under, resulting from the complexities these changes may bring about.
During this timeframe, the government espoused different institutional logics under the influence of
broader dynamic global complexities, which in turn significantly affected how ground level actors should
view the reflection of, and operate under, these institutional complexities in carrying out their daily
activities. Institutional complexities create critical contexts (Pettigrew, 1990) warranting in-depth
explorations to understand their varying dynamics, conceptual underpinnings and reflections on the
parties that are exposed to them. Hence, untangling and thereby making sense of the institutional
complexities experienced by organizations and organizational actors requires a research approach which should be ‘exploratory in nature’ (Jarzabkowski, Matthiesen, & Van de Ven, 2009).

In this exploratory study, we adopted a qualitative approach with a grounded theory design (Glaser & Strauss, 1967; Strauss & Corbin, 1994, 1998) to investigate the real-world perspectives and experiences of physicians through processes of change. Grounded theory research employs an emergent design in which a comprehensive analysis is performed in a systematic fashion via a process of continuous interplay of data collection, analysis and purposeful selection of informants with rich information, which collectively contribute to advancement of development of theory (Strauss & Corbin, 1998). Consequently, adoption of grounded theory design allowed us to develop an explanatory model (substantive theory) which sought to outline the relationships among concepts and set of concepts as they relate to human experiences and behavior. Throughout this study, our primary goal was to "write about concepts, not people” (Glaser, 1978, p. 134, emphasis in original). By means of adopting this method, we were able to have a fine-grained look at the way physicians made sense of their world, carried out their practices, and interpreted their role as a physician. The data, grounded in the accounts of physicians, arising from this research provided a rich foundation on which the substantive theory established is based.

**Data Collection**

Data collection and analyses were accomplished concomitantly, but for the purposes of providing clarity for this paper, data collection efforts are reported under this subsection. Data gathering was not a linear process and was driven by the inductive and interpretative method being employed. During all phases of data collection protocol, we continually and carefully examined whether the analyses of newly collected data provided consistent or similar categories and/or themes or whether new patterns emerged. Data collection continued until diminishing returns from analysis of each new data collection (i.e., to the point where the overlaps and consistencies [i.e., saturation] in the participant accounts began to emerge as a more thematic and abstract story) were being achieved and that newly collected data confirmed findings from previous data (Charmaz, 2008; Glaser, 1992).

Data collection consisted of archival documents (from 1920 to present), observations and interviews (from 2015 to 2016) and was conducted as part of a dissertation project. Data collection was accomplished in three stages. In the first stage, a combination of archival and interview data was collected to establish a baseline understanding of the healthcare field and its dominating rule and belief systems from a policy making perspective. Accordingly, the first author collected archival data regarding the legal environment, in which healthcare was embedded. Toward this aim, the first author collected all available material regarding Turkish health system such as law texts (22), decree law texts (4), directives (3), five-year development plans (10), Turkish Grand National Assembly Minutes of Proceedings (2), and memorandums (2) for the duration spanning 1920 to present. Additionally, the first author conducted interviews, lasting from 45 to 120 minutes with two policy leads from the upper echelons of the Turkish government. The aim of collection of archival and interview data was to obtain a deep and broad understanding of evolution of the Turkish healthcare, and to thus improve and strengthen credibility of our data (Miles & Huberman, 1994).

Determination of the structure of the sample for the interviewees in a way that it socially represented various views on ground level cognitive frameworks and associated practices was a formidable task. To address this issue, we had some starting points. The first one was that how physicians may interpret and enact their social world may be dependent upon their specialty in medicine. The second was that these interpretations and enactments may be influenced by physician’s gender. The third one was that professional experience may also affect how they absorb and reflect those cognitive structures in their everyday practices, and finally the fourth being that those interpretations and enactments may be influenced by the cultural and political contexts (i.e., specific organization). In order to address these factors, we ensured that physicians from various (almost all) specialties were included in the study. These specialties included orthopedic surgery (4), general surgery (3), cardio-vascular surgery (5), brain surgery (3), thoracic surgery (2), pediatric surgery (3), plastic surgery (2), ear, nose and throat surgery (3), obstetrics/gynecology (3), anesthesiology (3), urology (3), ophthalmology (2), endocrinology (2), pulmonology (3), nephrology (2), gastroenterology (3), neurology (2), dermatology (2), pediatrics (2),
mental health (4), general practice (3), family medicine (3), and emergency medicine (2). Male and female physicians were integrated into the study as equally as possible (36% female and 64% male). Special care was taken to ensure a wealth of professional experience was represented in the sample, and toward this aim, only physicians with a certain level of experience was included in the research. Accordingly, the physicians participating in the study were professionally involved in provision of healthcare for 21 to 44 years. In order to eliminate the issue of context-specificity, researcher purposefully selected participants from five different government hospitals.

The interview schedule involved an exploratory phase in which the first author conducted extensive interviews with ten well-experienced physicians who had been in practice for over thirty years through purposeful sampling strategy. These physicians were particularly selected by the first author (using his own network links) for interviews due to their experience in the public healthcare system for at least thirty years. The length of interviews ranged from two hours to four hours, and these interviews were repeated three times with each interviewee. At the beginning, data were gathered by means of conversational interviews to enable participants to describe their experiences and observations in their own words and from their own perspective. Interviewees generally chose their own starting point; however, if a further prompt was requested, then elaboration on the possible influences of recent set of changes on delivery of healthcare, which began with the implementation of HTP and PBSPS, was suggested. This approach was chosen so that interviewees would have the maximum flexibility to (re)construct their experience of new policy implementation as well as reflect on events affecting practice of medicine in a way that made sense to them. Later interviews, however, increasingly and progressively focused on whether the physicians felt a difference in terms of the way in which they delivered healthcare in Era 1 and Era 2 in their own regular course. Interviews were channeled into that direction via accounts provided by the participants as “We used to do things differently before we were asked to be a physician and a businessman at the same time,” “If you asked me how I am doing it now (referring to post policy implementation) I would have said it differently,” or “We have changed a lot. I mean the way we provide healthcare seems to be way more different than how we used to do it in the old days.” In general, during the interviews, depending on the courses of the interviews, various open-ended questions were addressed (by adding the clause, “could you please elaborate upon this subject?” including but are not limited to: “how do you define your work as a medical professional?” “what do you believe as important in the performance of your work?”, “are there certain principles you abide by or draw from while performing your work,” “have you experienced any differences in terms of how you view your duties and responsibilities in any time in your career as a physician?” and “do you believe the values, belief and rule systems of practicing medicine have in any way changed within the past 30 years?” The goal of these interviews was to gain a comprehensive insight into the ground level incarnations of logics as well as whether the values, belief systems and/or work practices of the ground level actors had, in any way, been modified in line with the implementation of the HTP and PBSPS over time.

Next, the first author conducted semi-structured interviews with fifty-four physicians currently employed at five different public hospitals. This stage also involved recruitment of participant physicians into the study through snowball sampling strategy along with a shift from purposeful sampling to theoretical sampling. All interviews were face to face and took place at the workplace location of the interviewees. These workplace environments ranged from pre-op or post-up preparation areas (mainly for surgeons and anesthesiologists), practice offices, examination rooms, procedure rooms, conference rooms and break rooms within the hospitals, which allowed the researcher to make observations in terms of the nature and conditions of healthcare provided by the physicians participated in the study. During the interviews, the first author utilized an interview guide with an open-ended approach in an effort to (1) elicit answers fully from the perspective of the study participant, (2) progressively gain deeper understanding of the context and meaning of the responses provided through various forms of probing, and to (3) steer the conversation in those channels that lead to discovering the culture, norms, belief systems and experience of the respondents in their own words.

During interviews, extensive and detailed notes were taken verbatim. The hand-written notes were transcribed onto Word documents (Reay & Hinings, 2009) immediately following the interviews. These data were supplemented with unobtrusive observations, which were also hand-transcribed as field notes, which later were integrated into the theoretical memos documented. Collected interview notes and memos
were reviewed after each interview and before the next interview to assist in building knowledge and understanding of the nature of logic representations at the ground level. Interviews and memos made after each interview were followed up in subsequent interviews, thus iterating perceptions to gain better understanding. Interviews ranged in length from one hour to three hours, but in a few rare cases, to five hours. The text material encompassing archival documents, interviews and memos reviewed amounted to a total of 6,416 pages.

Data Analysis

Data analyses involved iterative and reflective cycles and there have been a constant “flip-flop process” (Pidgeon & Henwood, 1996, p. 88) between the collection of data and simultaneous data analyses, and data and emerging theoretical conceptualizations (Bulmer, 1979; Locke, 2001; Strauss & Corbin, 1990). Data analyses encompassed the following major steps.

Step 1. Developing first-order codes and provisional categories

We began sweeping through the data and assigned all meaningful quotations, and then drew on common statements to develop our first-order codes via open coding (Strauss & Corbin, 1998), which served as bases for formation of our subsequent provisional categories. We performed multiple waves of data analysis to constantly compare newly-collected data with the existing data to further analyze emerging concepts with reference to communalities and differences, generate patterns, and to ultimately develop relationships amongst preliminary patterns and codes. This analysis stage continued until the point of coding saturation, which is the stage in the data analysis process where no further codes are necessary to categorize the data (Glaser, 1965).

Step 2. Integrating first-order codes and developing unified categories

In this stage, our primary aim was to find patterns and relationships in the data for further refinement and organization of the established open codes under more generic categories, the process of which has been defined as ‘axial coding’ by Strauss and Corbin (1990) and ‘substantive coding’ by Glaser (1998). We attempted to sift through the data in order to determine the adequacy of the first-order codes and provisional categories (Charmaz, 2006, s. 57), which, by means of further cyclic analyses, we later condensed under more unified categories. This stage involved linking of saturated codes and preliminary categories to theoretical core categories.

Step 3. Clustering theoretical categories under overarching themes

This stage involved progression of categorization to the highest level of abstraction by means of reduction of categories based on their underlying uniformities, which corresponds to the ‘selective coding’ stage in qualitative analysis as identified by Strauss and Corbin (1998). In this stage, our efforts were geared toward reduction of categories which resulted in smaller set of saturated concepts, through paring off non-relevant categories and integrating categories into higher level abstractions in the form of overarching categories or themes, which were forced by constant comparison procedures. At this point, we also consulted relevant literature to ensure there was a close correspondence between extant theory and data and that our emergent theory was applicable to a wide range of situations with our ultimate aim being achieving parsimony in the number of conceptualizations and applicability of the scope of the theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Step 4. Confirmation of aggregate theoretical dimensions

Following these in-depth data analyses procedures involving moving the essence of the data from the lowest level abstraction to highest level of abstraction, we were able to identify and explain the practice level manifestations of logics and their subcharacteristics. Next, we wanted to confirm our findings using
various information sources. Informed by the fact that local new or key informants, referred to as “confidants,” who are built into the study as sources of verification, can act as judges, evaluating the major findings of a study (Miles & Huberman, 1994, p. 275), we met with four other physicians with over 30-year experience in the sector to review and discuss our observations and findings. We also consulted leading institutional logics scholars in the Turkish academic community for confirmation of the identified logic matrix. In this manner, the analyses pertaining to the identification and description of logics and their sub-elements were cross-validated via consultation of various actors (Pache & Santos, 2013). The physicians consulted were actively involved in Turkish healthcare for the periods pertaining to Era 1 and Era 2. Similarly, institutional scholars consulted were deeply-involved in the development and progress of the institutional logics literature.

Data were collected from these key informants through confidential interviews and the main objective was to improve the credibility of findings and secure a breadth of information and insights from well-experienced physicians with high level of expertise and leading scholars in the field, who might have complementary, inconsistent or even contradictory perspectives (Hurley, 1999). Though not to the fullest extent, the analyses undertaken were also triangulated with research material describing various institutional contexts of the health sector (Özseven et al., 2014; Reay & Hinings, 2005, 2009; Reay et al., 2016). At this stage, the ground-level instantiations of logics and their associated practices pertaining to the healthcare organizations under study were successfully identified (see Table 1 under Findings section).

Step 5. Numerical evaluation of findings

Our main endeavor was to identify the observable practices in relationship to the theoretical characteristics of logics in Era 1 and Era 2. To achieve this aim, we conducted subsequent rounds of analyses on the data. By means of these analyses, we were able to measure the strength of each logic attribute by evaluating the extent to which the physicians’ daily practices as indicated in their accounts were consistent with the practices implied by the identified practices pertaining to the sub-characteristics of the logics (Goodrick & Reay, 2011). These analyses enabled the researcher to compare the already-identified behavior prescribed by each logic with the actual behavior enacted or invoked (Pache & Santos, 2013) by the physicians on the ground. Then, we, by means further analyses of the data, conducted counts of the occurrences of themes (Dey, 1993; Maxwell, 2010; Sandelowski, 2000, 2001; Sandelowski & Jones, 1996; Sandelowski, Voils, & Knafl, 2009) in terms of logic sub-characteristics enactments or invocations (Goodrick & Reay, 2011; McPherson & Sauder, 2013) for the two eras being studied. We then arrived at numerical evaluations in terms of the closeness of the day-to-day practices to the identified logic characteristics (Goodrick & Reay, 2011) by assigning a value of 1 in cases where a logic characteristic was invoked (McPherson & Sauder, 2013).

Next, we computed the strength of each logic characteristic, over a scale of 1 to 5 (Goodrick & Reay, 2011), where 1 indicates very low consistency and 5 indicates very high consistency, based on the aggregate total of the logic characteristics invocations grouped under each overarching logic for the two specified eras. We also reflected full depiction of logic evaluations for the two eras by means of calculating the mean value for each logic attribute within a logic for each period (Goodrick & Reay, 2011).

Findings

In order to address our research questions in a streamlined fashion, we organize our findings around two topics: ‘nature and characteristics of logics enacted at the coalface’ and ‘ground-level logic invocations through processes of institutional change.’

Nature and characteristics of logics enacted at the coalface

The results of our analyses revealed that physicians were indeed under the influence of logic plurality while performing their day-to-day duties and responsibilities, which indeed confirmed that logics exert
substantial influence on which practices organizational actors should adopt (Goodrick & Reay, 2011; Jay, 2013; McPherson & Sauder, 2013; Murray, 2010; Pache & Santos, 2013; Reay et al., 2016; Smets et al., 2012; Thornton et al., 2012). However, our findings reflected that physicians' daily practices were guided by not only the logics of the higher societal orders, defined as family, community, religion, state, market, profession, and corporation (Besharov & Smith, 2014; Friedland & Alford, 1991; Thornton, 2004; Thornton et al., 2012), or their derivatives such as business-like logic (Özseven, et al., 2014; Reay & Hinings, 2005, 2009) and medical professionalism logic (Reay & Hinings, 2005, 2009) as suggested by the imprinting institutional logics literature, but they were also significantly steered by a homegrown logic, which was generated and espoused by the physicians over a period of time. Our analyses reflected that physicians were under the quadruple influence of medical professionalism, business-like, state and ‘rogue logics’ while performing their routine daily practices. Table 1 summarizes the logics and their associated characteristics mobilized by physicians in their ground level practices where “institutional myths are coupled to actual work” (Hallett, 2010, p. 56). Table 2 provides further granularity in terms of the underlying text segments supporting the structure of the themes identified for each logic subcharacteristic.

Medical professionalism logic derives from the societal level professional logic. In the medical professionalism logic, the content and organization of work is determined and controlled only by the profession (Friedson, 2001; Reay & Hinings, 2005, 2009; Reay et al., 2016). When guided strictly by medical professionalism logic, physicians would practice medicine autonomously or in partnership with other physicians with relevant expertise and experience. Physicians would practice medicine solely relying on abstract knowledge, abiding by a moral code of ethical conduct, the principles of Hippocratic Oath. Patients and the rest of the healthcare team (i.e., nurses, technicians and other professionals) are expected to follow physicians’ orders and medical direction without question. Physicians guided by medical professionalism logic would maintain complete and uninterrupted authority, autonomy and control to provide medical care in a way that only they deem most appropriate.

State logic is one of the core institutions of the society. State logic refers to “the basic orientation of the state in securing social and political order” (Greenwood, Diaz, Li, & Lorente, 2010, p. 523). In viewing state logic through the lenses of highly professionalized organizational actors, governments are regarded as entities “taking direct responsibility for professional work as opposed to ratifying professional desires” (Goodrick & Reay, 2011, p. 379). In state logic, physicians are expected to provide healthcare services with an orientation toward governmental rules and standards. Physicians are employees of the state (Goodrick & Reay, 2011) and thus would see themselves as representatives of the government while providing healthcare with an ultimate obligation and aim to provide equal service for all citizens and also strive to improve general health of the population (Reay et al., 2016). Government officials hold the authority and responsibility to ensure the appropriateness of medical care provided, and physicians are expected to conform to the standards set forth by the government while organizing and delivering healthcare.
**Table 1. Institutional logics and their associated characteristics at practice level**

<table>
<thead>
<tr>
<th>Nature of Demands</th>
<th>Aggregate Theoretical Characteristics</th>
<th>Medical Professionalism Logic</th>
<th>Business-like Logic</th>
<th>State Logic</th>
<th>Rogue Logic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief Systems (which core values and/or cognitive structures guide behavior [i.e., practices])</td>
<td>Basis of Goals and Mission</td>
<td>Mission Orientation</td>
<td>Provision of healthcare services with an orientation toward medicine</td>
<td>Provision of healthcare services with an orientation toward business principles</td>
<td>Provision of healthcare services with an orientation toward governmental rules and standards</td>
</tr>
<tr>
<td></td>
<td>Goal Focus</td>
<td>Treatment</td>
<td>Effective and efficient treatment</td>
<td>Treatment as a social right</td>
<td>Treatment as means to maximize private revenue</td>
</tr>
<tr>
<td></td>
<td>Definition of Target Audience</td>
<td>Patient</td>
<td>Consumer/customer</td>
<td>Government healthcare beneficiary</td>
<td>Commodity</td>
</tr>
<tr>
<td></td>
<td>Definition of Own Status</td>
<td>Healer-professional</td>
<td>Stakeholder/Profit partner</td>
<td>Public servant</td>
<td>Rogue Intrapreneur</td>
</tr>
<tr>
<td></td>
<td>Service Orientation</td>
<td>Service Characteristics Conception</td>
<td>Medicine-based service</td>
<td>Market-oriented service</td>
<td>Public service</td>
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<td></td>
<td></td>
<td>Quality Conception</td>
<td>Physicians’ prerogative to define</td>
<td>Service is defined quality to the extent it is commensurate with generally-accepted quality standards</td>
<td>Service is deemed ‘appropriate’ to the extent it is commensurate with bureaucratic or legislative requirements</td>
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<td></td>
<td></td>
<td>Service Organization</td>
<td>Physician-centered</td>
<td>Consumer-centered</td>
<td>Bureaucratic rules-centered</td>
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<td></td>
<td></td>
<td>Information Provision Role</td>
<td>Instruction provider</td>
<td>Information provider</td>
<td>Documentation provider</td>
</tr>
<tr>
<td></td>
<td>Ground Level Practices (as means to pursue core values)</td>
<td>Professional Role Relationship</td>
<td>Professional information exchange- and cooperation-based practice</td>
<td>Individual and autonomous practice</td>
<td>Hierarchical- and division of labor-based practice</td>
</tr>
<tr>
<td></td>
<td>Success Criteria</td>
<td>Physicians’ prerogative to define</td>
<td>Performance point</td>
<td>Performing in accordance with laws, rules, procedures, duties and responsibilities</td>
<td>Highest private revenue generation</td>
</tr>
<tr>
<td></td>
<td>Control of Work Processes</td>
<td>Quantitative Service Assessment</td>
<td>Professionally autonomous</td>
<td>Performed regularly by management and inspection committees</td>
<td>Performed occasionally by state officials</td>
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<tr>
<td></td>
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<td>Theoretical Subcharacteristics</td>
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<tr>
<td>Mission Orientation</td>
<td>We are supposed to perform our work with a strong attachment to our professional norms and values and Hippocratic Oath</td>
<td>This is a business and we must protect the interests of this business. While we provide healthcare, we must take into consideration our organization’s benefit and profitability</td>
<td>In a healthcare system completely designed by the government, I do not think you have a choice in whether you need to work in line with how government wants you work. We are being paid by the government and thus comply with the laws and rules of the government</td>
<td>I developed a philosophy for my own ... and I am performing according to this philosophy ... I have to think about my financial welfare as well ... when we think about majority of the physician practices, we see major deviations from Hippocratic Oath and our professional values and norms ... those values are now sort of a matter of derision for us. The majority of physicians have totally ignored professional ethics</td>
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<tr>
<td>Goal Focus</td>
<td>Our focus as a physician is to heal our patients. This focus has never been ignored; it has always been at the forefront. It is in the fundamentals of practicing medicine</td>
<td>To me, what is more important is to be able to provide the optimal as well as most cost-effective treatment.</td>
<td>We see more patients and that means more patients are being healed. Of course, this has some positive effects on the improvement of health of the overall society</td>
<td>The main focus is to generate as much private revenue as possible. Physician uses the secrets of his profession to reach that goal. Physicians have an ‘only I have the knowledge and thus the power’ type mentality</td>
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<tr>
<td>Definition of Target Audience</td>
<td>Of course they are being viewed as patients by physicians. They come to you with hopes that their illnesses will be cured</td>
<td>We need to satisfy the population we provide healthcare services to. That is how you can win their patronage. So, the patients we serve are our customers whose needs we must satisfy</td>
<td>They are our citizens entitled to receive government healthcare services</td>
<td>Patients are now viewed by us as commodities; we view the patient as a vehicle, a commodity, by means of which we will reach our aim, and that aim is to gain the most possible private revenue</td>
<td></td>
</tr>
<tr>
<td>Definition of Own Status</td>
<td>We are physicians whose aim and role should be to free our patients from any disease and ailment, keeping in mind our conventional professional norms and values</td>
<td>We are considering ourselves as profit partners; how can we think otherwise? The more this enterprise makes profit, the more my share is out of that profit</td>
<td>We are employed by the government. We are a professional group working under the government umbrella and serving the public</td>
<td>I really do not know what our status is as physicians at this time. I cannot say we are performing as physicians because physicians have long ignored ethical considerations while practicing medicine; I want to say that we are profit partners, but cannot see physicians as profit partners as we are only sharing the profits of this enterprise, and not feeling any obligation to share the risks involved with the operations of the enterprise, and thus we do not feel the responsibility of a regular stakeholder or profit partner. We are not government employees either because government employees are obligated to protect public interest; patients, in my view, are medically miserable. All we are concerned about is protecting our own interests while enjoying the benefits of being a government employee.</td>
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<tr>
<td>Theoretical Subcharacteristics</td>
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<tr>
<td>Service Characteristics Conception</td>
<td>The service we provide is essentially a healthcare service; a very sensitive service, and it should be viewed as that, nothing else</td>
<td>It [healthcare] is completely an individualized market service now. There are enormous profits in this business; similar to the profits realized in the private sector</td>
<td>At first sight, it looks like you are only treating the individual. But in the whole scheme of things, you are actually providing a service to the public. Why? Because that person is gained back to the society as being a healthy individual and that way you have actually protected and improved public health</td>
<td>When you consider the physicians’ main aim being making money out of it, and not curing; then you see that it is a service practiced just for that purpose</td>
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<tr>
<td>Quality Conception</td>
<td>What is important for us is the healing of patient. We have spent our whole lives in learning and practicing this profession. Administrators are of course thinking differently. What is important for us is not those so-called quality standards, or in other words the make-up, but to restore the health of the patient. Quality healthcare service is one that enables the fastest and comfortable healthcare recovery and the physician is and should be the sole authority determining the properties of those services.</td>
<td>There are some quality criteria set forth by the management and we, as physicians, have been striving to comply with those criteria … Everything we do now is associated with a specific set of guidelines or instructions, which we are supposed to follow</td>
<td>… but, all healthcare-related services have to be in line with the government rules and directives. If everything were in line with the preset standards, then I guess you would call it a quality service</td>
<td>Quality? Who cares? You cannot show me a physician who is truly concerned about the quality of care. For physicians, quality service is the most private revenue earning service</td>
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</tr>
<tr>
<td>Service Organization</td>
<td>Physician directs the entire process of the course of the treatment. It is completely under the control of the physician</td>
<td>In the past, whatever the physician said would be the rule. Now, the most important thing is patient satisfaction … there has truly been a radical change in the dynamics of delivery of healthcare</td>
<td>We must organize the services we provide around the rules and procedures; you cannot do otherwise; you are essentially a government employee</td>
<td>The only and most important thing for physicians while coordinating care and selection of a particular course of treatment is the private revenue it will bring to the physician</td>
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</tr>
<tr>
<td>Information Provision Role</td>
<td>We tell the patient ‘I will cut [operate on you] you tomorrow, and the patient can never ask why they are being operated on or whether there are any complications involved in the procedure … Physicians only give orders and patients fulfill those orders</td>
<td>We have increasingly been providing more information to patients about their treatment. We provide clear explanations on how they should use the medication prescribed to them. We give information about what to do if/when adverse effects are experienced. We have brochures prepared for these purposes and they are being handed out to patients</td>
<td>We routinely get some standard documentation filled out by the patients … for instance, we have to obtain an informed consent from each and every patient … I cannot operate on a patient without those signed consent forms anymore</td>
<td>We are not providing information; we are actually doing nothing. We do not want to. Physicians do not like doing their jobs … with all the patients we have to see, what directive or information provision are we talking about? These are utopian concepts nowadays. All we want is to make as much money as possible. They [patients] do not even know which operation they will be undergoing or why they are being operated on. Physician deemed it necessary; that is why … are all surgeries being performed truly necessary? I do not believe majority of them are</td>
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Table 2. (Continued)

<table>
<thead>
<tr>
<th>Theoretical Subcharacteristics</th>
<th>Medical Professionalism Logic</th>
<th>Business-like Logic</th>
<th>State Logic</th>
<th>Rogue Logic</th>
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</thead>
<tbody>
<tr>
<td>Professional Role Relationship</td>
<td>Physicians consult with their colleagues in different specialties for the best treatment method. It is done so as not to miss anything before the treatment option is chosen.</td>
<td>There is no teamwork amongst physicians anymore. It occurred only in the past. Physicians are now working individually and autonomously. If the physician knows more or has more experience about a specific treatment or procedure, that physician strives to keep it all to himself or herself to prevent others to learn what s/he knows. The logic behind it is that others should not be privy to that information, so s/he is the only one who can administer those procedures.</td>
<td>Everyone knows his or her roles and responsibilities. Nurses only do nurses’ work and other healthcare personnel do whatever is required of them at the time of delivery of healthcare.</td>
<td>Physicians are working in groups with the main aim being maximizing the group members’ private revenue. Physicians are operating without knowing what other physicians are doing. Everybody is after maximizing their private revenue. For this reason, a lot of unfriendly arguments have frequently been occurring amongst physicians.</td>
</tr>
<tr>
<td>Success Criteria</td>
<td>Physicians do not like interference into their professional domain. Whether s/he is successful is none of anybody’s business, except the physician’s.</td>
<td>A good physician is not an ethical one at this time; the most valuable physician is the one who unInterruptedly sees the highest number of patients and performs the highest number of surgeries and thus generates the highest amount of performance points.</td>
<td>The more you follow the rules and procedures of the facility and the government related to your work, the more successful you are.</td>
<td>For the physician, success is being measured by the money s/he earns, not whether s/he is conforming to the principles of Hippocratic Oath while performing his or her work. It is a way of displaying their social class. The more expensive physicians’ cars, houses and summer villas are the more successful are the physicians. Physician’s success is a matter of how much money they have made out of their patients.</td>
</tr>
<tr>
<td>Quantitative Service Assessment</td>
<td>No one would question the quantity of healthcare services delivered. No one would ask how many patients I saw or how many procedures I performed, or why I saw the number of patients I saw, or whether I should have seen more or less patients. If the physician saw those patients, it was out of the physician’s own initiative to see them.</td>
<td>The work you produce is under constant control now. During our periodically-held provider staff meetings, which are chaired by the chief of medical staff, the work that has been produced by physicians are being discussed and various clinics’ productivity ratios are being compared.</td>
<td>Statistics were being maintained for the purposes of the Ministry of Health. At times, we would have meetings to discuss, and being a former chief of medical staff back in the day, I would say that we might decide on increasing the number of patient encounters by, say 3% to 5%. But, since the hospital pretty much had a set budget and that it would not generate any additional revenue for physicians, we would decide not to even bother.</td>
<td>Physicians are autonomous in how much work they want to generate. Autonomous in the sense that they use their professional discretionary space to determine how much work they should generate, but they do it based on how much private revenue that work will gain them. For instance, once we have reached our performance point target, we start to not see patients; honestly, we tend to slack off.</td>
</tr>
<tr>
<td>Qualitative Service Assessment</td>
<td>Physicians autonomously decide what needs to be done and how it needs to be done. The content and quality of the service can only be determined and shaped by the physicians. Even another physician from another specialty cannot understand why’s and how’s of a service a physician performs anyway.</td>
<td>There are inspection committees acting as mechanisms for evaluating physicians’ performances in terms of appropriateness, timeliness, ethics, etc. They [inspection committees] are periodically evaluating the work that is being performed.</td>
<td>They [government authorities] would, from time to time, conduct unannounced visits and inspections with no prior notification. These inspections would be performed to check whether or not government standards were being met in terms of delivery of care.</td>
<td>Service quality is not something physicians are concerned about. There is not a real evaluation for quality. That is not a real concern for anyone, really. They cannot truly assess my work in terms of service quality anyway. Besides, you cannot show me a physician who is genuinely concerned about service quality. The only thing physician is thinking about and is motivated to do is to maximize his or her private revenue.</td>
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</table>
Business-like logic is a derivative of the societal level market logic. Business-like logic ascribes a great deal of importance to practices, which could lead to cost reduction (Reay & Hinings, 2005, 2009), better management and accountability (Townley, 2002) and performance enhancement. In business-like logic, physicians are expected to provide healthcare services with an orientation toward, though not completely (thus the name business-like), business principles. Effective and efficient service provision with a customer service orientation is highly valued. In this logic, physicians are expected to view their target audience not just as patients but also consumers or customers whose needs need to be satisfied in the most effective and efficient manner possible. Physicians, when guided by business-like logic, structure and implement the content and organization of their healthcare provision practices under the principles of efficiency, effectiveness, customer service, accountability, and performance improvement.

Identification of the homegrown practices routinely enacted by the physicians under ‘rogue’ logic was a formidable task. In tackling this task, we first screened the nature and characteristics of certain practice patterns, which seemed to be non-conformant to the prescriptions of any of the broader societal orders and/or their derivatives due to their unique characteristics. These deviant practice patterns were coded, densified under categories, and then further abstracted as themes. These nonconforming outlier themes were later discussed with various academics whose research focus was on institutional logics as well as seasoned physicians. Numerous vigorous discussions held in an effort to most appropriately identify and map these discordant themes resulted in a consensus that they were roguish in nature, involving abnormal and deviant organizational phenomena, which impinge upon organizational action, thereby being representatives of patterns of rogue practices, and thus could be organized under the logic identified as ‘rogue.’ In addition, we conducted a comprehensive literature review, which indicated that those patterns of behaviors were indeed encountered and documented in various different organizational domains and practices, discovered as a “serendipitous by-product of other more straightforward activities … [which] can be revealed to be far more obvious and accessible than was anticipated” (Linstead, Maréchal, & Griffin, 2014, p. 178). In this body of literature, it was emphasized that these organizational phenomena, which are observed in professions, institutions, workplaces, public spaces and everyday life, occurring in the dark side, have long been neglected and should be brought back into the focus of organizational theory (Linstead et al., 2014; Vaughan, 1999). In this tradition, the dark side has been recognized as “not only dark out-side, but is to be found within organizational boundaries, practices and logics … and it can be … addressed in existing organizational theory” (Linstead et al., 2014, pp. 166-178, emphasis in original; see also Land, Loren, & Metelmann, 2014; Vaughan, 1999).

Rogue logic is not rooted in any of the seven societal level distinct institutional orders and associated logics identified by Friedland and Alford (1991) and Thornton et al. (2012), but may arise from the gap or gray area of undecidability opening up out of the discrepant norms one or more of those societal level logics or their derivatives may bring with them or cause in organizational life. This indeterminate gray zone is where some or most of organizational activities and practices across a range of institutional contexts are likely to be ambiguously situated (Land et al., 2014). Organizational actors operating in the gray zone, under the influence of divergent logics, may lack certain level of clarity regarding methods of producing order and sense making in relation to potentially conflicting constitutive expectations of the acceptable behavior and misconduct. When there is a gray zone of obfuscation resulting from the inconsistencies or contradictions of multiple logics, the boundaries of what is acceptable and what is unacceptable may thus become constantly obscured or blurred (Land et al., 2014). Under these circumstances, organizational actors may take a calculated gamble and either “deviate” from or “reject” the institutional templates (Quirke, 2013), or may even be engaged in systemic damaging, illegal or fraudulent activities or practices (Land et al., 2014). This gray area is where most of systematically produced routine nonconformity and misconduct occur (Linstead et al., 2014; Vaughan, 1999). Actors’ systemic engagement in malfeasance or enactment of ethical misconduct is usually driven by personal gain or some other private agenda and these behaviors follow “a logic whereby the rogue is produced, and in that production, creates a boundary dividing ethical from unethical behavior … [and] without the rogue we would never know where the boundaries of good order lie … this production … is double in sense that it is both produced by the rogue and produces the rogue” (Land et al., 2014, s. 247-248). Actors following rogue logics are generally at work, but work under the radar (without being noticed until named as such); they are only potential rogues operating in a gray zone of undecidability. Hence the “rogue is
characterized by an indeterminacy that functions in the unclear borders of organizational action. The real rogue logic, however, is the process of producing rogues, and thereby determining the limits of ethical organizational action itself” (Land et al., 2014, s. 248).

It should be noted; however, when following the rogue logic, organizational actors, setting out on their own account, actively and purposely deviate from the status quo and break with the convention, customary practices and established social norms of acceptable behavior. Considering the fact that organizational actor is the agency behind deviation and the agent responsible for deviant behavior (Land et al., 2014), the degree and scope of deviation may be even greater when actors with a high level of professional autonomy and authority over the content and organization of their work are the ones themselves determining the fine line between acceptable and unacceptable behavior (Quirke, 2013). Physicians are known to have complete autonomy and authority over the content and organization of their work (Friedson, 2001; Reay and Hinings, 2005, 2009; Thornton et al., 2012) and the findings of this study show that they exhibit varying types and degrees of rouguish behavior in the performance of their daily practices while greatly benefitting from their sacred authority and autonomy. Findings of this study reflect that physicians following rouguish logics provide healthcare with an orientation toward private interest maximization. In this view, physicians regard their target audiences as commodities (the term commodity, in this study, is taken to mean “the general name given to goods and services considered as the basic objects of production and exchange” [Auld, Bannock, Baxter, & Rees, 1983, p. 45]) rather than patients, customers or healthcare beneficiaries seeking treatment and these commodities can be ‘utilized’ as means to reach their optimal goal: maximum private revenue generation.

These various rouguish inclinations of physicians observed in this study are in agreement with the notion that “physicians are human … no one should be surprised if physicians readily succumb to excessive temptations to put their interest ahead of those of patients … acting in self-interest makes it more difficult for physicians to strive for the ideal that patient needs come first” (Light & Hughes, 2001; Sulmasy, 1992, p. 922). When enacting rouguish practices, physicians use a great deal of professional autonomy and authority toward maximizing their private revenue by means of arranging for doctor’s visits at their own private practice office when they are supposed to be seeing those patients at government medical treatment facilities, or by exercising various methods of overtreatment in an effort to gain more performance points and thus to collect more revenue from the government revolving funds. In this manner, physicians organize healthcare services in a way that they get the maximum private revenue in return. It is also noteworthy to mention here that these types of systemic rouguish practices are widely known within and across healthcare organizations, but are condoned by professionals and others at all levels, first because they aid in maximization of private revenue for physicians, and second, in most cases, they contribute to enhanced profit generation and meeting performance targets for the healthcare organizations. The following interview excerpts illustrate this point:

… For example, in one instance, a government official, who was a xxx specialist (the same as the participant’s), had come to our hospital for an inspection, and I told the government official the dilemma we were in (referring to having to enter the system the procedures with performance points, versus the ones that are without), and basically said, ‘my xxx specialist knows what to do’ [meaning physicians are clever enough to get around this problem by entering the procedures with high performance points]. Look at this, we are being told to basically manipulate the system. Why would I need to do that?

… Everyone knows about these (unethical) practices, but no one says anything. Because the work produced by physicians ultimately results in increased profits for all parties involved. I mean patients are now at the mercy of physicians and physicians can use their discretionary space as they see fit and everyone involved in this whole thing will make profit out of it in some way. But, who will be miserable in this case? Of course, patients

Previous institutional logics research conducted at the micro level shows that actors, at times creatively, use, modify, blend, balance or combine logics through their interactions with others in the same or other professions or positions. A majority of these studies emphasize the role of agency of the actor in various levels of institutional work within the constraints of the existing societal level institutional orders or their derivatives. While this study also acknowledges that actors indeed do exercise a great deal of agency in
their work within the confines of the cognitive and normative orders they are exposed to, as previous institutional logics research attests to, it, by means of this study, furthers these explanations, and shows that actors use their exclusive autonomy and authority to break through these institutional spheres as rogue intrapreneurs and adopt various roguish practices solely toward satisfying their immediate private financial needs.

In this study, these roguish practices are viewed as “organizing principles” (Friedland & Alford, 1991, s. 248), “activity patterns” or material “practice[s] as a kind of institution” (Lounsbury & Crumley, 2007, s. 996). It is also recognized that “practices … are available to individuals to further elaborate, manipulate, and use to their own advantage” (Friedland & Alford, 1991; Thornton & Ocasio, 2008, s. 101).

**Ground-level logic invocations through processes of institutional change**

We further analyzed physicians’ routine practices for each era in order to evaluate the pattern of logics characterizing those eras respectively. Toward that goal, the themes were numerically represented in order to more fully describe and/or interpret the logic instantiations of participant physicians for the two eras investigated in this study: Era 1 and Era 2. To refresh the readers’ memories, the historical marker demarcating Era 1 and Era 2 is the year 2005, in, or subsequently beyond, which the laws were enacted by the government delineating and enforcing the specific rules of engagement for the implementation of PBSPS, as well as laws pertaining to privatization and corporatization of the Turkish healthcare were devised and put in place, as part of the HTP. Figure 1 and 2 show the strength of influence of logic characteristics and logics for Era 1 and Era 2 respectively.

Findings of this study show that while carrying out their duties and responsibilities, ground-level actors are indeed under the influence of societal level logics or their derivatives; namely, medical professionalism, business-like and state logics, to varying degrees. However, as reflected in the Figures 1 and 2, ground level actors are also under the strong influence of a home-grown rogue logic operating in the gray zone where the lines between acceptable behavior and misconduct cannot be clearly demarcated. Findings reflected that physicians perform a great deal of edgework within their discretionary space, a prerogative of physicians, which their professional authority and autonomy grant them, in an effort to maximize their private revenue. Rogue practices, so this study shows, are created and maintained within a gray zone, into which no one other than physicians is privileged to have access to, and physicians enjoy a great deal of autonomy and authority in expanding and pushing the limits of this area as their immediate needs dictate.

In Era 1, medical professionalism logic exerts little influence on structuring physicians’ cognition and guide their decision making with reference to mission orientation, goal focus, quality conception, service organization, information provision role, role relationship, success criteria, quantitative service assessment and qualitative service assessment while rogue logics seem to exert moderate to strong influence on all logic characteristics. State logic exerts very little to little influence on mission orientation, definition of target audience, definition of own status, role relationship, and success criteria. Medical professionalism logic exerts no influence on definition of target audience, service characteristics conception, service organization, information provision role and role relationship attributes. Business-like logic has no influence on guiding physicians’ behavior during performance of daily tasks.

In Era 2, only subtle shades of medical professionalism logic seem to continue to exert influence on cognition and decision-making processes of physicians’ practice to a very little degree on mission orientation, goal focus, definition of own status, quality conception, service organization, information provision role, role relationship and success criteria. Medical professionalism logic exerts no influence on definition of target audience, service characteristics conception, quantitative service assessment and qualitative service assessment attributes in physicians’ daily invocation of logics at practice level. State logic seems to drift away substantially with its decreased levels of influence being very little on mission orientation, goal focus, definition of target audience, definition of own status, service characteristics conception, service organization and role relationship, and continues to have a relatively increased level of influence (little) on information provision role.
Figure 1. Strength of influence of logic characteristics in Era 1
Note: 0-1 = very little influence; 1.1-2 = little influence; 2.1-3 = moderate influence; 3.1-4 = strong influence; 4.1-5 = very strong influence

Figure 2. Strength of influence of logic characteristics in Era 2
Note: 0-1 = very little influence; 1.1-2 = little influence; 2.1-3 = moderate influence; 3.1-4 = strong influence; 4.1-5 = very strong influence
In Era 2, rogue logic continues to maintain its dominance in influencing structuring and guiding physicians’ behavior in all logic characteristics with the strength of influence ranging from moderate to very strong. Specifically, rogue logic seems to be more influential on goal focus, definition of target audience, definition of status, service characteristics conception, quality conception, service organization, and qualitative service assessment logic attributes, with its strength of influence being very strong. Rogue logic exerts the same exact level of influence on mission orientation attribute, but reflects decreased levels of influence on information provision role, role relationship, success criteria and quantitative service assessment, with the strength of influence being moderate. In Era 2, business-like logic enters into physicians’ toolkit of logics, and physicians are influenced by the prescriptions of the characteristics of this logic from very little to moderate levels in terms of deciding which practices to enact. Business-like logic exhibits moderate levels of influence on quantitative service assessment, but little influence on success criteria and role relationship attributes. The other attributes on which business-like logic exerts very little influence are mission orientation, goal focus, definition of target audience, definition of own status, service characteristics conception, quality conception, service organization, information provision role and qualitative service assessment.

Table 3. Strength of logic characteristics’ influence by respective eras

<table>
<thead>
<tr>
<th>Logic</th>
<th>Medical Professionalism Logic</th>
<th>Business-like Logic</th>
<th>State Logic</th>
<th>Rogue Logic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Era 1</td>
<td>Era 2</td>
<td>Era 1</td>
<td>Era 2</td>
<td>Era 1</td>
</tr>
<tr>
<td>Mission Orientation</td>
<td>0.6</td>
<td>0.3</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Goal Focus</td>
<td>0.6</td>
<td>0.4</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Definition of Target Audience</td>
<td>0.6</td>
<td>0.0</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Definition of Own Status</td>
<td>0.6</td>
<td>0.1</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Service Characteristics Conception</td>
<td>0.5</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Quality Conception</td>
<td>0.3</td>
<td>0.2</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Service Organization</td>
<td>0.4</td>
<td>0.1</td>
<td>0.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Information Provision Role</td>
<td>0.6</td>
<td>0.1</td>
<td>0.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Role Relationship</td>
<td>0.6</td>
<td>0.5</td>
<td>0.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Success Criteria</td>
<td>0.2</td>
<td>0.2</td>
<td>0.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Quantitative Service Assessment</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Qualitative Service Assessment</td>
<td>0.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Note: 0-1 = very little influence; 1.1-2 = little influence; 2.1-3 = moderate influence; 3.1-4 = strong influence; 4.1-5 = very strong influence

In viewing the influence of logics on guiding physicians’ behaviors for the two eras side by side, as depicted in Table 3, it is noticed that medical professionalism and state logics lose their relative strength of influence on almost all logic characteristics in Era 2 in comparison to Era 1 (except the success criteria attribute, on which the level of influence did not change by era), and business-like logic starts to exert very little influence in terms of all logic characteristics (except role relationship and success criteria attributes, on which it had little influence; and quantitative service assessment attribute, on which it had moderate influence). Rogue logic, however, appears to be the single dominant logic in both eras with its strength of influence ranging from moderate (lowest) to very strong (highest).

In an effort to provide a single evaluation for each logic, mean values for attributes within each logic for each era was also computed (Goodrick & Reay, 2011). These evaluations are reflected in Figure 3. Two significant logic constellations were observed: a single dominant logic (rogue) with strong influence and two considerably weaker logics (medical professionalism and state) and another with no influence at all (business-like) (Era 1), and a single dominant logic (rogue) with stronger influence (compared to Era 1) and three strikingly weaker logics (medical professionalism, business-like and state) with almost no influence at all.
Discussion

This study reflected that professional work of physicians was under the simultaneous influences of multiple and different logics. The data analyses showed that while performing their daily duties and responsibilities resulting in carrying out certain practices, physicians were faintly guided by the prescriptions of multiple societal level logics, namely medical professionalism, business-like, and state logics, but they were, surprisingly, also strongly influenced by a homegrown rogue logic over time.

In Era 1 (i.e., before the implementation of government policy initiatives, for which the historical marker was the year 2005), physicians were under the strong influences of rogue logics, but the other logics which were available in their toolkit; namely, medical professionalism and state logics seemed to have virtually no influence on their enactment of practice work. Business-like logics had no influence on physicians’ cognitive frameworks and associated medical practices. In Era 2, the effects of the government policy initiative on the cognitive structures and belief systems of physicians were observed, and a new logic; namely, business-like logic, entered the toolbox of physicians. Physicians, however, was surprisingly not affected by the prescriptions of business-like logics and did not materialize them into action in their daily practices to a significant degree. Physicians were still under the influence of a single dominant logic (rogue), as was the case in Era 1. In Era 2, analyses showed relatively stronger influence of rogue logics with only subtle shades of medical professionalism and state logics (even with lower levels of influence compared to Era 1), as well as very little influences from business-like logics.

In terms of diagrammatic representation of the results, this research also adopted the use of constellation of logics as defined by Goodrick and Reay (2011, p. 399) as “the combination of institutional logics guiding behavior at any point of time … which helps us to see the ways that societal logics can combine to simultaneously influence professional work, since the concept of constellation captures the pattern in which these multiple logics are combined at a given time.” In this study, two patterns of constellations were detected across the two eras under investigation, which was a different
finding compared to the study of Goodrick and Reay (2011), in which three different constellation of patterns were observed. In the first constellation observed in Era 1, the absolute dominance of rogue logics with a strong influence, and two strikingly weaker logics; namely, medical professionalism and state, with very little influence (business logics reflected no influence on physicians’ cognition and behavior related to their practice work) were observed. In the second constellation observed in Era 2, rogue logics not only remained dominant, but also increased its influence on seven of the twelve logic attributes, ranging from ‘goal focus’ to ‘qualitative service assessment,’ from strong to very strong influence levels. Also, in the second constellation reflected in Era 2, medical professionalism and state logics maintained to have a very little influence, but with strikingly weaker levels of strength in comparison to influences of the rogue logics, as well as business-like logics entered the logic toolbox of physicians with very little influence on physicians’ cognitive structures and belief systems guiding their behaviors. In sum, in both of the eras studied, the data reflected that only one single logic dominated the constellation of logics. In both eras under investigation, it was observed that physicians’ practices almost exclusively reflected the rogue logics with virtually no influence by the medical professionalism, business-like and state logics. Though business-like logic was integrated into the toolkit of physicians in Era 2, data showed that it had almost no influence on physicians’ cognitive frameworks guiding their thoughts and actions.

The fact that rogue logic was most influential and dominant across eras, and other available logics had only very minimal effects on physicians’ cognition and behavior deserve discussion. In Era 1, one would think that physicians’ practices would be significantly influenced by the state, as the field was strictly regulated by the state. Also worthy of discussion is government’s efforts to ensure appropriate code of conduct is adhered to by the physicians, the fact of which would be rendered possible by activities of another actor; namely, Turkish Physicians Association (TPA), introduced and integrated into the field by the government in 1953, via law no 6023. It should be noted that one of the duties of the TPA, as defined by law no 6023 was: “Association is to maintain and promote profession’s traditions fed by the philosophy in which servicing public health and patients altruistically and unselfishly are regarded as ideal values of the profession.” Based on the establishment of TPA, coupled with the fact that physicians go through extensive training and education at medical schools, one would also reasonably assume that physicians should show noticeable levels of ties to their professional logics and thus be guided by the norms, values and principles of medical professionalism in terms of their daily activities and practices in Era 1. It should also not go unnoticed that the Turkish government also strove to infuse business principles into the healthcare field as of the establishment of 1982 Constitution, the fact of which might have influenced the way healthcare was being delivered in the field. In Era 2, however, it would be fair to expect that physicians would show a significant amount of attachment to business-like logics, affected by the government’s rigorous efforts to transform the healthcare field from a state-oriented to a business-oriented field as of the early parts of 2000s, with other aforementioned logics still being potentially influential to various degrees. However, none of these assumptions was valid. The beauty of grounded theory approach undertaken here is that it focuses on the perspective of perspectives and reaches its outcomes through abstract conceptualization based on the standpoint and views of participants, and not on the preconceived assumptions (Glaser, 1978, 1998, 2001).

Previous research conducted at the micro level shows that actors, at times creatively, use, modify, blend, balance or combine logics through their interactions with others in the same or other professions or positions. A majority of these studies emphasize the role of agency of the actor in various levels of institutional work within the constraints of the existing societal level institutional orders or their derivatives. While this study also acknowledges that actors indeed do exercise a great deal of agency in their work within the confines of the cognitive and normative orders they are exposed to, as previous institutional logics research attests to, it, by means of this study, furthers these explanations, and shows that actors use their exclusive autonomy and authority to break through these institutional spheres as
rogue intrapreneurs and adopt various roguish practices solely toward satisfying their immediate private financial needs.

Extant research shows that these types of roguish practices and activities become “part and parcel of everyday organizational life,” and thus are institutionalized within organizations (Brief, Buttram, & Dukerich, 2001; Misangyi, Weaver, & Elms, 2008). It was the case in this study, in which physicians, by means of utilizing their discretionary space, a prerogative of physicians, created and adopted deviant practices in pursuit of private revenue maximization - which are systemically wide-spread across healthcare organizations - that break with the demands, prescriptions or the dictates of the various logics they operate under. Rogue practices, so this study shows, are created and maintained within a gray zone, the dark side of where some or most organizational behavior takes place, into which no one other than physicians is privileged to have access to, and physicians enjoy a great deal of autonomy and authority in expanding and pushing the limits of this area as their immediate financial needs dictate. These systemically roguish practices are widely known within and across healthcare organizations, but are willfully condoned by professionals and others at all levels due to the benefits they bring to the implementers and their organizations.

The results of this study reflect absolute dominance of rogue logics both before and after the policy implementation with other available logics’ influences being considerably low. The fact that business-like logic starts to exert very little influence, medical professionalism and state logics lose their influence to lower levels and rogue logics gains more influence in guiding physicians behavior post government intrusion shows that logics are indeed “historically contingent” (Thornton et al., 2012, s. 13-51). The results also reflect that rogue logics are not just “short-lived fads or fashions” (Rao et al., 2003, s. 811), but are indeed rooted in “socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their daily activity” (Thornton et al., 2012, s. 13-51), which have become “routinized and habitual and, thus, institutionalized within the organization” (Misangyi et al., 2008, p. 752), as illustrated in physicians’ comments below:

Our way of doing business has always been this way. I do not think there is a difference at the cognitive level between the doctor exploiting his/her patients’ financial income by telling his/her patients that they need to visit his/her private practice office and pay a doctor’s visit and/or surgery fee in order to get operated on at the [public] hospital [before policy implementation], and the doctor making the same money via a different method under the pay-for-performance system. To wit, this performance system is just a different and legitimated version of the previous methods doctors were utilizing to maximize their revenue by means of referral of their patients to their private practice offices [after policy implementation]” (Physician interview, 2016).

What did I do? I developed a philosophy for my own and said to my patients, ‘if you want me to operate on you, you then will need to come to my private practice office first.’ This was the correct way of doing business to me and to all my colleagues [before policy implementation]. We are now very motivated and productive, but for what? Not that we love our job or want to heal more patients. The only motivation we have is to increase our performance points and to get paid more. If we have enough performance points, then fine, we do not need to see patients. If we do not, however, we then need to do whatever it takes to collect more performance points, and we start operating like machines. While doing that, though, we unavoidably end up violating some of our professional values and norms. Within this new [pay-for-performance] system, the only and most important thing for physicians is performance points and the financial revenue they bring to physicians [after policy implementation]” (Physician interview, 2016).

By its explanatory empirical power reflecting highly-professionalized actors’ ability (or agency) to move beyond existing institutional orders and systematically establish their own socio-historical “rule systems” (Jepperson, 1991) stabilizing around a particular logic (rogue), this study reemphasizes social actors’ crucial agentic role in creating, embodying and enacting the logics within organizations (McPherson & Sauder, 2013; Scott et al., 2000). Physicians, in this research, emerged to be those “actors with sufficient
Conclusion

This study set out to examine the influence of logics on physicians’ daily practices and the variations in physicians’ logical inclinations as they perform their daily duties over a period of time, in which a revolutionary policy-driven initiative was implemented by the government.

We were drawn to this study because extant research stops short in providing explanations for how logics become tangible in everyday practices of professionals, as they perform their daily routine, from the real-time perspectives of the actors doing the actual work. In this regard, “most studies focus[ed] only on field level actors … but they gave little attention to actors inside organizations” (Reay & Hinings, 2009, p. 632). Some of the studies attempted to devise universal institutional logics frameworks for later use by other researchers (Besharov & Smith, 2014; Pache & Santos, 2010). Other research adopted established logical frameworks or taxonomies as ‘taken-for-granted’ and sought to reveal the degree of consistency of these ‘ideal logics’ with what is happening on the ground (Goodrick & Reay, 2011; Reay et al., 2016). Although some researchers may strive to generate time- and space-invariant general frameworks and laws of social behavior from a macro perspective or seek mechanic compatibility between universal frameworks or taxonomies and the real life experiences of persons who translate them into action, others, like the authors of this paper, may attempt to uncover and understand the real and “deep structure” of everyday life (Hanneman, 1988, p. 16). As was the case in this study, performing a research of this sort may reveal surprising results in terms of the diversity of the kinds of models through which ground level practices are employed in everyday life (Shoemaker, Tankard, & Lasorsa, 2004) and on the potential differences between the ‘logics on the books’ and ‘logics in action.’

Another reason the researchers were interested in this research endeavor was to address a gap as well as possibly contribute to the institutional logics theory by means of providing insights from a practice level lens. Though institutional logics literature is replete with studies investigating how institutions and organizations mutually influence one another (Haveman & Rao, 1997; Lounsbury, 2002; Murray, 2010; Pache & Santos, 2013; Scott et al., 2000; Smets et al., 2012), research on institutional logics with a practice level focus in terms of how “social actors translate logics into action as they engage in everyday organizational work” (McPherson & Sauder, 2013, p. 166) was very rare, and thus further research in this area was warranted (Barley, 2008; Hallett, 2010; Powell & Colyvas, 2008; Smets et al., 2012; Thornton et al., 2012). Specifically, from the perspective of professionals, more research was required to understand how logics are reflected in and affect professional work in various professional domains (Goodrick & Reay, 2011).

Professional groups possess unique knowledge, skill set and expertise, and the society grants them increased levels of authority and autonomy than it grants non-professionals (Larson, 1977) and their importance has increasingly been recognized across organizational sciences (Wallace, 1995). Specifically, medicine is regarded to be a prototypical profession (Hughes, 1956) with esoteric knowledge, which has economic value when applied to health-related issues or problems (i.e., illness) faced by individuals in a society (Carr-Saunders & Wilson, 1936; MacDonald, 1995). In the field of medicine, especially physicians receive intense socialization, orientation and education and are known to hold complete autonomy and control over the content and organization of their work (Friedson, 2001; Thornton et al., 2012). From an institutional logics perspective, individuals with strong authority, autonomy and control over a specific domain have the ability to define, defend or otherwise influence specific institutional values and norms (Selznick, 1949; 1957), and institutions are known to “operate through the influence and agency of individuals” (Suddaby, 2010, s. 17). Physicians are thus well situated to exercise various levels of agency to interpret, negotiate and blend logics, or create logics while they
perform their practical work (Currie & Spyridonitis, 2015). Though it has been long acknowledged that “the agency used by organizational and individual actors contributes to variation in how multiple logics become instantiated within organizations” (Besharov & Smith, 2014, p. 366), the concept of “individual level agency” has largely been given short shrift in previous institutional logics research (Smets & Jarzabkowski, 2013, p. 1283). Institutional logics literature will greatly benefit from more research exploring this phenomenon (Battilana, Leca, & Boxenbaum, 2009; Smets & Jarzabkowski, 2013). This was one of the other reasons this study concentrated on how physicians, who belong to a highly-professionalized group, use their unconstrained authority, autonomy and control to legitimize organization and enactment of their daily practices at the cognitive level from the lens of the institutional logics perspective with a practice level approach.

Hence, this study also strove to provide accounts in “illuminating the relationship between agency and logics when multiple logics exist and hold potential to influence professional work” (Goodrick & Reay, 2011, p. 405). Consequently, the main aim of this study was to contribute to and possibly extend existing theory in the area of institutional logics, with a practice lens, by making it “more dense by filling in what has been left out – that is by extending and refining its existing categories and relationships” (Locke, 2001, p. 103) by means of conceptually comparing and integrating substantive concepts emerging from the fieldwork accomplished herein with their counterparts in the literature. This gap was long overdue, mostly, to the fact that the importance of practice level approach was often emphasized, and the lack of it was frequently lamented on, by institutional scholars, rather than being their main research focus.

This study adopted grounded theory methodology in order to explain and describe (Strauss & Corbin, 1998) patterns of physicians’ behavior they enact at practice level and their cognitive roots in a generalizable manner with a primary goal to “write about concepts, not people” (Glaser, 1978, p. 134, emphasis in original). Drawing on physicians’ own perspectives as basis for understanding their experience addresses another substantive gap in literature. As such, this research offers a more nuanced understanding of ground level actors’ experiences than has previously been available. Qualitative methods in this respect are the microscope through which researchers explore the details of lived experience. Throughout the study, every effort was made to ensure that an opportunity was provided to various multiple voices and perspectives to be shared. Toward reaching the broadest diversity of views, physicians from twenty-three different specialties were recruited into the study to get various standpoints related to the topic under investigation (Charmaz, 2000). Involvement of as many voices and experiments as possible in the study showed that physicians might have different views and experiences in terms of what constituted as basis for their practice enactments. By means of adopting this method, the researcher was able to have a fine-grained look at the way physicians made sense of their world, carried out their practices, and interpreted their role as a physician. The data, grounded in the accounts of physicians, arising from this research provided a rich foundation on which the substantive theory established is based.

The findings of this study are intriguing as they reflect counterpoints to some of the ideas and/or findings presented in the majority of the extant literature. Findings of this study indeed challenge most, if not all, of the previous explanations or findings reached in previous scholarly work in the area of institutionalization and institutional logics literature.

First and foremost, according to the early institutionalism literature, “… a critical feature of organizational life is … to assume that … everyone [to include professionals] is acting in good faith … professionalization … binds both supervisors and subordinates to act in good faith.” (Meyer & Rowan, 1977, p. 358; Powell & DiMaggio, 1991). Likewise, according to the professionalism literature, “professions create and maintain distinct professional values or moral obligations (e.g. codes of ethics) … inculcate ‘appropriate’ work identities, conducts and practices … [and thus] professionalism … is considered as a ‘disciplinary logic’ (Evett, 2012, p. 5; Friedson, 2001). The findings of this study reflected that professionalism is not a binding mechanism for acting in good faith, or a disciplinary logic regulating professionals’ behaviors or practices in accordance with the professional norms and values
within organizational life. Data showed that highly professionalized actors (in our study, physicians), indeed utilized their authority and autonomy professionally for achievement of deviant purposes, which involved actors’ tapping into their ability to exploit their discretionary power, afforded to them by their status and expertise, for personal gain, which, for the most part, might result in severe negative implications for the population health.

Second, the findings substantially contribute to the structure-agency debate. Early institutionalists maintained that institutions imposed strict constraints on organizational actors’ the cognitive structures and associated practices in highly institutionalized contexts, which meant that they had no hand in changing the taken-for-granted institutional orders, which define the rule systems and organizing principles of organizational life (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Tolbert & Zucker, 1983). In a somewhat similar vein, within the theories of embedded agency, prevailing logics were assumed to constrain the interests, values and strategies of actors within organizational fields and professional groups (Battilana, 2006; Greenwood & Suddaby, 2006; Seo & Creed, 2002). Later contributors, however, posited that organizational actors had some hand in manipulating and or re-structuring institutional arrangements (Besharov & Smith, 2014; Oliver, 1991; Seo & Creed, 2002; Smets et al., 2014; Thornton, 2004; Thornton & Ocasio, 2008). Professionalized actors’ use of their limited agency was indeed portrayed in a study conducted by McPherson and Sauder (2013, p. 181) in which it was found that “actors pragmatically and creatively invoke available logics in order to manage everyday work, often employing ‘competing’ logics” of other domains. The findings of this study, however, showed that members of a highly-professionalized group could determine or the set the limits of their conditions of practice themselves and act in accordance with them. The study undertaken here showed that rather than having no hand or some hand in restructuring institutional arrangements, actors actually had an unconstrained latitude in deciding how they wanted to structure the content and organization of their work both at the cognitive and the practice level. This study reflected that professionalized actors enjoyed the authority and autonomy their professional status, education and expertise granted them and utilized those attributes as means to satisfy their financial interests. It has been shown that “resources … serve as foundations on which an institutional logic is acted out … for example, education and expertise … or social status … and … institutional logics can be reproduced over time only to the extent that they are supported by and embedded in resources” (Misangyi et al., 2008, p. 755). Physicians, so this study showed, are highly intelligent and knowledgeable agents with a capacity to reflect and act in ways other than those prescribed by the taken-for-granted rules and order systems (Emirbayer & Mische, 1998; Garud & Karnoe, 2003; Mutch, 2007). These findings show that actors of a highly professional group can reflect extremely autonomous and agentic behaviors. They do it by means of institutionalizing alternative practices which are by no means the extensions of, and associated with, belief systems and cognitive frameworks of the ordinary organizational life; these behaviors seem to be completely ‘out-of-the-ordinary.’

Third, extant institutional logics literature suggests that institutional change is associated with a new logic for the field (Lounsbury, 2002; Scott et al., 2000; Suddaby & Greenwood, 2005). When a new logic enters an established field, competition between or amongst logics occur, eventually resolving to a dominant logic (Hensmans, 2003; Hoffman, 1999; Lounsbury, 2002; Thornton et al., 2005). The results of this study showed a different pattern. Despite government’s rigorous attempts to transform the healthcare to a more business-oriented field, the physicians maintained their already-existing strong attachment to their homegrown rogue logic, and reflected negligible levels of attachment to business-like logics. In other words, the field’s most powerful actor’s (i.e., the government) change efforts did not substantially influence the logical inclinations of the ground level implementers. This is intriguing because governments are regarded as being the most influential institutional entrepreneurs, which have the legitimately recognized formal authority (Battilana et al., 2009; DiMaggio, 1983; Fligstein, 2001; Garud, Jain, & Kumaraswamy, 2002; Lounsbury, 2002) to “reshape the social organization of the fields
and/or help establish a new dominant practice” (Lounsbury & Crumley, 2007, p. 993).

Fourth, previous scholarship posits that “actors affiliated with a professional or organizational group will adhere to that group’s primary logic” and that “at any one moment, professions exhibit a temporary consensus in their logical orientations” (Battilana & Dorado, 2010; Ferlie, Montgomery, & Pedersen, 2016; Greenwood et al., 2002, p. 62; McPherson & Sauder, 2013, p. 186). In rare cases, however, research delving into professionals’ logical orientations while under the concomitant influences of competing logics showed somewhat of a different pattern. Studies inquiring into how professionals are influenced by the multiplicity of logics in accomplishment of their work showed that professionals enjoy substantial levels of freedom in drawing from the available logics under the confines of the existing institutional orders pertaining to professional work (Goodrick & Reay, 2011; McPherson & Sauder, 2013). However, in this study, results of the analyses reflected that physicians effectively deviated from and rejected the prescriptions of their home logic as well as the prescriptions of other available logics which pertained to accomplishment of professional work, and drew from a logic that they themselves created as a resource to frame and serve their interest as well as to achieve their individual goals.

Fifth, there were no traces of the processes of logic blending (Glynn & Lounsbury, 2005; Pache & Santos, 2013; Thornton et al., 2005), replacement (Greenwood, Sudabby, & Hinings, 2002; Hoffman, 1999), segregation (Smets et al., 2014), segmenting (Goodrick & Reay, 2011; Smets et al., 2014), bridging (Smets et al., 2014), cooperation (McPherson & Sauder, 2013; Reay & Hinings, 2009), hijacking (McPherson & Sauder, 2013), or practice improvisation (Smets et al., 2012) observed in actors’ daily work, geared toward getting the job done. Instead, this study showed that ground level actors “discovered new ways of organizing … which was driven by individual agency operating somewhat under the radar” (Reay & Hinings, 2009, p. 632). Physicians used their unbridled authority and autonomy to structure the content and organization of their work toward maximizing their private financial interests.

In sum, contrary to the assertions of previous studies of institutions, in which creating, maintaining and/or disrupting institutional arrangements are imbued with emotions, and thus enactment of institutions should not be “reducible to the pursuit of rational interests” (Gilmore & Sillince, 2014, p. 327; Voronov & Vince, 2012), this study showed that the tendency of physicians toward private interest maximization and the associated patterns of practices they form and routinely enact are in line with the notion that “new institutions arise when organized actors with sufficient resources see in them an opportunity to realize interests that they value highly” (DiMaggio, 1988, p. 14). These findings are unique in that they suggest that ground level actors can create their own way of organizing, “stable designs for chronically repeated activit[es]” (Jepperson, 1991, p. 145), geared toward serving their own interests, regardless of the dictates or prescriptions of exogenous forces such as market, state and professions.

In conclusion, this study provides a novel empirical evidence of not just how actors under the influence of multiple logics appeal to their available logic toolbox and actively and flexibly “take them up and apply them … in ways that suit the purpose at hand” (McPherson & Sauder, 2013, p. 178), but also of how they dexterously and purposely set out on their own account and move beyond the confines of the available institutional orders and successfully create and maintain a logic of their own via heavily benefiting from the autonomy, authority and control their professional domain grants them.

Finally, with its unique findings reached through adoption of a sound qualitative methodology with a grounded theory design, we hope to have contributed to the institutionalization and institutional logics theory by introducing a micro-level account of an unstudied dark side of coalface practices perpetuating in the real institutional life.
References


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