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Initiating Divergent Organizational Change: The Enabling Role of Actors' Social Position

Julie Battilana
Harvard Business School
jbattilana@hbs.edu

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ROLE OF ACTORS' SOCIAL POSITION**

Julie Battilana

Harvard Business School
Morgan Hall 312
Boston, MA 02163
Ph. 617 495 6113
Fx. 617 496 6554
Email: jbattilana@hbs.edu

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ABSTRACT

This study addresses the paradox of embedded human agency, or the contradiction between actors' agency and institutional determinism. It helps to resolve this paradox by considering the enabling role of actors' social position. Adopting a relational view of human agency, I model the impact of their social position on the likelihood that actors will initiate changes that diverge from the existing institutions. I test this model using data from 93 change projects conducted by clinical managers at the National Health Service in the United Kingdom. My findings suggest that social position is an important enabling condition for divergent organizational change, and is a determinant as well of the type of divergent organizational change an actor may undertake.

Keywords: Divergent organizational change; institutional change; institutional entrepreneurship; social position.

INTRODUCTION

Institutions are social structures that are characterized by a high degree of resilience (Scott, 2001). Actors tend to take for granted and reproduce beliefs and practices that have become institutionalized (Zucker, 1977). How can institutions be changed by actors whose beliefs and actions are shaped by the institutional environment? This question captures the paradox of embedded human agency (Holm, 1995; Seo and Creed, 2002), or the contradiction between actors' agency and institutional determinism.

Recent works in institutional theory have barely tackled the issue of human agency. They have tended to neglect the individual level of analysis (Reay, Golden-Biddle and Germann, 2006), concentrating, instead, on the organizational and organizational field levels of analysis. The latter, which is defined as a recognized area of institutional life (DiMaggio and Powell, 1983), corresponds to the unit of analysis used in institutional works to account for the wider institutional context in which actors are embedded (Davis and Marquis, 2005). Such neglect of the role of individual actors in institutional phenomena is surprising because it is these very actors who will reproduce, transform or create institutions. Individual actors are not only shaped by, but may also shape, their institutional environment (Berger and Luckmann, 1967; DiMaggio and Powell, 1991).

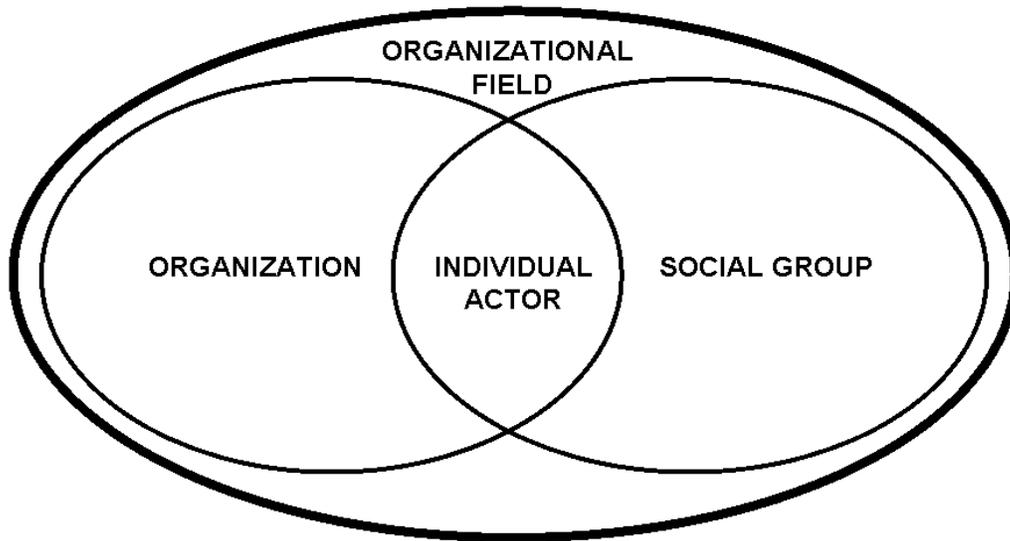
To understand how individual actors can diverge from and thereby possibly shape their institutional environment in the face of the institutional pressures towards stasis, one must consider the actors' relation to their environment (Emirbayer and Mische, 1998; Emirbayer, 1997). This relation is mediated by actors' positional characteristics (Rousseau, 1978), which, taken together, correspond to their social position. To resolve the paradox of

embedded human agency, it is thus necessary to understand how actors' social position may enable them to initiate changes that diverge from the existing institutions.

Some studies have examined the role of social position in enabling organizations to diverge from existing institutions (e.g., Leblebici, Salancik, Copay and King, 1991; Kraatz and Zajac, 1996; Rao, Morrill and Zald, 2000; Greenwood and Suddaby, 2006), but few have analyzed the enabling role of individual actors' social position (see Dorado, 2005; Maguire, Hardy and Lawrence, 2004; Cliff, Jennings and Greenwood, 2006). These latter studies have focused on individual actors' position within the organizational field, however, and have not accounted for their position within the organization, thus ignoring intra-organizational dynamics.

Because individual actors are embedded in organizations and social groups, both of which are embedded in organizational fields (see Figure 1), one must take into account when defining individual actors' social position both the organizational and the organizational field levels of analysis. Social groups—professional and occupational groups are examples—transcend organizational boundaries. Hence, individual actors' social position is determined by their position in the organizational field that is dependent on their organizational and social group memberships as well as by their position within their organization.

Figure 1: Individual actors' social position



Organizations are one setting within which individual actors may break with—or diverge from—the existing institutions. Divergent organizational changes are changes that diverge from the dominant institutionalized template for organizing within a given organizational field (D’Aunno, Succi and Alexander, 2000). One way to resolve the paradox of embedded human agency is thus to explain how their social position both in their organization and in the organizational field might enable individual actors to initiate divergent organizational changes despite institutional pressures towards stasis.

Other individual-level conditions apart from social position—psychological factors, for example—might influence the likelihood that an individual actor will initiate divergent organizational change, but to analyze the impact of such factors without accounting for the fact that actors are embedded in a social position would contradict the premises of

institutional theory by ignoring the influence of the institutional environment and, consequently, do nothing to resolve the paradox of embedded human agency. In contrast, actors' positional characteristics, which become associated with an individual actor through his or her membership in the organization and in the organizational field (Rousseau, 1978), account for the interaction between actors and their institutional environment.

At the heart of this study, then, is the question of how actors' social position affects the likelihood that they will initiate divergent organizational changes. I develop several hypotheses about the impact of actors' positional characteristics on the likelihood that they will initiate divergent organizational changes, and test these hypotheses using data from 93 change projects conducted between 2003 and 2004 by clinical managers at the National Health Service (NHS) in the United Kingdom. The NHS is a public, state-funded healthcare system. Some of the 93 clinical managers initiated change projects that diverged significantly from the dominant institutionalized model for organizing in the NHS, that is, the model of medical professionalism; others initiated change projects that did not diverge from this model. I developed a measure of the degree of divergence of the change projects from the model of medical professionalism. Then, I analyzed the relationship between the degree of divergence of each of the change projects initiated by a clinical manager and the characteristics of that manager's social position.

My results show that individual actors' social position is an important enabling condition for divergent organizational change, and is a determinant as well of the type of divergent organizational change an actor undertakes. These findings suggest that there are different types of divergent organizational change and that their social position influences

the type of divergent organizational change actors initiate. The positional characteristics of the actors most likely to initiate each type of divergent organizational change were observed to be quite different.

SOCIAL POSITION AND DIVERGENT ORGANIZATIONAL CHANGE

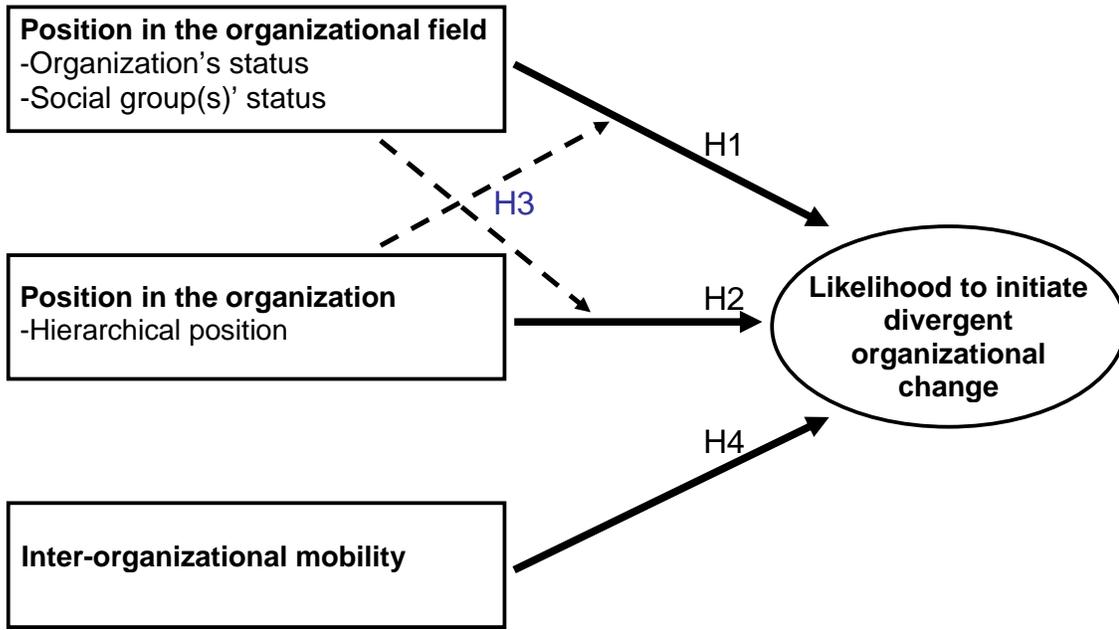
Apart from the influence of field-level and organizational-level enabling conditions (Battilana, 2006), the likelihood that actors will initiate divergent organizational change is also a function of willingness and ability (DiMaggio, 1988), which, will vary from one actor to another (Clemens and Cook, 1999). Willingness to act is dependent on actors' interest, while ability to act is mostly determined by the resources they possess or to which they have access (Lawrence, 1999). Ability and willingness to act are not givens, but likely vary with actors' social position.

We observed earlier that an actor's social position is determined by his or her position both within his or her organization and within the organizational field. Social groups' membership together with organizational membership contributes to determining actors' position in the organizational field. The existence of dominant institutions and their associated set of templates, rules, and practices imply differential access to and control over key resources and decision processes within a given organizational field (Hargrave and Van de Ven, 2006), and, thereby, within the organizations and social groups that are embedded in it. To the extent that organizational fields are thus political arenas (Brint and Karabel, 1991), existing institutional arrangements could, depending on the organizations and social groups to which actors belong, be a source of power for those who benefit from "positive privileges" and not for those who suffer from "negative privileges" (Weber, 1978: 305). In

other words, the status of the organizations and social groups in which individual actors are embedded, that is, the unearned ascription of their social rank (Washington and Zajac, 2005), varies depending on the values associated with the dominant institutionalized model for organizing. The status of both the organization and the social group(s) to which individual actors belong determines their position in the organizational field.

Actors' social position is also determined by their position in their organization that derives from their position in organizational hierarchy. Finally, individual actors are not only embedded in the social space but they are also embedded in time (Emirbayer, 1997; Emirbayer and Mische, 1998). Their social position is not given; it may change over time. Hence, there is a dynamic aspect to actors' social position that needs to be considered. Working from this definition of social position, I develop a model (see Figure 2) that predicts the impact of the different characteristics of actors' social position (including their position in the organizational field and in their organization) on the likelihood that they will initiate divergent organizational change. To account for the dynamic aspect of social position, I analyze the impact of actors' inter-organizational mobility on the likelihood that they will initiate divergent organizational change.

Figure 2: The impact of social position on actors' likelihood to initiate divergent organizational change



Position in the Organizational Field

Organization status. Susceptibility to institutional pressures within a given organizational field varies with the status of an organization (Podolny, 1993; Phillips and Zuckerman, 2001). Research has shown low status organizations to be more likely to introduce new practices that diverge from the existing institutions and high status organizations to be more likely to mobilize resources to maintain the status quo (Leblebici et al., 1991; Haveman and Rao, 1997; Palmer and Barber, 2001; Kraatz and Moore, 2002). Although organizations were the unit of analysis in the latter stream of research, it is apparent that individual members of low status organizations introduced these changes.

Actors who belong to low status organizations are in a challenger position (Fligstein,

1997; Hensmans, 2003) relative to actors who belong to high status organizations in a given organizational field. Because low status organizations, being less privileged by the dominant institutional arrangements, have less to lose from social deviance, members of these organizations are more likely to be willing to transform the existing institutional arrangements. The “pattern of value commitments” (Greenwood and Hinings, 1996: 1036) in low status organizations, that is, the extent to which members of low status organizations are committed to the prevailing institutional arrangements, is likely to facilitate the development and implementation of divergent organizational change insofar as other organizational members are likely to be less committed than actors who belong to high status organizations to the dominant institutional arrangements.

H1a: Actors who belong to low status organizations within a given organizational field are more likely to initiate divergent organizational change.

Social group status. Actors’ position in a given organizational field is also partly determined by the status of the social groups to which they belong. In organizational fields, relationships among members are structured by interaction rituals across social groups (Lawrence, 2004). These rituals are dictated by the dominant institutionalized template for organizing in the field, and contribute to establishing a status hierarchy among social groups. Different fields host different types of social groups with varying levels of social status. For example, in the healthcare sector, in which professional groups are the most salient social groups, physicians benefit from higher status than other groups of healthcare professionals (e.g., Starr, 1982).

Actors who belong to high status social groups benefit from the prevailing

institutional arrangements, which reinforce their dominance over actors who belong to low status social groups. In multi-professionalized organizational fields, different professions have different statuses. High status professional groups defend their traditional privileges and autonomy, whereas low status professional groups, less favored by the prevailing institutional arrangements, might be more willing to fight the status quo (Abbott, 1988; Starr, 1982). Being in a challenger position (Fligstein, 1997; Hensmans, 2003), members of low status social groups might have more incentive than members of high status social groups to modify the prevailing institutional arrangements.

H1b: Actors who belong to low status social groups within a given organizational field are more likely to initiate divergent organizational change.

Position in the Organization

Because actors low in the organizational hierarchy do not have sufficient legitimacy or access to the resources needed to initiate divergent organizational change, it falls to those who occupy higher hierarchical positions to initiate such change (Tushman and Romanelli, 1985). Research on top management teams has highlighted the key role of top managers in organizational change (e.g., Hambrick and Mason, 1984; Finkelstein and Hambrick, 1996). Executives, for example, played a key role during the 1970s and 1980s in the adoption of professional programs that diverged from taken-for-granted practices in liberal arts colleges (Kraatz and Moore, 2002).

Actors who occupy higher hierarchical positions can leverage the authority associated with those positions to impose divergent organizational changes that break with the norms for the field. They are also more likely to have access to key resources needed to

support the initiation of divergent organizational change.

H2: The higher actors are in the hierarchy of their organization, the more likely they are to initiate divergent organizational change.

Joint Effect of Position in the Organizational Field and Position in the Organization

Thus far I have discussed the possible independent contributions to the initiation of divergent organizational change of actors' positions in their organization and in the organizational field. The arguments advanced to justify the impact of position in the organizational field (H1a and H1b) revolve mainly around actors' willingness to initiate divergent organizational change, while the arguments used to justify the impact of position in the organizational hierarchy (H2) revolve mainly around actors' ability to initiate divergent organizational change. But willingness and ability to act are not independent (Vroom, 1964). Whereas able individuals are more likely to anticipate success and thus be more willing to act, the opposite is true of those with less ability. This relationship between motivation and ability to act suggests that the effect of position in the organizational field on the likelihood that an actor will initiate divergent organizational change will be stronger for actors who are higher in the hierarchy of their organization.

H3a: Actors who belong to low status organizations and who are higher in the hierarchy of their organization are more likely to initiate divergent organizational change.

H3b: Actors who belong to low status social groups and who are higher in the hierarchy of their organization are more likely to initiate divergent organizational change.

Changes in Social Position

Capturing changes in social position within an organization and an organizational

field can also help to explain why some actors are more likely than others to initiate divergent organizational change. The characteristics of a new position will dispose an actor to be more or less likely to initiate such change (see hypotheses H1a, H1b, H2, H3a, and H3b). Potential consequences of changes in actors' positions within organizations and organizational fields are dealt with indirectly by the foregoing hypotheses, but one important dimension of such changes has yet to be considered. To account for the dynamic aspect of social position, it is necessary to take into account an actor's level of inter-organizational mobility, that is, the number of different organizations in which the actor has worked.

Research suggests that degree of inter-organizational mobility might be an important predictor of who initiates divergent organizational change (Kraatz and Moore, 2002; Boxenbaum and Battilana, 2005). Actors' with higher levels of inter-organizational mobility, having been exposed to greater numbers of different organizational contexts, are less likely to take for granted the functioning of their current organizations and more likely to be aware of existing opportunities for action in their organizational field. They are more likely, for instance, to be aware of the existence of heterogeneous institutional arrangements across their organizational field. To the extent that such awareness is likely to trigger their reflective capacity (Emirbayer and Mische, 1998; Seo and Creed, 2002; Sewell, 1992) and thereby enable them to take some critical distance with the existing institutional arrangements, they will be more likely to initiate divergent organizational change.

H4: The higher the actors' level of inter-organizational mobility, the more likely they are to initiate divergent organizational change.

THE UNITED KINGDOM'S NATIONAL HEALTH SERVICE

Inaugurated in 1948, the NHS is a public, state-funded healthcare system. In 2004, its budget was approximately £42 billion and it employed more than a million people. All UK residents have access to NHS services, which are free at the point of delivery. Although the NHS has undergone some changes over the past 60 years, the key actors and dominant institutionalized template for organizing have remained virtually the same.

Key Actors in the Organizational Field

The government has always played a central role in the management of the NHS (Le Grand, 1999, 2002), including mandating strategic change initiatives, but managers at the regional and organizational levels are responsible for implementing such change guided by local needs and circumstances. Hence, rather than provide a specific blueprint for change, NHS policies tend to offer a broad outline, allowing for local innovation during implementation (Harrison and Wood, 1999; Peckham and Exworthy, 2003).

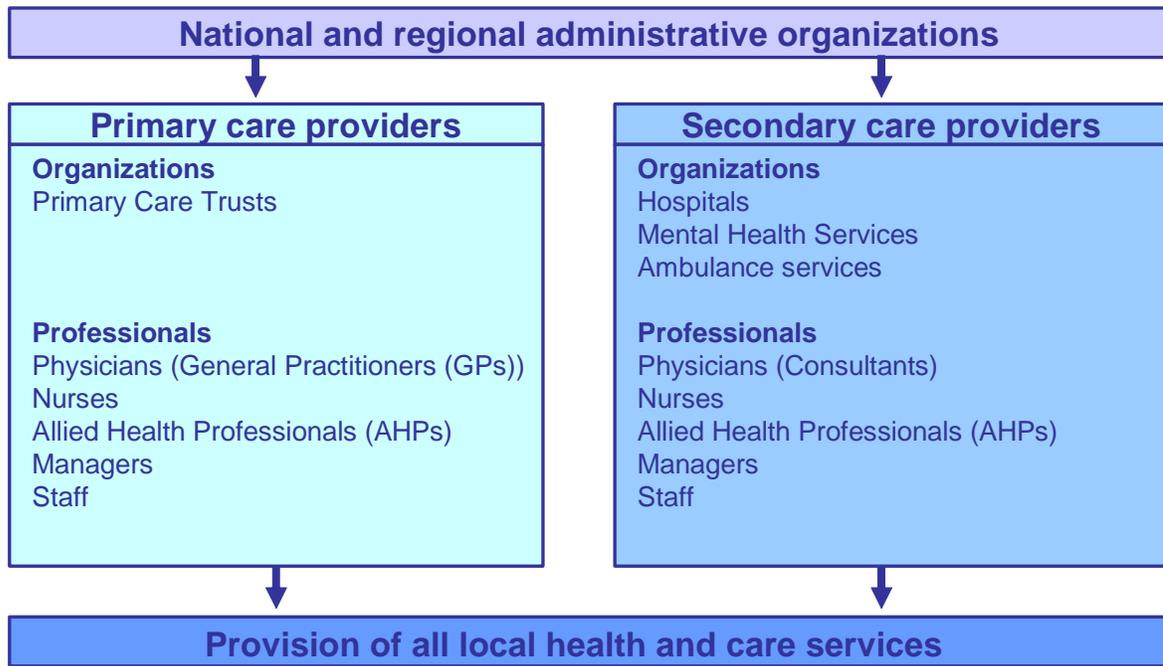
Seven classes of professionals deliver services within the NHS: physicians, including consultants who work in hospitals and general practitioners (GPs) who work in general practices; nurses; allied health professionals¹; pharmacists; health assistants; managers; and support staff such as porters and cleaners. Healthcare professionals, be they physicians, nurses, or allied health professionals, can fill purely clinical positions, but might also have either both clinical and managerial responsibilities or only managerial

¹ Allied health professionals include art therapists, chiropodists and podiatrists, dietitians, drama therapists, music therapists, occupational therapists, orthoptists, paramedics, prosthetists and orthotists, physiotherapists, diagnostic radiographers, speech and language therapists, and therapeutic radiographers.

responsibilities. Those who fall into the two latter categories are said to be clinical managers.

The organizational field of the NHS includes a multitude of organizations that fall into three broad categories: administrative organizations; primary care service providers; and secondary care service providers. Administrative organizations are responsible for running the NHS at the regional and/or national level. All NHS professionals who provide primary care services, that is, services provided to patients when they first have a health problem, are managed by local health organizations called Primary Care Trusts (PCTs) that serve large populations of 250,000 or more. All general practices were required to join PCTs when the latter were created in 1998. PCTs provide primary care services and commission secondary care services from hospitals. NHS hospitals provide secondary care services, that is, acute and specialist services, to treat conditions that normally cannot be dealt with by primary care providers. Hospitals are managed by NHS Trusts that closely monitor the quality of hospital health care and the efficiency of hospital budgets. Figure 3 identifies the key organizational and professional actors in the organizational field of the NHS.

Figure 3: Key organizational and professional actors of the NHS

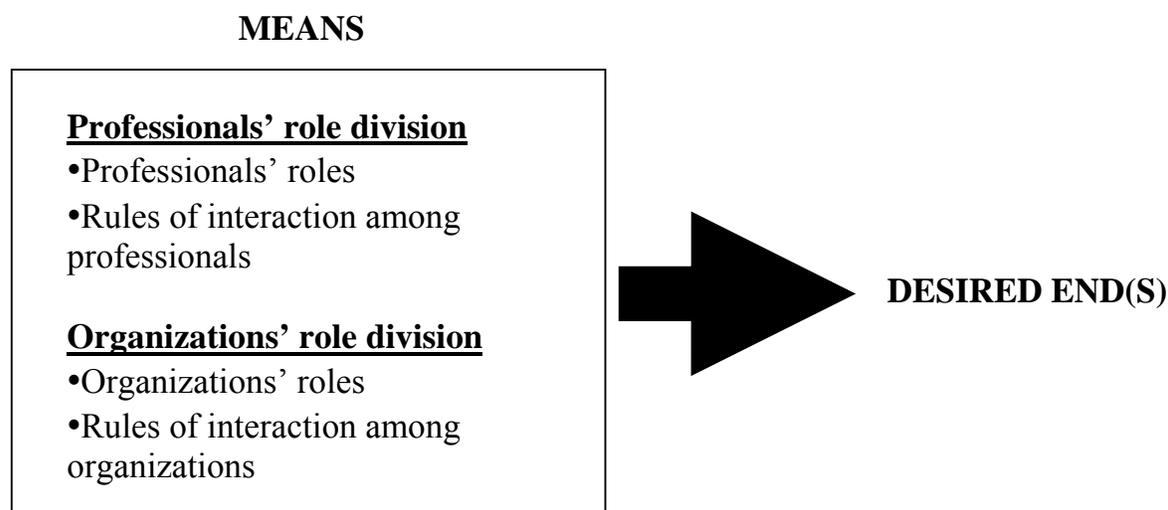


The Dominant Institutional Logic of Medical Professionalism

The institutionalized template for organizing within a given organizational field is often referred to as an institutional logic (Scott, 1987, 1994; Dobbin, 1994). Institutional logics are taken-for-granted social prescriptions that guide actors' behavior in the respective fields. They are collective means-ends designations that represent a field's shared understanding of what goals to pursue and how to pursue them. Institutional logics, like rationalized myths (Meyer and Rowan, 1977), have two main properties. First, they are rationalized, impersonal prescriptions that identify desired ends and specify, in a rule-like way, the appropriate means to pursue those ends. Second, they are highly institutionalized and thus widely shared at the organizational field level.

Logics are characterized in terms of the desired ends and appropriate means that they specify. Means refer to the role identities of the organizational field members (Rao, Monin and Durand, 2003), that is, who should be involved in the organizational field, what they should be doing, and how they should interact with one another. In other words, means specify actors' role division in a field. Professionals' role division and organizations' role division are the two different types of means in multi-professionalized organizational fields like the NHS. I use these two dimensions to characterize logics in multi-professionalized fields (see Figure 4).

Figure 4: Characterization of logics



Following the same approach as Thornton (2002) (also see Thornton and Ocasio, 1999), I identified the ideal-type (Weber, 1904) of the dominant institutional logic in the NHS, that is, the logic of medical professionalism. I determined this prevailing institutional logic through a comprehensive literature review and forty-six semi-structured interviews with different categories of NHS professionals. These two data sources yielded remarkably consistent descriptions of the dominant institutional logic. To cross-validate my analysis of

the organizational field of the NHS, I conducted three additional interviews with academics who are NHS specialists.

The NHS has, as have other healthcare systems throughout the western world (e.g., Kitchener, 2002; Scott et al., 2000; Reay and Hinings, 2005), been dominated since its creation by an institutional logic of medical professionalism, despite attempts by various Conservative and Labour governments to infuse new logics. The logic of medical professionalism, like most other logics in the healthcare sector, has as its desired end the reduction of morbidity and mortality. To that end, this logic specifies role divisions among both professionals and organizations.

The model of professionals' role division is predicated on physicians' dominance over all other categories of healthcare professionals. Physicians have been the key decision makers in the field, controlling not only the delivery of services but also, in collaboration with successive governments, the organization of the NHS (for a review, see Harrison, Hunter, Marnoch and Pollitt, 1992: 30-33). They are powerful, both collectively at the national level and individually at the local level (Harrison et al., 1992). Their power stems from both the social legitimacy of their mission and their exclusive ability to apply expert and esoteric knowledge to particular cases (Freidson, 1986; Abbott, 1988: 99-100). Physicians command deference from the general public as well as from most other groups of healthcare professionals. Nurses, for example, are expected to act as physicians' assistants; allied health professionals, termed medical auxiliaries when the NHS was created, depend on physicians' instructions (Jones, 1991). As for managers, they not only refrain from contradicting physicians but often act in the capacity of "diplomats" in order to smooth

internal conflicts in organizations and facilitate the physicians' work (Harrison, 1988; Giaimo, 2002).

The logic of medical professionalism also specifies a model of organizations' role division. This model places hospitals at the heart of the healthcare system. Hospitals often benefit from a monopoly position as providers of secondary care services in their health communities (Le Grand, 1999), within which they provide most of the healthcare services and receive most of the resources. Primary care organizations serve as gatekeepers to the secondary care sector, but primary and secondary care organizations tend to operate in isolation (Peckham and Exworthy, 2003). The emphasis in patient care on treating acute episodes of disease in the hospital setting rather than providing follow up and preventive care in the home or community setting that is under the responsibility of primary care organizations corresponds to an acute episodic health system. Table 1 presents the ideal-type of the logic of medical professionalism.

Table 1: Ideal-type of the logic of medical professionalism

Medical Professionalism Logic	
END	Reduce morbidity and mortality
MEANS	
Professionals' role division	
<i>Professionals' role</i>	<p>Physicians as key decision makers in the clinical and administrative domains</p> <p>Nurses as physicians' assistants</p> <p>Allied health professionals as medical auxiliaries</p> <p>Managers (administrators) as 'diplomats' facilitating the work of physicians</p>
<i>Rules of interaction among professionals</i>	<p>Physicians hold authority over all other NHS professionals in the clinical and in the administrative domains</p>
Organizations' role division	
<i>Organizations' role</i>	<p>Hospitals as both commissioners and providers of secondary care services</p> <p>Administrative bodies responsible for planning and budget allocation</p> <p>General practices as gatekeepers to the secondary care sector</p>
<i>Rules of interaction among organizations</i>	<p>Hospitals hold authority over all other NHS organizations</p>

Setting the Stage for the Possibility of Change

Different governments have challenged the dominant institutional logic of medical professionalism by attempting to infuse the NHS with new logics. The set of reforms implemented by the Conservative government of Margaret Thatcher, beginning in the mid-1980s with the Griffiths' report (Griffiths, 1983) and continuing with the implementation of quasi-market reforms in the early 1990s, aimed to make healthcare services manager-driven rather than profession-led and to shift the balance of power from the secondary to the primary care sector (Klein, 1998). Similarly, the Labour government of Tony Blair tried to infuse the NHS with a new logic that promoted collaboration across both professions (Peckham and Exworthy, 2003) and sectors (Hunter, 2000; Le Grand, 2002; Peckham and Exworthy, 2003). The public authorities' objective was to operate a shift from an acute episodic healthcare system to a system that would provide continuing care by integrating services and increasing cooperation among categories of professionals.

That a distinct dominance order that finds physicians (Harrison, 1988; Harrison et al., 1992; Crilly, 2000; Ferlie, Fitzgerald, Wood and Hawkins, 2005) and hospitals (Peckham and Exworthy, 2003) operating at the apex continues to prevail despite these attempts at change suggests that the NHS is a relatively institutionalized organizational field. But the attempts begun in mid-1980s to challenge the dominant institutional logic have set the stage for the possibility of change by introducing some degree of heterogeneity in the NHS (Sewell, 1992; Whittington, 1992; Clemens and Cook, 1999; D'Aunno, Succi and Alexander, 2000; Seo and Creed, 2002; Dorado, 2005; Lounsbury, 2007). The practices proposed as alternatives to the logic of medical professionalism, even though they have not been institutionalized, have introduced some variance across existing practices in the field

and thereby sowed the seeds of change. The organizational field of the NHS thus now offers some opportunity for action that diverges from the dominant institutional logic. As emphasized in the foregoing analysis of the field, however, the vast majority of actors in the NHS continue to take for granted the model of medical professionalism. What, then, enables some actors to diverge from this model? Very likely, given that all the actors are embedded in the same organizational field, factors other than organizational field characteristics such as social position are responsible for enabling actors to initiate divergent organizational change.

METHOD

Participants

I tested my hypotheses with data from 93 change projects, each conducted by a clinical manager from the NHS who had attended a strategic leadership executive education program between January 2003 and May 2004. Participation to the program was entirely voluntary. As part of the program, participants were required, among other things, to design and implement a change project within their organizations. Participants were free to choose the change project they wanted to implement. There was no reference to “divergent” organizational change in the presentation of the program. Hence, although they undoubtedly had some interest in change, the program being focused on leading change, the participants were neither selected nor self-selected into the program for their interest in engaging in divergent organizational change per se.

The 93 clinical managers who participated in the study ranged in age from 34 to 56 years, the average age was 43. Seventy one were women and 22 were men. All had clinical

backgrounds: 24 percent were physicians, 28 percent were allied health professionals, and 48 percent were nurses. All participants had managerial responsibilities, the level of responsibility varying from mid- to top-level management. The participants represented a variety of NHS organizations: 44 percent worked within PCTs; 45 percent worked in hospitals or other secondary care organizations; the remaining 11 percent were employed by NHS administrative bodies.

Data Collection

Participants were required before attending the program to write a comprehensive description of the change project they intended to initiate. This description was to be refined after two months of project implementation. They also participated, in groups of five, in two conference calls after five and ten months of implementation, respectively, for purposes of discussing any difficulties encountered during implementation. Being included in the conference calls enabled me to follow up on all the change projects. I tracked the 93 projects over a ten-month period to ensure that all participants had actually initiated their change projects.

The study participants agreed to let me use all available information about their projects over a two-year follow-up period, and granted me access to their curriculum vitae. Although study participation was voluntary, all 95 program participants agreed to participate; the final sample of 93 observations, corresponding to 93 change projects, reflects the omission of two participants for whom data were incomplete.

Dependent Variables

Following Cliff et al. (2006), I developed a rank-ordered categorical measure of the change projects' degree of divergence from the dominant institutional logic of medical professionalism. The measure is based on a questionnaire (see Appendix 1) designed to assess the divergence from the ideal-type of the logic of medical professionalism (see Table 1). Items 1 to 4 in the questionnaire capture the change projects' degree of divergence from the institutionalized model of professionals' role division that characterizes the logic of medical professionalism. The six additional items assess the change projects' degree of divergence from the institutionalized model of organizations' role division. I developed instructions (see Appendix 2) for coding the change projects that involved coders using, for each of the ten items, a three-point, rank ordered scale.

Coding was based on the project descriptions the program participants wrote after two months of project implementation. These were, on average, three pages long and followed the same template, presenting the project's goals, the resources required to implement the project, the people involved, the key success factors, and the measurement of the outcomes. I, and two independent coders blind to the study's hypotheses, coded the change projects. To facilitate discrepancy resolution, we noted passages in the change project descriptions deemed relevant to the codes (Larsson, 1993). Inter-rater reliability, as assessed by the kappa correlation coefficient, was 0.90, suggesting a high degree of agreement among the three raters (Landis and Koch, 1977; Fleiss, 1981).

I ran a factor analysis on the results of the coding to determine whether the ten items in the questionnaire had common underlying factors. As the data were rank-ordered

categorical, I had to generate polychoric correlations to be able to run the factor analysis (Pearson and Pearson, 1922; Olsson, 1979; Kolenikov and Angeles, 2004).² Using the resulting correlation matrix, I ran a principal component analysis (see Kim and Mueller, 1978; Selvin, 1995) to identify underlying constructs. I used varimax rotation (Kaiser, 1958) to increase the distinctiveness of clusters of inter-correlation among factors (see Rummel, 1970 for an in-depth discussion of rotation criteria).

Factor analysis of the ten items revealed two factors with eigenvalues greater than 1 (see Table 2): development of a more integrated healthcare system (Factor 1), and empowerment of non-physicians (Factor 2). These factors correspond to two dimensions on which change projects might diverge from the dominant logic of medical professionalism. The first has to do with organizations' role division. Change projects that diverge from the logic of medical professionalism on this dimension aim to substitute a more integrated healthcare system for the acute episodic healthcare system that has long prevailed at the NHS. The second factor has to do with professionals' role division. Change projects that diverge from the logic of medical professionalism on this dimension aim to substitute for the continuing dominance of physicians in the NHS the empowerment of non-physicians. The two multi-item scales that correspond to these two factors exhibited acceptable reliability

² The polychoric correlation of two ordinal variables is derived as follows. Suppose each of the ordinal variables was obtained by categorizing a normally distributed underlying variable, and those two unobserved variables follow a bivariate normal distribution. The (maximum likelihood) estimate of that correlation is the polychoric correlation. If each of the ordinal variables has only two categories, the correlation between the two variables is referred to as tetrachoric. This method is based on the assumption that observed rank ordered categorical variables are indeed latent continuous variables that follow a multivariate normal distribution.

values, 0.88 for the development of a more integrated health care system and 0.79 for the empowerment of non-physicians.

Table 2: Factor analysis results

	Factor 1	Factor 2	Communality
Item 1	.093	.964	.938
Item 2	-.226	.843	.763
Item 3	.155	.922	.875
Item 4	.331	.856	.843
Item 5	.968	.111	.949
Item 6	.919	.025	.845
Item 7	.976	.198	.992
Item 8	.953	.082	.915
Item 9	.827	-.044	.686
Item 10	.828	.110	.698
		Total	8.505
Eigenvalue	5.487	2.468	

All change projects were assigned a score ranging from 1 to 3 on each of the two dimensions. These scores, the average of the corresponding items for each factor, i.e., items 1 to 4 for the empowerment of non-physicians and items 5 to 10 for the development of a more integrated healthcare system, measure the extent to which each change project diverges from the institutionalized model of professionals' role division and the institutionalized model of organizations' role division. An example of a project that diverges from the institutionalized model of organizations' role division is a project aimed at offering an alternative to hospitalization by creating intermediate care services for older people in the primary care sector. Projects aimed at developing nurse-led preadmission clinics or nurse-

led discharge are examples of change projects that diverge from the institutionalized model of professionals' role division by transferring decision making power from physicians to nurses. An example of a project that diverges from the institutionalized model of both organizations' and professionals' role division is a project that would transfer the rehabilitation unit for stroke patients from the secondary to the primary care sector and substitute a physiotherapist for the physician who led the rehab unit. An example of a project that does not diverge from the institutionalized model of either organizations' or professionals' role division is a project that involved reorganizing the booking system in a general practice by hiring a new assistant and implementing a new work schedule.

Independent Variables

Organization status. Participants represented two organizational statuses: PCTs, the lower status organizations, and hospital and administrative organizations, the higher status organizations. Their role of commissioners of secondary care services in the NHS notwithstanding, PCTs are newer and still considered to be lower status organizations than hospitals and administrative organizations (Peckham and Exworthy, 2003). Healthcare professionals working in the primary care sector are still very often perceived to be gatekeepers, as if their only function was to regulate access to secondary care services. Even if they are the new budget holders, PCTs are always, because the NHS is state-funded, dependent on administrative organizations for budget allocation. Organizations' status was measured with a dummy variable where 1=low status organizations, i.e., PCTs and 0=high status organizations, i.e., non PCTs.

Social group status. Two social group statuses were represented: physicians are of higher status, and other healthcare professionals of lower status. Professional groups are the most salient social groups in the NHS. Ferlie et al. (2005) observed strong boundaries between the different professional groups, which have been educated and socialized in different ways. In the NHS, as in most healthcare systems, physicians benefit from a higher status position relative to other healthcare professionals (Harrison et al., 1992). Like organizations' status, professional groups' status was measured with a dummy variable where 1=low status professionals, i.e., non-physicians and 0=high status professionals, i.e., physicians.

Hierarchical position. I measured an actor's hierarchical position by means of a rank-ordered categorical variable that represented position in the organizational hierarchy (1=deputy head/assistant director, 2=head of service; 3=non executive director; 4=executive director with a seat on the organization's board). Note that my sample ranges from middle managers through top managers, and that two-thirds of the sample corresponds to executive and non-executive directors. As a government-run organization, the NHS has standardized definitions and pay scales for all positions, thus improving my confidence that subjects' roles, responsibilities and hierarchical positions were uniform across organizational sites.

Inter-organizational mobility. Actors' inter-organizational mobility was measured as the number of different organizations within the NHS in which they worked during the course of their career.

Control Variables

Managers might initiate divergent organizational changes for reasons other than their social position. I controlled for the potential impact of a number of demographic (age and gender), career specific (educational background, highest clinical and/or management degree earned, tenure in management positions and in current formal position), and organizational characteristics (budget and performance). Only two career specific variables, tenure in management positions and tenure in current formal position were significant or almost significant.

Tenure in management positions. Tenure in management positions, which I measure as the number of years spent in management positions, might influence how likely an actor is to initiate divergent organizational changes. Management experience is likely to make an actor more comfortable with initiating change, especially divergent organizational changes that break with practices widely used and accepted not only within a given organization, but throughout the organizational field. Actors with longer tenure in management positions might be more confident of their ability to implement divergent organizational changes and thereby more likely to do so.

Tenure in current position. The likelihood that actors will initiate divergent organizational changes might also be influenced by their tenure in their current position, which I measure as the number of years spent in the current position. Actors who would convince other organizational members to abandon practices that are widely accepted and used not only in their organization but throughout the organizational field must have legitimacy in the eyes of those other organizational members. They also need to have in-

depth knowledge of their organization in order to overcome the obstacles they will likely encounter as they attempt to implement divergent organizational change. Actors with longer tenure in their current position usually command greater legitimacy in the eyes of both subordinates and superiors, and tend to be highly knowledgeable about the specificities of their organization (Huber, Sutcliffe, Miller and Glick, 1993). For these reasons, longer tenure is likely to be positively related to actors' ability to, and therefore the likelihood that they will, initiate divergent organizational change.

Data Analysis

Because my dependent variables are categorical and rank-ordered, I used ordered logit estimations in all models. Several of my observations (13 out of 93) correspond to managers who belong to the same organization. To address the non-independence of these observations, I adjusted baseline ordered logit estimations by clustering data with repeated observations on organizations and report robust standard errors.

RESULTS

Below I report the results associated with the two dependent variables, that is, the development of a more integrated healthcare system and empowerment of non-physicians. Table 3 reports means, standard deviations, and correlations. There are no critically collinear variables, i.e., greater than .8 in absolute value (Kennedy, 2003) in my data set.

Table 3: Summary statistics and bivariate correlations

	Mean	S.D.	Min	Max	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]
[1] Development of a more integrated healthcare system	1.387	0.520	1.000	2.833	1.000							
[2] Empowerment of low status professionals	1.449	0.509	1.000	2.500	0.106	1.000						
[3] Seniority in a management position	11.624	4.917	2.000	26.000	-0.009	0.237	1.000					
[4] Duration of tenure in current position	2.677	2.102	0.000	11.000	-0.142	0.101	0.032	1.000				
[5] Interorganizational mobility	4.796	2.577	1.000	14.000	0.152	0.046	-0.055	-0.137	1.000			
[6] Low status organization	0.441	0.499	0.000	1.000	0.313	0.025	-0.171	-0.143	-0.014	1.000		
[7] Low status social group	0.763	0.427	0.000	1.000	0.009	0.169	0.542	-0.037	-0.104	-0.117	1.000	
[8] Hierarchical position	3.022	1.000	1.000	4.000	-0.020	0.125	-0.215	-0.064	0.331	0.046	-0.344	1.000

N=93

Diverging from the Institutionalized Model of Organizations' Role Division

Table 4 shows results from five ordered logit regressions predicting actors' likelihood to initiate a change aimed at changing organizations' role division. In column 1 are results from an equation with only the control variables (tenure in management positions and tenure in current position); column 2 shows results from an equation with control variables and the main effect variables that correspond to actors' position in the organizational field (organization's status and social group's status), actors' position in the organization (hierarchical position), and changes in actors' position (inter-organizational mobility). In column 3 are results from an equation with control variables and all the above cited main effect variables plus the first interaction term (organization status x hierarchical position); column 4 shows results with the same control variables and main effect variables plus the second interaction term (social group status x hierarchical position), and, finally, in column 5 are results from an equation with all variables. The contribution of one or more variables was assessed with the likelihood ratio test, which compares the goodness of fit of a pair of nested models distinguished by one or a set of variables (Bishop, Fienberg and Holland, 1975).

The results support H1a, which states that actors who belong to low status organizations are more likely to initiate divergent organizational change, in this case, to develop a more integrated healthcare system (see column 2). Social group status is not significantly related to the likelihood that actors will initiate divergent organizational change that breaks with organizations' role division (see column 2). Thus, the results do not support H1b, which states that actors who belong to low status social groups are more likely to initiate divergent organizational change. There is a statistically significant relationship

between actors' hierarchical position and the likelihood that they will initiate changes aimed at developing a more integrated healthcare system (see column 2). But this relationship is the opposite of the one hypothesized in H2, which states that the higher actors are in the hierarchy of their organization, the more likely they are to initiate divergent organizational change. Indeed, the results show that the higher they are in the hierarchy of their organization, the less likely actors are to break with the institutionalized model of organizations' role division.

H3a and H3b concern the interaction between actors' position in the organization and the organizational field. H3a, which states that actors who belong to low status organizations and who are higher in the hierarchy of their organization are more likely to initiate divergent organizational change, is not supported (see columns 3 and 5). But the results do support H3b, which states that actors who belong to low status social groups and who are higher in the hierarchy of their organization are more likely to initiate divergent organizational changes that break with organizations' role division (see columns 4 and 5).

H4, which states that the higher their level of inter-organizational mobility, the more likely actors are to initiate divergent organizational change aimed at developing a more integrated healthcare system, is supported (see column 2). As for the control variables, neither tenure in management positions nor tenure in current position is significantly related to the likelihood that actors will initiate divergent organizational change aimed at changing organizations' role division (see column 1).

Table 4: Ordered logit coefficients predicting actors' likelihood to initiate a change aimed at changing organizations' role division

	(1)	(2)	(3)	(4)	(5)
Tenure in management positions	-0.002 (0.037)	0.039 (0.043)	0.038 (0.043)	0.049 (0.042)	0.046 (0.042)
Tenure in current position	-0.088 (0.078)	-0.052 (0.075)	-0.050 (0.073)	-0.084 (0.076)	-0.080 (0.074)
Inter-organizational mobility		0.165 *** (0.065)	0.166 *** (0.064)	0.148 ** (0.073)	0.149 ** (0.072)
Low status organization		1.145 *** (0.441)	0.959 (1.462)	1.133 *** (0.434)	0.703 (1.488)
Low status social group		-0.459 (0.563)	-0.441 (0.570)	-5.140 ** (2.605)	-5.217 ** (2.617)
Hierarchical position		-0.307 * (0.203)	-0.324 ** (0.188)	-1.502 ** (0.689)	-1.573 ** (0.701)
Hierarchical position x Low status organization			0.062 (0.466)		0.143 (0.474)
Hierarchical position x Low status social group				1.297 ** (0.704)	1.330 ** (0.714)
Log pseudolikelihood	-172.54	-165.67	-165.66	-164.43	-164.38
Wald chi-squared	1.32	17.67 ***	17.99 **	17.64 **	17.89 **
Δ LR-test		13.75 ***	13.77 **	16.22 ***	16.33 **

N=93; Robust standard errors in parentheses

* significant at 10%; ** significant at 5%; *** significant at 1%

Statistical significance based on one-tailed tests for all independent variables and interaction terms

Δ LR-test based on comparison with model (1)

Diverging from the Institutionalized Model of Professionals' Role Division

The columns in table 5 correspond to the same models presented in table 4, save that the dependent variable is the empowerment of non-physicians. In this case, H1a, which states that actors who belong to low status organizations are more likely to initiate divergent organizational change, is not supported (see column 2). But H1b, which states that actors who belong to low status social groups are more likely to initiate divergent organizational change, in this case, to empower non-physicians, is supported (see column 2). The results also support H2, which states that the higher they are in the hierarchy of their organization, the more likely actors are to initiate divergent organizational changes aimed at empowering non-physicians (see column 2).

None of hypotheses that concern the interaction between actors' position in the organizational field and in the organization is supported (see columns 3 to 5), but there is a statistically significant relationship between actors' likelihood to break with social groups' role division and the interaction term between the status of the social group to which actors belong and their hierarchical position (see columns 4 and 5). This relationship is the opposite of the one hypothesized in H3b, which states that actors who belong to low status social groups and who are higher in the hierarchy of their organization are more likely to initiate divergent organizational change. Indeed, there is a negative relationship between actors' likelihood to break with social groups' role division and the interaction term between the status of the social group to which actors belong and their hierarchical position.

H4, which states that the higher their level of inter-organizational mobility, the more likely actors are to initiate divergent organizational changes aimed at empowering non-

physicians, is not supported (see column 2). As for the control variables (see column 1), tenure in management positions has a positive and significant impact on actors' likelihood to initiate changes that break with the institutionalized model of social groups' role division. Insofar as changing social groups' role division has important power implications, actors with longer tenure in management positions, who have more management experience, are more likely to initiate such changes. Finally, there is no statistically significant relationship between tenure in their current position and the likelihood that actors will initiate changes aimed at changing professionals' role division.

Table 5: Ordered logit coefficients predicting actors' likelihood to initiate a change aimed at changing professionals' role division

	(1)	(2)	(3)	(4)	(5)
Tenure in management positions	0.082 ** (0.032)	0.082 ** (0.039)	0.092 ** (0.042)	0.075 * (0.039)	0.087 ** (0.043)
Tenure in current position	0.058 (0.072)	0.102 (0.075)	0.094 (0.077)	0.129 (0.087)	0.123 (0.092)
Inter-organizational mobility		-0.020 (0.078)	-0.033 (0.084)	0.012 (0.082)	-0.001 (0.086)
Low status organization		0.264 (0.461)	1.564 (1.623)	0.268 (0.463)	1.768 (1.618)
Low status social group		0.777 * (0.556)	0.635 (0.601)	7.766 ** (4.482)	7.995 ** (4.564)
Hierarchical position		0.531 ** (0.236)	0.672 *** (0.263)	2.290 ** (1.136)	2.551 ** (1.189)
Hierarchical position x Low status organization			-0.428 (0.521)		-0.492 (0.514)
Hierarchical position x Low status social group				-1.869 * (1.188)	-1.977 * (1.220)
Log pseudolikelihood	-146.11	-142.81	-142.34	-141.36	-140.74
Wald chi-squared	8.54 **	13.29 **	14.20 **	20.88 ***	20.90 ***
Δ LR-test		6.60	7.53	9.51 *	10.74 *

N=93; Robust standard errors in parentheses

* significant at 10%; ** significant at 5%; *** significant at 1%

Statistical significance based on one-tailed tests for all independent variables and interaction terms

Δ LR-test based on comparison with model (1)

DISCUSSION

This study investigates whether social position in the organizational field and in the organization influences the likelihood that actors will initiate divergent organizational change. The results show that social position is an important enabling condition for divergent organizational change. The study also provides insight into the different types of divergent organizational change and suggests that their social position influences the type of divergent organizational change actors undertake. The positional characteristics of the actors who are more likely to initiate each type of divergent organizational change are quite different.

Social Position and Divergent Organizational Change

The results show the characteristics of actors' position in the organizational field to be related to the likelihood that they will initiate divergent organizational change, and these relationships to vary depending on the dimension on which the change constitutes a break with the dominant institutional logic. Actors who belong to low status organizations (PCTs in the study) are more likely to initiate divergent organizational change that breaks with the institutionalized model of organizations' role division, while actors who belong to low status social groups (low status professionals in the study) are more likely to initiate divergent organizational change that breaks with the institutionalized model of social groups' role division. These results are consistent with results of studies (Leblebici et al., 1991; Kraatz and Zajac, 1996; D'Aunno et al., 2000) conducted at the organizational level of analysis that showed that organizations disadvantaged by the existing institutional arrangements are more likely to initiate divergent organizational change.

More important, these results identify at least two different categories of institutional arrangements: those that have to do with organizations' role division, and those that have to do with social groups' role division. Actors might be advantaged by one and disadvantaged by another category of institutional arrangements. Actors might thus, depending on their position in the organizational field, initiate one type of divergent organizational change but not the other.

It is further clear that their position in the hierarchy of their organization also influences the likelihood that actors will initiate divergent organizational change. The results show the influence of actors' hierarchical position to differ depending on the dimension on which actors break with the dominant institutional logic in the organizational field. The higher they are in the hierarchy of their organization, the more likely actors are to initiate divergent organizational change aimed at changing social groups' role division, but the less likely they are to initiate divergent organizational change aimed at changing organizations' role division.

This radically different relationship between actors' hierarchical position and their likelihood to initiate divergent organizational change aimed at changing professionals' role division vs. organizations' role division might be due to the fact that one type of divergent organizational change, namely, change in social groups' role division, implies mainly changes that are internal to the organization, whereas the other type of divergent organizational change, namely, change in organizations' role division, implies changes that are also external to the organization. Actors higher in the hierarchy of their organization are more able, and more likely, to initiate divergent organizational change within their

organization, and thereby to change social groups' role division, because they have the legitimacy and access to resources that other organizational members might lack (Tushman and Romanelli, 1985). But actors who are higher in the hierarchy of their organization are also more likely to conform to inter-organizational rules of interaction and therefore be less likely to initiate divergent organizational change aimed at changing organizations' role division.

The influence of the interaction effect between the social group to which they belong and their position in the hierarchy of their organization is also radically different depending on the dimension on which actors break with the dominant institutional logic. To adequately interpret the influence of the different interaction terms on actors' likelihood to initiate divergent organizational change, it is necessary to keep in mind the findings associated with the variables involved in these interaction terms. These findings suggest that the higher they are in the hierarchy of their organization, the less likely actors are to initiate divergent organizational change that involves breaking with the institutionalized model of organizations' role division. But the results associated with the interaction term between the social group to which actors belong and their position in the hierarchy of their organization suggest that this effect is relatively more pronounced for actors who belong to high status than for those who belong to low status social groups. That the dampening effect of higher hierarchical position on actors' likelihood to initiate divergent organizational change appears to be less pronounced for those who belong to low status than for those who belong to high status social groups might be due to the fact that actors who belong to low status social groups have more experience fighting against the status quo. Thus, even as they ascend the

organizational hierarchy, they might be less likely than actors who belong to high status social groups to conform to the existing rules of inter-organizational relationship.

The results show that actors who belong to low status social groups are more likely to initiate divergent organizational change that involves breaking with social groups' role division because the existing institutional arrangements favor them less than actors who belong to high status social groups. But the results associated with the interaction term between the social group to which actors belong and their position in the hierarchy of their organization suggest that actors who have made it to the top of the hierarchy of their organization and who belong to low status social groups are relatively less likely to initiate changes aimed at changing social groups' role division.

A similar phenomenon has been observed in studies of women and ethnic minorities in the workplace. Women who have made it to the top of the organizational hierarchy sometimes display the so-called "queen bee" syndrome (Kanter, 1977a, 1977b; Cohen, Broshak and Haveman, 1998) whereby they perceive the inclusion of other women to be a threat to their special status. In the same vein, Smith (2005), studying the conditions that enable black, urban, poor job seekers to mobilize their network of relations for job-finding assistance, observed that their difficulty finding jobs might be partly due to the fact that job contacts within this community often express great reluctance to assist their job-seeking ties. The findings of the study I conducted are similar to those reported above in that they suggest that actors who belong to low status social groups but are currently high in the organizational hierarchy are more reluctant to promote other actors who belong to low status social groups.

There are several possible explanations for such behavior. It might be that having made it to “the top,” they adopt a highly individualistic approach, that having achieved their personal objective, they feel it is not necessary to fight anymore. They might also perceive others who still belong to low status social groups to be a potential threat, an explanation equivalent to the “queen bee” syndrome explanation related above. Another possibility is that as they get higher in the organizational hierarchy, actors might identify more with their organization and less with their social group. Finally, it might be that actors seeking to be regarded as legitimate members of the group of top managers attempt to forget, and have others forget, their initial low status social group membership. This type of behavior is a way for them to demonstrate loyalty to the group of top managers and put distance between themselves and their old group members.

Lastly, the results show that actors with higher inter-organizational mobility are more likely than others to initiate divergent organizational change that involves breaking with the institutionalized model of organizations’ role division. These actors are more likely to understand the need for inter-organizational cooperation and who should cooperate with whom to satisfy this need. No significant relationship was observed between inter-organizational mobility and actors’ likelihood to initiate changes aimed at changing social groups’ roles division.

Taken together, these results suggest that actors’ social position is an important enabling condition for divergent organizational change, but that the relationship between social position and actors’ likelihood to initiate divergent organizational change varies depending on the dimension on which actors break with the dominant institutional logic. It is

thus essential when dealing with divergent organizational change to analyze actors' profiles in terms of social position as well as the type of divergent organizational change they initiate.

Theoretical Contributions

This study makes four theoretical contributions. The first two relate to the literature on institutional change, the latter two to the literature on change in organizations. This study adds, first, to the body of research about institutional change. Researchers have already identified field-level and organizational-level enabling conditions for divergent change (Battilana, 2006). The present research complements their work by highlighting the influence of social position on the likelihood that actors will initiate divergent organizational change, and in doing so helps to resolve the paradox of embedded human agency. Resolving this paradox is crucial as it is a prerequisite for establishing the foundation for a theory of action within the framework of institutional theory. In the introduction of their seminal book, New Institutionalism in Organizational Analysis, DiMaggio and Powell (1991) called for the development of such a theory of action. This paper contributes to the micro-foundation needed to support the development of such a theory. Without solid micro-foundations, institutional theorists will not be able to fully account for institutionalization and deinstitutionalization processes (Zucker, 1991; Hirsch and Lounsbury, 1997).

Second, the focus on individual actors' social position contributes to the development of institutional theory by linking the individual level of analysis back to the organizational and organizational field levels. Individual change agents' actions, which have so far received scant attention, correspond to one type of force that might affect the

institutional order. This study contributes to the continuing awareness of the importance of human agents and paves the way for multi-level research that takes into account the individual, organizational, and organizational field levels of analysis suggested as a promising avenue of research within the framework of institutional theory (Friedland and Alford, 1991; Ocasio, 2002; Palmer and Biggart, 2002; Strang and Sine, 2002; Reay et al., 2006), and, more broadly, in the field of organizational studies (e.g., Rousseau, 1985). Such multi-level approaches should be taken not to imply that individual agents' actions are the only sources of institutional change, but rather to account for the fact that institutional change involves complex processes influenced by different types of forces and agents (Jepperson, 1991).

Finally, this study makes two important contributions to the literature about change in organizations. First, it broadens that literature by accounting for the influence on change initiatives of the wider institutional context as well as individual and organizational characteristics. While some studies about change in organizations (e.g., Armenakis, Harris and Mossholder, 1993; Cunningham, Woodward, Shannon, MacIntosh, Lendrum, Rosenbloom and Brown, 2002) account for the influence of the organizational context as well as individual actors' characteristics on their likelihood to implement change, most of these studies ignore the constraining role of institutional pressures stemming from the wider organizational field, as well as the influence that organizational change initiatives may have on this wider context.

Second, the findings suggest that divergent organizational change should be treated as a multi-dimensional rather than uni-dimensional concept. There are likely multiple

dimensions in organizational fields on which a change project might break with the dominant institutional logic. Studies conducted thus far about divergent organizational change (e.g., Greenwood and Hinings, 1996; D'Aunno et al., 2000) do not distinguish among dimensions on which such change diverges from the dominant institutional logic. The results presented here show there to be different types of divergent organizational change characterized by different predictors in terms of actors' positional characteristics.

Directions for Future Research

This study has a number of limitations that suggest directions for future research. First, because the analysis was limited to a non-probability sample of change projects initiated by clinical managers in the NHS, one cannot be assured that it is representative of any particular population of organizational leaders. I also cannot fully discount the possibility of sampling bias, as the study group consisted of self-selected individuals who applied, and were then all selected, for advanced leadership training.

Second, it would be interesting to test the model in different empirical settings. It might be that social position does not have the same impact as that observed in the present study in environments that are more (or less) conducive to change than that of the NHS. Some studies (Scherer and Lee, 2002; Greenwood and Suddaby, 2006) have shown that high status organizations might in certain situations initiate divergent change in a field. It is now necessary to explore whether the same phenomenon can be observed at the individual level and, if so, to highlight the circumstances under which individual actors who are privileged by the existing insitutional arrangements are more likely to initiate divergent organizational change. This would enable researchers to develop a contingent model of the impact of social

position on the likelihood that actors will initiate divergent organizational change.

Third, the impact of other positional characteristics such as actors' position in informal organizational networks and in multiple organizational fields might be a fruitful area of exploration. For example, their position in intra-organizational networks might enable actors who belong to low status social groups to undermine the resistance of actors who belong to high status social groups to divergent organizational change. Some studies (e.g., Boxenbaum and Battilana, 2005) have already highlighted multiple embeddedness' enabling role in fostering divergent organizational change. Because there is some variance across the institutional arrangements that characterize different fields, actors embedded in multiple fields are less likely to take any institutional arrangements for granted and thereby more likely to diverge from existing institutions (Sewell, 1992; Emirbayer and Mische, 1998; Seo and Creed, 2002). When they do so, they often transpose institutionalized practices from one field to another (Sewell, 1992; Schneiberg, 2002). A number of questions remain to be answered regarding the impact of actors' multiple embeddedness. Is the number of organizational fields in which actors have been, or are, embedded an indicator of the likelihood that they will initiate divergent organizational change? Is the likelihood of individuals to initiate divergent organizational change dependent on the degree of similarity of the organizational fields in which they are embedded? It might be that fields have to display a minimum degree of similarity for actors to be able to transpose institutionalized practices from one to another.

Future research should explore as well other individual factors that might enable divergent organizational change, individual psychological factors, for example. This line of

inquiry, although promising, is highly demanding because it requires researchers to control for the impact of other identified enabling conditions including field-level and organizational-level conditions. One way to avoid this trap is to examine the role of psychological factors in relation to actors' social position, which accounts for the interaction between the individual, organizational, and organizational field levels of analysis (Rousseau, 1978). Finally, future research should highlight the profiles, if any, of actors who are more likely to succeed in implementing divergent organizational change and examine the reasons for their success.

CONCLUSION

The results of this study show that actors' social position, among other variables, influences the likelihood that they will initiate divergent organizational change. The results further suggest that there are different types of divergent organizational change that tend to be undertaken by actors with radically different profiles in terms of social position. Such findings have important implications insofar as they contribute to better identifying individuals who are more likely to initiate major reforms in the private as well as in the public sector.

Agency occupies a prominent position among the indicators of the progress of institutional theory over the past 15 years considered by Scott (2001). The present study, in further examining the issue of agency in institutional theory, helps to resolve the paradox of embedded human agency and, in doing so, contributes to laying the micro-foundation for the development of a theory of action within the framework of institutional theory. Finally, this study suggests that organizational change initiatives are embedded in a broader

organizational field context that should be taken into account when studying organizational change. Any change initiative might be influenced by the institutional context in which it is embedded, and might, in turn, influence that context.

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APPENDIX 1
QUESTIONNAIRE FOR THE CODING OF THE CHANGE PROJECTS

Professionals' role division:

1. To what extent does the project aim to increase nurses'/AHPs'/managers' decision making power in the clinical domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. To what extent does the project aim to increase nurses'/AHPs'/managers' decision making power in the administrative domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. To what extent does the project aim to decrease doctors' decision making power in the clinical domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. To what extent does the project aim to decrease doctors' decision making power in the administrative domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Organizations' role division:

5. To what extent does the project aim to increase the influence of the primary care sector in the clinical domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. To what extent does the project aim to increase the influence of the primary care sector in the administrative domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. To what extent does the project aim decrease the influence of the secondary care sector in the clinical domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. To what extent does the project aim to decrease the influence of the secondary care sector in the administrative domain?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. To what extent does the project aim to improve cooperation across organizations (especially across primary, secondary and social care organizations)?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. To what extent does the project aim to promote continuous care through integration of services?

No extent	Some extent	Great extent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

APPENDIX 2

CODING INSTRUCTIONS FOR THE RATERS

All the project descriptions that you will read display the same structure. They fall into 6 parts:

- (1) Brief description of the change project
- (2) Goals and objectives of the change project
- (3) Required resources to implement the change project
- (4) Measurement of the outcomes of the change project
- (5) Key factors for success in implementing the change project
- (6) People involved in the change project

The objective of this coding is to assess the extent to which the different change projects diverge from the dominant model of organization and care provision used in the NHS, i.e., the model of medical professionalism (see the doc that you read about the NHS). For each category of items, I provide a framework and precise coding instructions.

I do not ask you to think of the potential consequences of the projects that you are going to code. Your coding should be based only on the information that is available in the different change project descriptions.

Professionals' role division

Professionals' role division specifies what each category of professionals should do, i.e., their scope of practice and the rules of interaction among these professionals.

In any healthcare organization, one can distinguish two domains: the clinical and the administrative domains. The clinical domain focuses on patients' treatment and the corresponding delivery of care for individuals or groups of patients (e.g., services for Mrs Jones who has just delivered a baby on the maternity ward). The administrative domain has to do with the management of organizational and clinical resources (e.g., beds rotation, machines purchase, staffing, physical plant). For this reason, it is necessary to distinguish between the roles that each category of professionals has in the clinical domain, on the one hand, and in the administrative domain, on the other hand.

According to the dominant model, i.e., the model of medical professionalism, doctors play a key role in decision making both in the clinical and in the administrative domains. Allied health professionals and nurses carry out the medical plan of care as prescribed by doctors. As for general managers, their role is to facilitate doctors' activity and to act as diplomats to reach a consensus any time there is some disagreement among organizational members.

1. To what extent does the project aim to increase nurses'/AHPs' decision making power in the clinical domain?

If the project has nothing to do with the role that nurses/AHPs play in decision making in the clinical domain or if it aims to either maintain the status quo regarding their decision making power in the clinical domain or decrease their decision making power in the clinical domain, then the answer should be NO EXTENT.

If the project aims to enable nurses/AHPs to perform medical procedures or examinations that they usually do not perform without giving them the power to participate more in decisions regarding patients' treatment, then the answer should be SOME EXTENT.

E.g.: nurses are enabled to make ultrasounds but they do not participate in their interpretation.

If the project aims to enable nurses/AHPs to participate more in decisions regarding patients' treatment, then the answer should be GREAT EXTENT.

2. To what extent does the project aim to increase nurses'/AHPs'/managers' decision making power in the administrative domain?

If the project has nothing to do with the role that nurses/AHPs/managers play in decision making in the administrative domain or if it aims to either maintain the status quo regarding their decision making power in the administrative domain or decrease their decision making power in the administrative domain, then the answer should be NO EXTENT.

If the project aims to enable nurses/AHPs/managers to participate more in administrative decisions about the management of their ward/service, then the answer should be SOME EXTENT.

If the project aims to enable nurses/AHPs/managers to participate more in administrative decisions about the management of their organization as a whole, then the answer should be GREAT EXTENT.

3. *To what extent does the project aim to decrease doctors' decision making power in the clinical domain?*

If the project has nothing do to with the role that doctors play in decision making in the clinical domain or if it aims to either maintain the status quo regarding their decision making power in the clinical domain or increase their decision making power in the clinical domain, then the answer should be NO EXTENT.

If the project aims to force doctors to make a decision collegially with other health professionals regarding some aspect of patients' treatment, then the answer should be SOME EXTENT.

If the project aims to transfer the decision making power from doctors to other health professionals regarding some aspects of the patients' treatment, then the answer should be GREAT EXTENT.

4. *To what extent does the project aim to decrease doctors' decision making power in the administrative domain?*

If the project has nothing do to with the role that doctors play in decision making in the administrative domain or if it aims to either maintain the status quo regarding their decision making power in the administrative domain or increase their decision making power in the administrative domain, then the answer should be NO EXTENT.

If the project aims to decrease the role or influence of doctors in administrative decisions about the management of their service, then the answer should be SOME EXTENT.

If the project aims to decrease the role or influence of doctors in administrative decisions about the management of their organization as a whole, then the answer should be GREAT EXTENT.

Organizations' role division

Organizations' role division specifies what each category of organization should do and the rules of interaction among these organizations. In the NHS, one can distinguish two main categories of organizations: primary care organizations and secondary care organizations. As already explained, there are two different decision making domains in the healthcare sector: the clinical domain that has to do with patients' treatment and the administrative domain that has to do with the management of organizational and clinical resources. For this reason, it is necessary to distinguish between the role that each category of organizations has in the clinical domain on the one hand, and in the administrative domain, on the other hand.

According to the dominant model, i.e., the model of medical professionalism that focuses on treating diseases, secondary care organizations have more influence than primary care organizations both in the clinical and in the administrative domains. Secondary care organizations provide most of the healthcare services and get most of the resources. In addition, each type of organizations delivers its services in a quite isolated way. In the dominant model of medical professionalism, a person's care is focused on treating acute episodes of disease in the hospital setting without providing follow up and preventive services in the home or community setting. As a result, this model of care is characterized as episodic and fragmented. Opposed to this model is a model of continuous care through integration of services. This model relies on integrated care pathways, which reduce fragmentation by setting out the interventions to be carried out by different services and/or organizations for the treatment of specific diseases.

5. *To what extent does the project aim to increase the influence of the primary care sector in the clinical domain?*

If the project has nothing do to with the influence of the primary care sector in the clinical domain or if it aims to either maintain the status quo regarding its influence in the clinical domain or decrease its influence in the clinical domain, then the answer should be NO EXTENT.

If the project aims to involve jointly the primary and the secondary care sectors in the provision of healthcare services that are usually provided only by the secondary care sector, then the answer should be SOME EXTENT.

Similarly, if the project aims to involve jointly the primary and the secondary care sectors in the provision of new healthcare services, then the answer should be SOME EXTENT.

If the project aims to either transfer responsibility for the provision of a healthcare service from the secondary care sector to the primary care sector or to create new healthcare services within the primary care sector, then the answer should be GREAT EXTENT.

6. *To what extent does the project aim to increase the influence of the primary care sector in the administrative domain?*

If the project has nothing do to with the influence of the primary care sector in the administrative domain or if it aims to either maintain the status quo regarding its influence in the administrative domain or decrease its influence in the administrative domain, then the answer should be NO EXTENT.

If the project aims to jointly involve the primary and the secondary care sectors in administrative tasks that are usually performed only by the secondary care sector, then the answer should be SOME EXTENT.

Similarly, if the project aims to involve jointly the primary and the secondary care sectors in new administrative tasks, then the answer should be SOME EXTENT.

If the project aims to either transfer responsibility for some administrative tasks from the secondary care sector to the primary care sector or to give new administrative responsibilities to the primary care sector, then the answer should be GREAT EXTENT.

7. *To what extent does the project aim to decrease the influence of the secondary care sector in the clinical domain?*

If the project has nothing do to with the influence of the secondary care sector in the clinical domain or if it aims to either maintain the status quo regarding its influence in the clinical domain or increase its influence in the clinical domain, then the answer should be NO EXTENT.

If the project aims to involve primary care organizations in the provision of health services that are usually provided only by secondary care organizations, then the answer should be SOME EXTENT.

If the project aims to transfer the provision of healthcare services from secondary care organizations to primary care organizations, then the answer should be GREAT EXTENT.

8. *To what extent does the project aim to decrease the influence of the secondary care sector in the administrative domain?*

If the project has nothing do to with the influence of the secondary care sector in the administrative domain or if it aims to either maintain the status quo regarding its influence in the administrative domain or increase its influence in the administrative domain, then the answer should be NO EXTENT.

If the project aims to involve the primary care sector in administrative tasks that are usually performed only by the secondary care sector, then the answer should be SOME EXTENT.

If the project aims to transfer responsibility for administrative tasks from the secondary to the primary care sector, then the answer should be GREAT EXTENT.

9. *To what extent does the project aim to improve cooperation across organizations (especially across primary, secondary and social care organizations)?*

If the project has nothing to do with cooperation across organizations or if it aims to maintain the status quo regarding such cooperation or to prevent it, then the answer should be NO EXTENT.

If the project, while not explicitly aiming to improve cooperation across organizations, involves different organizations, then the answer should be SOME EXTENT.

If the project aims to develop cooperation across organizations on an ongoing basis, then the answer should be GREAT EXTENT.

10. *To what extent does the project aim to promote continuous care through integration of services?*

If the project has nothing to do with the promotion of continuous care through integration of services, or if it aims to either maintain the status quo regarding the provision of care or prevent the promotion of continuous care, then the answer should be NO EXTENT.

If the project aims to develop integrated care pathways in a given organization, then the answer should be SOME EXTENT.

If the project aims to develop integrated care pathways across organizations, then the answer should be GREAT EXTENT.