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## Boundary-spanning in academic healthcare organisations

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### ABSTRACT

Policy makers view academic healthcare organisations as important to healthcare innovation because they act as boundary-spanning organisations that integrate science and care institutional logics. Institutional logics are implicit and socially shared rules of the game that prescribe behaviour within a social group. This paper explores how individuals affiliated with academic healthcare organisations negotiate science and care institutional logics within their day-to-day work through a qualitative case study of research and healthcare within academic healthcare organisations in Vancouver, Canada. It highlights that there is less hybridisation of institutional logics than policy makers might hope: some researchers hosted in academic healthcare organisations are not part of the care institutional logic, others are not well integrated with the research institutional logic. Clinician–scientists often struggle to integrate the science and care institutional logics in their day-to-day work; other workers do integrate science and care institutional logics through experiments of nature but their research may not be viewed as high quality science. Because of poor hybridisation, academic healthcare organisations may not be as effective in facilitating healthcare innovation as policy makers assume.

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### 1. Introduction

Science is funded primarily on the promise of increased economic competitiveness in an era where science and engineering capabilities are seen as crucial in the new knowledge economy (Gibbons et al., 1994; Owen-Smith, 2001). Science policy makers encourage research collaboration between universities and the private sector as a condition for funding (Atkinson-Grosjean, 2006) and almost all research universities in the USA and Europe have established technology transfer offices that connect the university and private sector (Siegel et al., 2007). These policies draw on the assumption that strong connections between universities—seen as producers of new knowledge—and the private sector—seen as producers of new products—are necessary for economic development (Etzkowitz and Leydesdorff, 1999). The majority of previous innovation studies related to healthcare take this traditional innovation focus, concentrating on the private sector and product

development through analyses of biotechnology, pharmaceutical, and medical device innovation.

The focus on innovation—or the interrelated and more commonly used terms ‘translational science,’ ‘knowledge translation,’ and ‘implementation science’—within hospitals is relatively new, gaining popularity in the 1990s. Here improving health (not economic development) and translation from research to diagnoses and treatments in a linear fashion are often perceived as primary goals (Kerner, 2006; Khoury et al., 2007). Since the 1990s translational science has permeated policy documents and funding programmes (Lander and Atkinson-Grosjean, 2011).

This linear conception of translational science is in contrast to bi-directional innovation models (Kline and Rosenberg, 1986). An older model of translation within healthcare also exists based on ‘experiments of nature.’ This concept has a history in both the science and technology studies literature and within scientific and medical practice. Ben-David (1960), in his sociological study of roles and innovations in medicine, argued that experiments of nature involve analysing puzzles from clinical practice through the scientific research process. Good (1994) similarly described an experiment of nature as originating as a clinical problem and moving to the bench. Good was a clinician–scientist who is commonly regarded as the founder of modern immunology. He was also the most cited author in science from 1965 to 1978 (Cooper, 2003). Good based his research on experiments of nature in the 1950s and

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1960s at the University of Minnesota. Thus two models of translational science in healthcare that emphasise reverse directions exist: translational science focuses on bench to bedside translation while experiments of nature focus on bedside to bench translation (Lander and Atkinson-Grosjean, 2011).

Policy makers often perceive that healthcare organisations with academic affiliations are key to achieving translational science through their three pronged missions of care, training, and research (Gelijns et al., 2001). By enacting their tripartite mission, academic healthcare organisations act as boundary-spanning organisations between care and science institutional logics manifesting implicit and socially shared rules of the game that prescribe behaviour within a social group, thereby facilitating clinical translation (Lander and Atkinson-Grosjean, 2011). However, this boundary-spanning role brings with it potential tensions (Dunn and Jones, 2010). French et al. (2014) reviewed 372 papers describing managerial, institutional, political, or cultural aspects of academic healthcare organisations. They argued that the major gap in existing literature centres on understanding social and organisational processes within academic healthcare organisations. It is unclear how individuals within academic healthcare organisations negotiate differing institutional logics, how these institutional logics play out in their day-to-day work, and the different strategies for addressing tensions between institutional logics.

I explore these issues through a study of how people working within academic healthcare organisations negotiate their environment and are influenced by the care and science institutional logics. I investigate to what extent the two institutional logics are integrated within academic healthcare organisations, explore how organisational structures affect integration of these two institutional logics, and analyse whether the influence of the two institutional logics varies between individuals within organisations. I do this through a qualitative study of infection and immunity health research and healthcare within academic healthcare organisations in Vancouver, Canada.

The rest of the paper is organised as follows. I begin by outlining three relevant theoretical concepts: care and science institutional logics, boundary-spanning, and negotiating institutional tensions. I then outline the methodology used in this analysis. This is followed by a description of infection and immunity research and care in academic healthcare organisations in Vancouver. For individuals working within these organisations, I outline how the two institutional logics influence their day-to-day work. This is followed by a discussion and conclusion.

## 2. Institutional logics, boundaries, and tensions

In this paper I draw on three key interrelated theoretical concepts: institutional logics, boundary-spanning, and negotiating institutional tensions.

### 2.1. Care and science institutional logics

Institutional logics are implicit and socially shared rules of the game that describe behaviour in a rule-like way while being so entrenched in a social group that they become taken-for-granted as legitimate. Institutional logics form the basis of what is seen as legitimate behaviour. Legitimacy is conferred to institutional logics through several means including formal rules and regulations, social norms and values, and shared concepts of social reality and meaning (Lander, 2014; Scott, 2008). Institutional logics are embodied in practices and ideas. They can support certain practices while inhibiting others by setting bounds on rationality and restricting perceived opportunities and alternatives. This increases the probability of certain behaviour. Institutional logics are produced and reproduced by the ways that people behave and interact

(Deephouse and Suchman, 2008; DiMaggio and Powell, 1983; Dunn and Jones, 2010; Greenwood et al., 2008; Jepperson, 1991; Meyer and Rowan, 1977; Scott, 2008; Wooten and Hoffman, 2008).

Institutional logics originate in societal sectors—such as professions, corporations, the market, and family—where social groups cohere and share rules and beliefs (DiMaggio and Powell, 1983; Dunn and Jones, 2010; Friedland and Alford, 1991). Professional groups often create strong social boundaries between groups and coherent social and cognitive worldviews within them. Because of this, professional groups can have a dominant institutional logic that provides actors within the group with vocabularies, identities, and rationales for action (Dunn and Jones, 2010; Ferlie et al., 2005; Gieryn, 1983).

Dunn and Jones (2010) identify two main institutional logics within academic health centres: care and science. The purpose of academic health centres is to bring together and ideally integrate these institutional logics. Care institutional logics dominate healthcare professionals' work and science institutional logics dominate the work of academic professionals. Other individuals such as clinician-scientists—found at the nexus of these two groups—are ostensibly influenced by both institutional logics.

Scholars identify several cultural, cognitive, and normative differences between science and care institutional logics. Traditionally, the science institutional logic inhabits a privileged place in society (Gieryn, 1983). It builds on Merton's (1979) CUDOS—communalism, universalism, disinterestedness, and organised scepticism—as idealisations of the norms of the scientific professions and primarily focuses on generating theory using scientific methods. However, basic forms of research garner greater prestige than applied forms (Barley and Bechky, 1994; Calvert, 2001). Scientific grants and publications form the 'currency' and rewards within the science institutional logic (Ben-David, 1960; Haeussler and Sauermann, 2013; Lander, 2014; Löwy, 1987; Wainwright et al., 2006).

Patient care is the paramount goal of the care institutional logic; legitimacy and authority are derived from the science institutional logic, which is often called the 'science' of medicine (Dunn and Jones, 2010). Care work does not focus on how something works—the domain of the science institutional logic—but rather that it will work (Lander, 2014; Löwy, 1987; Wainwright et al., 2006). Scientific breakthroughs and international practice guidelines are not the primary drivers of care work, which instead draws on clinical experience, intuition, diagnostic testing, and patient preferences to enact the 'art' of medicine (Malterud, 2001; McDonald et al., 2013; Reay and Hinings, 2009).

These two logics enable the three-pronged mission of care (drawing from the care logic), research (drawing from the science logic), and training (drawing from the science logic for graduate students and the care logic for medical students, residents, and fellows) to exist within academic healthcare organisations. Other institutional logics—such as commercialism—are becoming increasingly institutionalised in the academic setting through technology transfer offices and related federal and organisational policy changes. Several other studies focus on the integration of science and commercial institutional logics (see for example Colyvas and Powell, 2006; Vallas and Kleinman, 2008). The commercial institutional logic is also increasingly integrated into academic healthcare organisations (French and Miller, 2012). This paper focuses on the interface between science and care institutional logics because these are the primary *foci* of academic healthcare organisations.

### 2.2. Boundary-spanning

Social boundaries demarcate different institutional logics (Gieryn, 1983); boundary-spanning attempts to break down the social boundaries between institutional logics. Boundary-spanning

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