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The hierarchization of competing logics in psychiatric care in Sweden

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Summary In many healthcare organizations, the managerial institutional logic co-exists and competes with the professional institutional logic in the day-to-day work of managers and professionals. In its examination of the relationship between these two institutional logics at three psychiatric care units for children and adolescents, this study contributes to our understanding of the theoretical concepts and their practical implications for the actor-to-actor approaches to competing institutional healthcare logics. Many earlier studies use theoretical concepts to describe this co-existence as a relatively equal relationship between the competing logics. This study, using data from interviews, observations and shadowing, reveals the existence of a process we label ''hierarchization''. In this process, the managerial logic dominates the professional logic although the latter logic still co-exists and competes, albeit in a subordinate role. The study also reveals that quantification of primarily patient throughput is used to legitimize the dominant managerial logic. Such use of quantification supports the meta-trend of placing trust in numbers.

Introduction

Many studies have examined the competition between institutional logics[1] in large, professional organizations (Goodrick & Reay, 2011; Kitchener, 2002; Reay & Hinings, 2009; Scott, Ruef, Mendel, & Caronna, 2000; Thornton & Ocasio, 2008; Thornton, Ocasio, & Lounsbury, 2012; Townley, 2002). Research has shown that the logics compete at the same time as they coexist over long or indefinite periods of time (Hill & Lynn, 2005; Olsen, 2008; Scott et al., 2000). One explanation for the phenomenon of competing logics is the addition of management regimes, with their own logics, to organizations previously dominated by the institutional logics of the professions such as in healthcare (Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996; Scott et al., 2000).

Researchers have found that healthcare organizations commonly have competing institutional logics (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011). Until

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[1] A commonly used definition of institutional logics is: ''The socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality'' (Thornton and Ocasio, 1999:804, in Thornton and Ocasio, 2008: 101).

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recently, most researchers of competing logics in healthcare have used new institutional theory in their investigations of how these logics shape organizational structures and processes that lead to isomorphism on the organizational field level and to stable logics on the organizational level (for overviews, see Greenwood et al., 2011; Thornton et al., 2012).

Various healthcare studies report on how competition between logics has led to co-operation (Reay & Hinings, 2009), mediation (Llewellyn, 2001), and buffering or hybridization (Choi, Holmberg, Löwstedt, & Brommels, 2010; Ferlie et al., 1996; Kitchener, 2002; Wikström & Dellve, 2009). These studies develop concepts that are useful for describing situations where the competing logics can co-exist in a situation of balanced levels of strength (see also Greenwood et al., 2011; Östergren & Sahlin-Andersson, 1998; Scott et al., 2000). Several studies specifically focus on physician-managers who, as both caregivers and administrators, must balance two competing logics (Kitchener, 2000; Llewellyn, 2001; Östergren & Sahlin-Andersson, 1998; Wikström & Dellve, 2009; Witman, Smid, Meurs, & Willems, 2011).

However, none of these studies addresses how organizational members deal with competing logics in decision-making situations, particularly when physician-managers and managers with other backgrounds work with *other* healthcare professional groups. Also, these studies generally lack an in-depth analysis of the competition between different logics when it comes to actor-to-actor episodes inside organizations — referred to by Lounsbury (2007: 289) as the ''finer-grained mechanisms''. Moreover, we have also found that theoretical concepts do not reflect how competing logics continue to co-exist despite the dominance of one over the other(s) (see e.g. Ferlie et al., 1996; Kitchener, 2002; Llewellyn, 2001; Reay & Hinings, 2009; Scott et al., 2000).

One prominent feature of healthcare is its multi-professional organization. Therefore, studies on the competing logics in healthcare should analyse both the interaction between different professionals and the interaction between managers and professionals. Such analyses can increase our understanding of how actors exercise agency in (re-)producing and changing institutional logics inside the organization (Thornton & Ocasio, 2008). In addition, because most studies use the research methods of document analysis and interviews, the use of participant observations has been underutilized (see e.g. Kitchener, 2002; Reay & Hinings, 2009; Scott et al., 2000). As a result, we lack first-hand observations of how professionals and managers interact, in actor-to-actor episodes, as they deal with competing logics in their day-to-day work (see also Greenwood et al., 2011; Lounsbury, 2007; Reay & Hinings, 2009).

In an attempt to fill this gap in the research, our study examines the co-existence of competing logics at the level of managers' and healthcare professionals' activities inside organizations. Specifically, our aim is to develop the theoretical concepts needed to describe the consequences of introducing new and competing logics in healthcare organizations. Our research question is: How do healthcare managers and professionals handle competing institutional logics in an environment with continued competition?

The settings of the study are three child and adolescent psychiatric care (CAP) units in Sweden. In the last ten years, changes in the CAP units have resulted in increased professionalization as new professions (e.g., physicians and nurses) have been added to the CAP unit teams. In addition to these changes, there has been a demand for greater use of various quantitative measurements intended to provide more accountability and transparency (i.e. numerical goals and performance measurements; see Miller, 2001; Porter, 1995; Samuel, Dirsmith, & McElroy, 2005; Sauder & Espeland, 2009). Consequently, CAP units provide fertile ground for studying competing institutional logics because they employ multiple professions in a context that has implemented a managerial logic. This logic promotes organizing that prioritizes efficiency and ''marketized'' or market-like arrangements in accordance with government policy usually labelled New Public Management (NPM) (Christensen & Lægreid, 2011; Hasselblad, Bejerot, & Gustafsson, 2008; Hood, 1991).

Following this introduction, we review previous studies relevant to our research. In our theoretical framework section, we describe the competition between professional and managerial institutional logics and the legitimacy claims for the two logics. Thereafter, we describe our study's settings and the collection and analysis of our empirical data. Next, we present our analysis of the co-existence of the two competing institutional logics at the CAP units. Following this analysis, we discuss our findings and conclude with comments on our study's contributions to practice and theory.

Institutional logics in healthcare organizations

In institutional theory, institutional logics, as a concept, concerns the interests, identities, values, and assumptions of individuals and organizations that are embedded in prevailing patterns of cognition and action (Thornton & Ocasio, 2008). Studies have shown that when a new institutional logic is introduced, such as the managerial logic in healthcare, the old logics do not always fade away; instead, the complexity among the logics increases (Hill & Lynn, 2005; Olsen, 2008; Scott et al., 2000). Researchers have also shown that managers and professionals at many different organizations work at the intersection of these co-existing and sometimes competing institutional logics (Thornton & Ocasio, 2008; Thornton et al., 2012). This area of research, which has grown in recent years, currently focuses on the exploration of individual organizational responses and experiences, the connections between the levels of analysis, and the enduring competition between the logics (Goodrick & Reay, 2011; Greenwood et al., 2011). The co-existence of competing institutional logics is particularly evident in the healthcare sector (Greenwood et al., 2011).

In previous healthcare studies of how competition between co-existing institutional logics is handled on the organizational level, researchers have developed various concepts to describe this co-existence (Greenwood et al., 2011; Reay & Hinings, 2009). These studies, which mainly focus on the role of managers, conclude that managers either avoid dealing with the competition between the institutional logics or find ways of resolving the resulting conflicts (Doolin, 2002; Ferlie et al., 1996; Kitchener, 2000, 2002; Llewellyn, 2001; Mintzberg, 2002; Reay & Hinings, 2009; Scott et al., 2000; Wikström & Dellve, 2009). Numerous studies have examined ways of handling the situation aimed at gaining