



Logic fluidity: How frontline professionals use institutional logics in their day-to-day work

Eline M. ten Dam ^{1,2,*} and Maikel Waardenburg ²

¹Rob Giel Research Centre, University Center of Psychiatry, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands,

²Faculty of Law, Economics and Governance, Utrecht University, School of Governance, Utrecht, The Netherlands

*Corresponding author. Email: h.m.ten.dam@umcg.nl

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ABSTRACT

This article aims to gain a better understanding on micro processes of how frontline professionals use institutional logics in their day-to-day work. It contributes to the growing literature on the dynamics between institutions and the professional frontline. To further develop this field of study, a conceptual framework is presented that integrates institutional logics, vocabularies of practice, and narratives as central concepts. By adopting a composite narrative approach and identifying vocabularies of practice, the article interprets how frontline professionals make use of different logics to make sense of a new principle introduced in their professional field. Findings are based on a case study of professional patient collaboration in healthcare. The article composes five narratives that act as vehicles through which healthcare professionals use five logics: a medical professional logic, managerial logic, commercial logic, consultation logic, and patient-centeredness logic. It argues that frontline professionals use vocabularies of practice to assemble narratives that help them to navigate between a plurality of logics. It further shows that professionals move fluently from one narrative to another, critiquing the ideas of adherence to a dominant logic and conflict solving. The article finalizes with a discussion that advocates for a process studies perspective and a stronger focus on micro processes in research on professional performance in the context of institutional plurality.

KEYWORDS Institutional logics; narrative analysis; vocabularies of practice; frontline professionals; micro processes; healthcare

INTRODUCTION

The professional frontline is characterized by the prevalence of multiple, sometimes competing, logics such as professionalism, managerialism, and commercialism (Reay and Hinings 2009; McPherson and Sauder 2013; Bode, Lange and Märker 2017). Professionals' interests, identities, values, and assumptions are embedded within such institutional logics. Each institutional logic provides a set of assumptions and values that guide the behavior of

professionals (Thornton and Ocasio 1999). Institutional logics send multiple, ambiguous, or conflicting messages and formats that need to be organized at the frontline (Goodrick and Reay 2011; Andersson and Liff 2018). Thus, the means and ends of professionals' interests and agency are both enabled and constrained by these logics (Thornton and Ocasio 2008). Professionals, as agents working on the frontline, can change and reinterpret symbols and practices in order to try and change social

relationships (Friedland and Alford 1991). The way they do this contributes to sustainment and change in prevailing institutional structures (Van de Bovenkamp, Stoopendaal and Bal 2017).

There is a broad range of research on the way actors and organizations interact with logics. This research is mainly focused on strategic use of the institutional context (Van de Bovenkamp, Stoopendaal and Bal 2017) and on analyses of structures and practices (Blomgren and Waks 2015). On organizational level, Thornton et al. (2012: 164), for example, mention forms of change. These are further developed as hybrid forms—segmented, segregated, assimilated, blended, and blocked—by Skelcher and Smith (2015). Identifying such hybrid forms shows how organizations try to navigate through institutional logics (Mair, Mayer and Lutz 2015). On actor level, a large stream of research distinguishes strategic responses of actors when dealing with multiple logics, with which they let one logic guide their actions, select elements from others, switch between logics, or blend logics. Examples of these are bridging (e.g. Smets et al. 2015; Grinevich et al. 2019), informal co-optation (Andersson and Liff 2018), switching between logics (e.g. Gautier, Pache and Santos 2018), using scripts (Voronov, de Clercq and Hinings 2013), and blending logics (Svenningsen-Berthélem, Boxenbaum and Ravasi 2018).

Research on individual actors and institutional logics thus strongly focuses on strategies, structures, and practices. Several scholars argue more attention should be given to micro processes of institutional complexity and day-to-day organizational activity in professional contexts (McPherson and Sauder 2013; Van de Bovenkamp, Stoopendaal and Bal 2017; Felder et al. 2018). Understanding how frontline professionals relate to and work with institutional logics helps us to understand the dynamic between institutions and professionals (Felder et al. 2018). Other scholars have already tried to gain understanding on this frontline process. For example, research on *institutional work* focuses on the role of actors in creating, maintaining, and disrupting institutions (Lawrence and Suddaby 2006), which concerns both the strategic use of institutions as well as the day-to-day interactions with multiple logics (Van de Bovenkamp, Stoopendaal and Bal 2017). However, there is still a lack of understanding how professionals translate and

use logics on the ground (McPherson and Sauder, 2013). More attention must be given to micro processes of interpretation and meaning-making in contexts with multiple logics (Blomgren and Waks 2015; Bishop and Waring 2016). As Felder et al. (2018: 101) argue: ‘professionals do not merely create or maintain institutions. Rather, professionals give meaning to new institutional arrangements and governance principles in the context of their interpretation of other institutional arrangements already in place.’ In this article, we focus on this process of meaning-making. We move away from understanding *which* responses professionals have on multiple institutional logics and focus instead on *how* professionals use these logics to *give meaning* to principles in their day-to-day work. To do so, we use a case study on frontline professionals in healthcare and pose the question ‘*how* do frontline professionals in healthcare give meaning to a new principle – patient collaboration – in an environment with multiple institutional logics?’. We believe this contributes to a better understanding of how frontline professionals use multiple logics in their day-to-day work.

We connect to a recent institutional *theoretical* understanding of (practices of) patient collaboration (e.g. Felder et al. 2018; Kvæl, et al 2019; Beedholm and Frederiksen 2019) and argue that patient collaboration is a new principle that builds on existing institutional logics. Frontline professionals give meaning to this principle in the context of multiple institutional logics. We use an institutional narrative approach in which we compose narratives on patient collaboration. We connect those narratives to institutional logics. This way, we aim to contribute to a better micro-level understanding of how professionals use multiple logics in their day-to-day work.

In the following section, we discuss literature on institutional logics in healthcare, on patient collaboration, and on narratives. We combine these into a theoretical framework. This underlies our institutional narrative approach which we adopt to understand how frontline professionals use multiple logics in giving meaning to the principle of patient collaboration in healthcare. We present our case study and five field-specific narratives that follow from our analysis. Finally, we discuss the articles’ contribution to literature on dynamics between institutions and frontline professionals’ day-to-day experiences.

PATIENT COLLABORATION IN A MULTIPLE INSTITUTIONAL LOGICS ENVIRONMENT

One principle that has grown in importance in the healthcare sector over the last decades is that of involving patients in (hospital) healthcare. The rise of this principle is due to demographic, societal, and technological developments and changes in patients' interests (Halabi et al. 2020). Over the years, different forms and concepts of professional collaboration with patients (hereafter patient collaboration) have arisen, as well as research on these forms and concepts. Examples are patient participation, patient involvement, patient-centered care, patient education, patient activation, and patient partnership. Where some do believe patient collaboration is an established practice performed by healthcare professionals, others consider it a shift in paradigm from a medical model to a patient-centered model (Beedholm and Frederiksen 2019). There is a broad range of research on patient collaboration. The majority of this research focuses on its empirical practices and conceptual understanding. Scholars that aim for better understanding of empirical practices, for example, map or evaluate promoting factors (Renedo et al. 2015; Sahlström et al. 2019), levels, variety and best practices (Miqueu et al. 2019), and innovative practices and strategies (Spazzapan, Vijayakumar and Stewart 2020). They implicitly assume that difficulties that professionals have when collaborating with patients are caused by issues related to the methods or to the actors implementing the methods (Beedholm and Frederiksen 2019). Patient collaboration thus asks for a development of the healthcare profession. Other scholars have noticed that a range of singular concepts has arisen related to patient collaboration and focus on a better conceptual understanding of patient collaboration (Castro et al. 2016; Higgins, Larson and Schnell 2017; Halabi et al. 2020). They argue that conceptual clarity contributes to, for example, empirical development and implementation (Halabi et al. 2020), improvement of understanding between groups of professionals (Castro et al. 2016), and improving and measuring strategies (Higgins et al. 2017). Recently, scholars have turned toward a theoretical understanding of patient collaboration (e.g. Felder et al. 2018; Kvæl, et al 2019; Beedholm and

Frederiksen 2019). In addition to an empirical and conceptual understanding, patient collaboration is to be understood in its institutional context. It is a principle that gains meaning in the light of multiple institutional logics (Felder et al. 2018).

Like other sectors, the healthcare sector is characterized by different institutional orders or arrangements (Andersson and Liff 2018; Bode, Lange and Märker 2017; Kyratsis et al. 2017). Van de Bovenkamp, Stoopendaal and Bal (2017) describe how specifically the arrangements of professional self-regulation, state regulation, civil association, and market-based healthcare have layered the Dutch healthcare sector. Originally, the healthcare sector was determined by *self-regulation of professionals*, drawing on instruments as medical education, peer review and clinical guidelines, and holding a strong focus on norms of professionalism. Alongside there was some *state regulation* on mainly the supervision of quality of care. Later, *civil association arrangements* involving consultation with professionals, healthcare providers, patient organizations, insurers, and government, started to play a bigger role, leading to new legal arrangements. Around the beginning of the twenty-first century, *market-based healthcare* was introduced, bringing along competition. Together with a stronger *state regulation*, it also resulted in a stronger focus on transparency of healthcare quality (Van de Bovenkamp, Stoopendaal and Bal 2017). These orders or arrangements are connected to multiple logics, such as medical professionalism and managerialism (Reay and Hinings 2009; Bode, Lange and Märker 2017; Andersson and Liff 2018) that layer the field of healthcare (Van de Bovenkamp, Stoopendaal and Bal 2017) and that frontline professionals use in their day-to-day work, to give meaning to principles such as patient collaboration.

THEORETICAL FRAMEWORK: A NARRATIVE APPROACH TO FRONTLINE PROFESSIONALS' MEANING- GIVING

A wide range of literature suggests that a narrative approach is an 'appropriate interpretive lens for understanding organizations and processes of organizing' (Currie and Brown 2003: 1). Narratives 'play a key function in terms of stability and change in

organizations' (Vaara, Sonenshein and Boje 2016: 499). They not only provide descriptions of sequences of events, showing change or stability, they also influence organizational processes by creating change or stability. Institutional change does not occur without an institution being 'simplified and abstracted into an idea, or at least approximated in a narrative permitting a vicarious experience, therefore converted into words or images' (Czarniawska 2009: 425). Narratives are strongly connected to meaning-giving and meaning-making. According to Thornton et al. (2012), narratives help actors attribute meanings to, and communicate about, specific social practices. This is especially significant in times of strategic change (Dunford and Jones 2000). Individuals and groups create sense-making or constructing narratives that enable people to organize their experiences. Narratives are significant vehicles by which ideas, practices, and people are legitimated in periods of change (Currie and Brown 2003). Narratives thus are relevant in understanding how actors give meaning to new principles or arrangements.

More specifically, a narrative approach is helpful in a context with multiple institutional logics. Logic dissemination and change can be achieved through narratives that succeed in linking the desired new or transformed meanings (Greenwood, Suddaby and Hinings 2002). Narratives connect individual meanings to institutional logics and hence construct the legitimacy of actions and identities of (groups of) actors. Since the existence of multiple institutional logics often implies organizational dynamics and change (Reay and Hinings 2009; Schildt and Perkmann 2017), and narratives play a key function in this, studying narratives could help understand these dynamics. Furthermore, narratives have performative power and agency (Vaara et al. 2016) and grant a degree of agency to individual actors in changing institutional settings (Cornelissen et al. 2015). This makes them a valuable source for understanding individual and organizational actions in the context of multiple institutional logics.

Different narrative approaches exist, varying from for example the realist approach of studying factual individual narratives on organizational phenomena to the poststructuralist approach searching for marginalized voices in dominating organizational

narratives (Vaara et al. 2016). We advocate an interpretative, composite narrative approach. In this approach, researchers put together narratives about a certain topic by collecting fragments of narratives from several actors to gain understanding of processes of stability and change. Sonenshein (2010), for example, constructed four narratives in a Fortune 500 retail company during strategic change implementations. These narratives show three ways—resisting, championing, and accepting—in which employees construct change. Sköldbberg (1994) identified three types of narrative genre—tragedy, romantic comedy, and satire—that formed the meaning of changes in local government organizations for people involved. Interpretive, composite narratives thus can help understand how actors (differently) give meaning to new phenomena.

Narratives can be identified through so-called vocabularies of practice. Thornton et al. (2012) consider such vocabularies of practice a system of labeled categories that members of a social group use to construct and give meaning to organizational practices. For example, they argue that share price, auditing, and accountability are labeled categories within an umbrella corporate governance narrative. Such a narrative directs decision-making and gives members of a social group a sense of collective identity. We view such vocabularies of practice as a methodological tool to recognize and identify narrative fragments (Sonenshein 2010) and to composite the case narratives as well as interpret different logics. Our narrative approach thus suggests a two-step process in identifying how professionals give meaning to institutional change, here in the form of a new principle. First, vocabularies of practice need to be identified as the rough material through which meaning-giving can be understood. These vocabularies of practice can be used to composite overarching narratives that different frontline professionals use in making sense of the new principle. Second, the vocabularies of practice connect to institutional logics which professionals use to give meaning to the new principle.

In this article, we work toward understanding on how frontline professionals in healthcare give meaning to patient collaboration. Following from the above-presented framework, we regard patient collaboration as a new institutional arrangement that

Table 1. Summary theoretical framework

Vocabularies of practice	The vocabularies of practice that are both a tool for composing the narratives (1) and recognizing the institutional logics (2).
Narratives (1)	The narratives on patient collaboration, composed with help of the vocabularies of practice.
Institutional logics (2)	The institutional logics that are connected to the vocabularies of practice and the narratives. These logics are connected to the institutional arrangements in the health-care field (e.g. professional self-regulation, state regulation, civil association, and market-based healthcare— Van de Bovenkamp, Stoopendaal and Bal 2017). Professionals use these logics to give meaning to the new principle of patient collaboration.

professionals give meaning to in the context of their interpretation of prevailing institutional logics. To get insights into this meaning-giving, we compose interpretative narratives on the topic of patient collaboration. We use Thornton's vocabularies of practices (2012) to compose these narratives and to link them to institutional logics. This framework is summarized in [Table 1](#).

NARRATIVES ON PATIENT COLLABORATION: AN ILLUSTRATIVE CASE

Research setting

Our illustrative case involves a case study at a hospital in the Netherlands. Hospital care in the Netherlands is subjected to a rapidly changing environment. Hospitals need to deliver high-quality care and are expected to be transparent, flexible, patient-centered, and efficient, while dealing with limited financial means ([RVZ 2011](#): 33–5). Additionally, several developments are foreseen for the coming years, including technological developments, decrease in hospital size and numbers, focus on care that is valuable, personal, and 'in the right place', and a simplification of rules, accountability, and funding. These developments create institutional complexity for healthcare organizations in general and hospitals in particular.

The hospital in our case is one of 26 hospitals that form a partnership of elite clinical hospital in the Netherlands. Hospitals in the Netherlands can be roughly divided into three 'levels'. At one end are the regional hospitals: general hospitals that offer

basic care to patients living in the surrounding area. At the other end are the academic hospitals: university hospitals that deliver complex care and are involved with academic research and education. Somewhere in between those two are 'elite clinical hospitals'. Those hospitals are joined in the Foundation of Elite Clinical Hospitals (STZ) and must fulfill criteria to gain and retain their membership. They deliver general basic care in their region and additionally offer highly complex care on one or several medical functions (e.g. a highly developed treatment, care path, or diagnosing method), the so-called elite clinical functions. In 2017, at the time of our data collection, STZ renewed their criteria for the elite clinical functions. One of these criteria was 'patient collaboration'. All targeted elite clinical functions—six in the hospital in our case—needed to collaborate with patients and/or patient organizations in relation to the specific healthcare they offered. The hospital's staff member responsible for maintaining the STZ-membership noted much ambiguity surrounding this criterion. It was unclear where, to what extent and in which forms this collaboration existed, or how professionals felt about this criterion. There were six (possible) elite clinical functions in this hospital, and to maintain or receive their status, they would need to fulfill all criteria in the future—including collaboration with patients and/or patient organizations. The staff member lacked insights into patient collaboration in the hospital and therefore wanted to know what the different functions were doing now in the field of patient collaboration and how the related professionals felt about that, in order to know where to work on in the

future. After discussing the research setting with the policy division, the main author agreed to focus on this theme for her case research. Over a period of 5 months, she was to investigate how and to what extent collaboration between professionals working at elite clinical functions and patients and/or patient organizations was performed and what was needed to improve or extend this. During the first phase of the research, the main author decided, in consultation with a senior policy officer, to focus specifically on the professionals' point of view and their experiences and beliefs concerning patient collaboration.

Data collection

The data collection consisted of two strategies: in-depth interviews and observations. The main topics were 'collaboration with patients and/or patient organizations' and 'elite clinical healthcare'. The first was the main topic of interest of our research. The second was important because this was the motivation for and context of the interviews. We interviewed the professionals about patient collaboration in relation to their elite clinical function. Several professionals also had other tasks (e.g. in other diagnoses or treatments) that were not related to elite clinical healthcare, but our interviews were focused on their work related to elite clinical functions.

First, the first author conducted 20 semistructured, in-depth interviews with staff members working on or making policy on issues concerning patient collaboration and/or elite clinical healthcare and with professionals related to an elite clinical function. These interviews were composed in three sets that roughly followed after each other. The first set consisted of five orienting interviews with staff members related, to, e.g. quality, client council, or executive board. These interviews gave insights into how the topics were treated in the hospital. The second set consisted of three interviews with external people: one STZ employee and two professionals from another STZ hospital. Those interviews gave insights into the larger, extra-organizational context. The third set was most central to the research question. It consisted of 12 semistructured, in-depth interviews with professionals related to one of the elite clinical functions, either as professional (10) or as manager (2). These interviews gave insights into the specific ideas on, experiences with, knowledge of, and

position toward collaboration with patients and/or patient organizations in or not in relation to the elite clinical functions. No definition of 'collaboration with patients (organizations)' was provided to the interviewees, which left room for the respondents to use their own definitions and interpretations. The main interview topics were 'job and tasks', 'patient organizations', 'collaboration with patients and/or patient organizations within job or function', 'collaboration with patients and/or patient organizations generally speaking in hospital or broader', and 'elite clinical care and criteria'. Within those topics, questions centered around e.g. images, opinions, experiences, roles, responsibilities, obstacles, strengths and weaknesses, and future expectations. In the first interviews, these topics were followed rather strongly. Later on, the interviews were more open, with the topics as backup. Interviews generally lasted 1 hour. One was shorter, as it was combined with a meeting observation. The first author had some visible influence in the interviews. For example, some respondents decided to get into contact with colleagues or patient organizations after the interview. Also, some respondents started searching for information during the interview, when they faced questions they were unable to answer. The first author did not promote nor obstruct this, as it seemed a natural consequence of talking about topics that were not always part of the respondents' daily affairs. This process could have been interesting to follow as well, but this was not in the scope of our article.

Second, the first author observed meetings dedicated to collaboration and/or elite clinical functions. These observations were used to gain understandings in the organizational aspects of the hospital, as well as insights on the connection between policymakers and professionals. This was useful background information during interviews. The observations were not used as findings in this article. The observations consisted of a new employee meeting on organizational goals and policies; two STZ meetings; a meeting between a policymaker and a respondent on patient collaboration; a patient event on lung diseases; and a patient event on eye diseases. In addition, due to the first author's prolonged engagement in the hospital for several days a week for 5 months, she was able to observe daily affairs. These observations were mainly limited to the daily

affairs at the policy-making department and in hallways, due to the limited access to other (care) departments. The observations varied from nonparticipating with interaction, to minimally or partially participating (Bryman 2012). All observations were written down as field notes in a logbook. Those field notes were discussed both with the mentioned policymaker and with the second author on several occasions during the research process as a form of peer debriefing.

Third, the first author organized a meeting between interviewed professionals and staff members in which preliminary research findings were shared, and several attendees were asked to share their experiences with collaboration with patient (organizations) and all to give feedback on the findings. This was a moment of member checking for our research. For the hospital, this was a possible start to discuss the topic of patient collaboration more often and openly.

The first respondent was a staff member who was selected by our contact person. Other staff members were selected through snowball sampling. The respondents from outside the hospital presented themselves during the first STZ meeting. Professionals associated with the elite clinical function were selected by purposive sampling based on their relationships with the elite clinical function and their availability. The hospital covered six elite clinical functions spread over four departments. In each of those four departments, we interviewed three professionals. The aim in this selection was not to get a representative group of respondents throughout the different functions, but to gain insights into the different ways professionals felt and dealt around collaboration with patient and/or patient organizations concerning their elite clinical function.

Data analysis

We chose the approach of composite narratives (Vaara et al. 2016). These are research led constructed narratives around a certain topic. Researchers collect data from several actors and select fragments, which they put together into coherent narratives. This way, different fragments told by one actor may appear in different narratives. In our case study, the data analysis was thus focused on selecting and coding fragments related to patient

collaboration and composing narratives from these fragments. We used the idea of 'labelled categories' in this process. Vocabularies of practice are an ideal methodological tool to identify narratives and recognize and interpret logics. Thornton et al. (2012) consider such vocabularies of practice a system of labeled categories that members of a social group use to construct and give meaning to organizational practices. More specifically, Loewenstein, Ocasio and Jones (2012) describe vocabularies as 'systems of words, and the meaning of these words, used by collectives at different levels of analysis in communication, thought, and action' (2012: 44). We used labeled categories to be able to compose different fragments into coherent narratives. We went back and forth between, on the one hand, identifying vocabularies of practice in our data and composing narratives and, on the other hand, institutional logics in the literature on healthcare. The data were analyzed through multiple successive phases of open, axial, and selective coding.

Going back and forth between the literature on institutional logics in healthcare and our data, we were able to identify narratives that we could link to different logics. We continued this iterative–recursive process until we felt saturation had taken place. The indicators for this were that (1) to our believes, all narratives were coherent and could be linked to a logic and (2) all the fragments that we had selected from our interviews as meaningful to our main question were part of a vocabulary of practice in a narrative. This resulted in five different narratives with their own vocabularies, which we could link to institutional logics identified in the literature. These vocabularies and narratives are presented in Table 2 and in the following section. The vocabularies of practice are printed in italics in the narratives.

NARRATIVES ON PATIENT COLLABORATION

Expertise narrative

Medical knowledge and expertise are most important in delivering elite clinical healthcare. Patient collaboration can be supportive, but professionals argue that it is not part of their daily job. 'It is an *extra task* for these professionals. Another talk, another . . .' Time is a problem. Professionals run from 'department, to

Table 2. How frontline professionals give meaning to patient collaboration: vocabularies of practice, narratives, and institutional logics

Vocabularies of practice	<p><i>Far from things we are good at</i>; extra task, service-thing; relevant; opportunity to our patients; difficult cases; diffuse, small groups</p> <p><i>Perform this treatment</i>; outcome (treatment); trust; positive thinking; fear reduction; over-anxious (parents); solutions</p> <p><i>Education</i>; offer good information; explain things slowly and more broadly; lay nights; symposia; reference talks; patient events for this subject; pre-operative conversations; information folders; websites; fora; offer good information; right knowledge; monitor information</p> <p><i>Professionalization of patient</i>; professional; skills; thinking level; professionalization; amateurish; professional point of view; representation; training; selection; critical thinking; keep up medically</p> <p><i>Relevant</i>; research projects; proposals; medicine availability; experience</p>	<p><i>Improve healthcare</i>; improve; development of care; improvement; better care and services; satisfied patients; insufficiently functioning; trajectory; improve quality and patients' satisfaction; basic principle; contributes to quality of care</p> <p><i>Organize or do differently</i>; perform own quality improvement loops; checking; better work out the trajectory; things to work on; must; prove; well-organized</p> <p><i>Feedback</i>; patients' input; consciously critical; critical; demanding; complain; complaints officer; expectations; send a questionnaire</p> <p><i>Gains priority</i>; set our priorities; deliver best healthcare on paper; things will get better</p>	<p><i>Company</i>; product; attracted; entrepreneurship; build something; kickoff of center; revenue model</p> <p><i>Profiling</i>; publicity; marketing; announce; PR; big stream of people; bridge to our patient; supply</p> <p><i>Competition</i>; stay alive; refer</p>	<p><i>Political agenda</i>; politics; leverage; reimbursed; institutions; insurance companies keep demanding</p> <p><i>Partner</i>; writing research proposals; support; updated; inform; update on policy changes; checks right; right things written down; align with them; interviewed; important issue to map with them</p>	<p><i>Logical</i>; all about the patients; logical; work, live and be; perspective; ruined by our jobs</p> <p><i>Influence of the patients important</i>; active involvement; offer what patients want; make sense for patients; pleased; satisfied; good; enthusiasm; patients really like it; approachable; feel important; safety net; reassuring; being heard; additional role</p> <p><i>Feeling with what patients experience</i>; know our patients; difference in wanting and needing; learn their needs and expectations; what's going on; match; ask them to assess their situation; desired answers; reflection; stories; theoretically; need to hear from people that matter; matches; change; experienced; keep up with what they are doing; keep feeling with what is going on; opinions; choice; feel the need (or not); it's all fine</p> <p><i>Do it together</i>; make each other stronger; need each other; fellow contact; not alone</p> <p><i>Practical subjects</i>; not wearing a white coat; practical subjects; discuss practical things; different level</p> <p><i>New</i>; (gaining) experience; quest; tools; manual; invent our own wheel; figure out; find out; chaotically</p>
Narratives (1) Institutional logics (2)	Expertise Medical professional	Quality improvement Managerial	Marketing Commercial	Partnership Consultation	Patient Patient-centeredness

surgery room, to clinics . . . , phone calls . . . , e-mail and reports'. They lack the time to 'get into contact with patient organizations'. Patient collaboration possibly is 'too far from *the things we are good at*' and it might be more a '*service thing*' for patients. 'It can be *relevant*. We have done patient evenings, selecting a group of people. They appreciate it very much.' Although it is an '*opportunity to our patients*', it is 'hard to estimate whether people are interested'. Patients do not always seem to find it worth their time and 'don't show up'.

Patient collaboration focuses on three things: better treatment results, gaining knowledge relevant for treatment, and spreading medical knowledge. Better treatment results are reached by, for example, trust, positive thinking, and fear reduction. Patient organizations can help enlarge '*trust*' in professionals and information sessions offer time to explain treatment plans, which stimulates '*positive thinking*' and '*fear reduction*'. 'In [consults] I can explain everything very quickly During such a [session], I can *explain things slowly and more broadly*.' Patient collaboration is sometimes necessary to get unavailable medical knowledge. For example, when 'children's *research projects* are very hard to complete' because 'parents are *overanxious*', patient organizations help to make '*proposals*' that parents understand. Professionals ask patient organization for other knowledge, like '*medicine availability*', practical knowledge, or knowledge that requires personal experience, as well. 'Almost incontinent or going to the toilet eight times a day, I can mention that *number* from my *professional point of view*, but I lack the experience.' Patient collaboration also is a tool for spreading medical knowledge. There is, for example, '*group education*', '*lay nights*', and '*symposia*' on which professionals do '*reference talks*' and '*pre-operative conversations*', '*information folders*', '*fora*', and '*websites*' to which professionals refer to, to make sure patients receive the '*right knowledge*'. Patient organizations are important. 'We *inform* patients about patients organizations . . . that *offer good information*.' Patient organizations ask professionals for '*solutions*' when 'they have *difficult cases*'.

The elite clinical character brings along issues for patient collaboration. The condition might be too specialized, causing 'a very *diffuse, small group* with patients all over the country' or the condition might

be too common, which makes 'the need to form a patient organization low.' When there are only a small number of patients, 'we will not organize a *patients event for this subject*.' The highly medical character also lowers the relevance of patient collaboration. 'I cannot do it any differently from what I am doing now If I don't *perform this treatment* this way, the *outcome* is [certain condition].'

Professionalism is considered an issue. Patient organizations are not always 'able to keep up *medically*' and some of their magazines are 'trash'. It is important 'to *monitor the information* they spread and to check their *sources*'. Some organizations are 'very active and *professional*', some have contributed to 'the *professionalization* of healthcare' while others 'act *amateurish*' and 'do not bring you any further'. The same concerns go for patients. 'I would like a *professionalization of the patient*' and 'I wonder, how *professional* is this *patient*.' Professionals bring up issues on '*representation*', 'a certain *thinking level*', '*skills*', and '*training*', '*careful selection*' and '*critical thinking*'.

Quality improvement narrative

As a healthcare professional, it is important to aim for high quality. 'I assume that your ambition is to *improve your healthcare*. That's a doctor's *basic principle*. So that's why we need to do this [talking with patients]. If not, your job is not much fun If you can *improve* and have *satisfied patients*, your job is more fun.' For the '*development of your care*', it is necessary to be '*consciously critical* on what you do'. Patients are needed to know what to improve. 'At a certain point, you want to *improve*. This *improvement* entails delivering even *better care and service* to the patient. We need *patients' input* for this.' Patient organizations are also important in this process. 'When there are patients organizations that are *well organized* and collaborative, we can *improve* healthcare and that's good.' Patient collaboration itself can also be an improvement. 'I wanted to *send a questionnaire* to our patients. Did not exist. I wanted a poster in the GP waiting rooms.' This entails professionals have to develop these things themselves. 'Because we have tried these things, other hospitals have been able to *improve* themselves as well.'

Patient can give useful feedback from their experiences. 'Our patients are fairly *critical* and *demanding* They *complain*, this gives us a lot of *feedback*. We

discuss this with our *complaints officer* (...) are there things we need to organize or do *differently*, or is our care insufficiently *functioning*?' Organizing feedback sessions in groups is valuable for the professionals to receive '*feedback*', '*patient stories*', and '*experiences*'. This helps to '*improve healthcare*', '*better work out the trajectory*', '*improve quality and patient satisfaction*', and know what '*things to work on*'. Feedback can also be given on specific items, for example, information leaflets. '*This information is revised every year*. We give it to five patients and they tell us what they think of it . . . This way, our nurses *perform their own quality improvements loops*, by *checking* with their patients who have experience [on receiving healthcare].' Patient organizations can be a support in this quality improvement. A patient organization can help to '*aim at the expectations of patients*'. It can also share insights on less visible things, like '*side effects or problems with delivering medicine*' which '*contributes to quality of care*' or more generally '*make a real quality improvement because the patients organization tells about the issues they have*'.

Meanwhile, collaboration with patients is sometimes experienced as another quality-aimed demand, on top of many others. '*It is all a must, everything is a must . . . But I don't know whether we can escape it*.' For certain certifications, like the elite clinical certification, '*you have to prove that you are doing this, while you are doing this every day with your patients*. The trust in the doctor is undermined.' Because of this, there is a risk that '*you cannot guarantee that you deliver best healthcare, but on paper you do*'. However, such demands do help to pay more attention. '*This is a big stick. Because it is very good. But well, we need to set our priorities*. That is what it comes down too.' So patient collaboration '*gains priority*' and because of it, '*some things will get better*'.

Marketing narrative

The elite clinical healthcare functions are more than just top medical care. They are also small businesses and patient collaboration can help to promote these businesses and compete with others. '*I was attracted as a doctor with a heart for entrepreneurship, someone who wants to build something*.' '*Publicity*' and '*marketing*' are therefore very important. '*It helps receive patients from all over the province to our*

hospital. We need to. We need to *stay alive* . . . But we shouldn't break each other down in *competition*'.

Forms of patient collaboration, like patient events and special newspapers written with patients, can be very useful for publicity, especially when something new is happening. '*We have done an information event, as a kick-off of our center*. To let them know we are here.' This helps to get more patients, '*We do one information event each year, for patients and referrers*. To *announce* that we are a [new] center.' This way, '*parents can go to the GP and know about us, and the GP can refer to us*.' Also for more shameful subjects, this is a fruitful way to reach patients. '*Our department needs a lot of PR*. People need to recognize themselves. One time, we published three patient stories in a [patients] paper. . . . It lead to a *big stream of people* who recognized their own story.' Patient organizations also can be '*a bridge to our patients*.' Although professionals are not always motivated to organize a patient event, '*specialists know that profiling themselves benefits them*'. Moreover, patient collaboration can add something to the business. '*It would definitely be a big plus, I think*. For the *product* as a whole.'

Other actors in the hospital might need to be involved in patient collaboration. '*I do miss support*. That is difficult in a hospital. There is the specialist, delivering healthcare, and the hospital. And together we have a partnership. And we have our own *revenue model* . . . So both the specialist and hospital should *supply* people, for example to organize such an evening . . . How would you deal with this in a *company*? . . . Who should organize [patient collaboration]. The *PR* department? The *Quality* department?'

Partnership narrative

Patients and especially patient organization are an important partner within the context of insurance companies, government, politics, and other actors. '*With a patient organization, you have extra leverage* which you can use to approach *politics* and other *institutions*.' Therefore, professionals '*have a problem when there is no patients organization*' because '*they are an important partner*.' These patient organizations have '*important tasks*'. They help to get certain treatments '*reimbursed*', help in writing '*research proposals*', and make sure things are '*on the political*

agenda. If there is one, it is important to ‘support the patient organization’. Keeping in touch can be important. ‘So you keep each other *updated*. They *inform* us about their ideas and what they prefer. And we *update* them on *policy changes*, or implementing something new, or when something has happened.’ Some professionals literally sit around the table with patients’ organizations ‘to get our *checks* right, to get the *right things* written down’. Others do not, but then it is still important ‘to make sure we *align* with them.’

Sometimes, patient organizations are consulted by the professionals. ‘Five years ago we needed to make decisions on educating a number of new doctors, and estimate the demand. We *interviewed* the heads of the patients organizations, to gain insights in demands and on how they would organize our care That is an important issue to *map* with them.’

Other parties at the table might demand patient collaboration. Within the hospital, ‘*policy* says that [panel conversations] should be done. But they are not so strict on checking this.’ In nonhospital care, ‘*insurance companies* keep *demanding* things on this [patient collaboration], so this keeps you awake. You can tell this is now happening here [in hospital] as well.’ The elite clinical certification also forms a factor here. ‘If we were not talking about [the elite clinical certification], my answer would be no.’

Patient narrative

Healthcare is ‘*all about the patients*’, so patient collaboration is ‘*very logical*’. Patients ‘know how to *work, live and be* with [condition]’. Recent developments, like ‘*value based* healthcare’, imply an ‘*active involvement* of patients, which is very important’. The ‘*influence of the patients*’ is something that ‘we consider to be *important* for some time now.’ Professionals recognize that patients might have different experiences, needs, and ideas than expected. Professionals organize healthcare from their ‘*own perspective*’, having the ‘*impression that we offer what patients want*’. Professionals are ‘*a bit ruined by our jobs*’, and think that ‘*everything we say makes sense* for our [patients], while often it does not,’ or that ‘*we know our patients* very well . . . , while I think we do not’. It is therefore important to ‘*assess your actions* critically, even if they are medically completely right. There is always

a *difference* in what a doctor or nurse wants, and what the parents [of young patients] *need*’.

Patient collaboration helps ‘to learn their *needs and expectations*’ and to understand ‘*what’s going on* for patients’ and to ‘*match* with this’. Sometimes happens during regular visits. ‘At times I ask them to *assess their situation*. They tell me: seven out of ten. Then I wonder But you know, they are *pleased* with their situation.’ This means that ‘if the patient is *satisfied*, we do not need to do anything. You should not make your own ideas leading.’

When professionals ‘see patients for a longer period of time’, it is easier to assess the trajectory ‘*critically*.’ ‘*Not wearing a white coat*’ and ‘*practical subjects*’ are also helpful. ‘We *discuss practical things*. So we do talk about the peanut-allergy, but also about not kissing someone who ate peanuts We are on a *different level*.’ However, not all needs and expectations become clear during regular visits. Patients tend to give ‘*desired answers*’ and avoid certain topics ‘in the consulting room’.

If there is not enough time or openness in the consulting room, professionals look for other ways to learn and integrate their patients’ perspectives. ‘We do not structurally ask for *reflection* . . . but it is something I would like to do.’ Different forms of collaboration are considered to gain ‘*more feeling* with what patients experience.’ ‘You need to hear *stories* about how patients *experience* [the care]. We can think through all of it *theoretically*, but you *need to hear from the people that matter* whether it’s *good* or not, whether it *matches*, whether things need to *change* or are *experienced* negatively This way, we *make each other stronger*. We need to *do it together*, we *need each other*.’ These experiences can be shared during organized events, such as patient panels or information events, but can also be shared by patient organizations. ‘We get their magazines and read them to *keep up with what they are doing* . . . trying to *keep feeling* with *what is going on*.’

Patient collaboration itself can also be used as a way to meet those needs, for example, through patient events. ‘We thought it would be *nice* to organize another patient event. We always notice that there is a lot of *enthusiasm* [from patients] and *patients really like it* when it’s this *approachable*.’ Asking patients on, for example, panels, helps patients to ‘*feel important*, they really appreciate it being asked to give their

opinions'. Helping patients to get in contact with other patients or a patient organization, is also of importance. 'I think that this *fellow contact* and seeing and hearing that you are *not alone* . . . , this *safety net* can be *reassuring* for patients. That you can ask questions and that you are *being heard*. There is thus 'an *additional role* here' for patient organizations. Free choice is important. 'We tell them about patients organizations, but the *choice* is theirs One might *feel the need* to [become member], or *not feel the need* at all It's *all fine*.'

Because it is '*new*', professionals often lack the experience to organize patient collaboration. 'We do not have much *experience*. So who should I invite?' It is thus 'a matter of *gaining experience*.' It can become a '*personal quest*' to get in contact with patients and patients' organizations. This brings along some organizational issues. 'It's very interesting. We are looking for *tools* to start, a *manual* Because we do have to *invent our own wheel*, which is not so fast. It's difficult to *figure out* ourselves.' There is, however, willingness to do so. 'Maybe we should just *find out*, I don't know. I can think of many obstacles on our way, but maybe there aren't any.' One way to deal with this is to set up a panel for trial, by 'actively recruiting people' or 'asking a patient organization for patients'. These things happen quite '*chaotically*'. When someone 'screams something, we put it on our to-do list and then it will unroll further'.

DISCUSSION

In this article, we wanted to gain an understanding on *how* frontline professionals give meaning to a new principle—patient collaboration in healthcare—in an environment with multiple institutional logics. With this focus on micro processes of meaning-making, we aim to contribute to a better understanding of how frontline professionals use institutional logics in their day-to-day work. To contribute to and further develop this micro-level understanding of how professionals use multiple institutional logics in their day-to-day work we introduced a conceptual framework of which the foundation can be found in a narrative approach. We applied this approach in a case study of a Dutch elite clinical hospital.

Our analysis revealed five narratives on patient collaboration. These five narratives show that

healthcare professionals attach different meanings to collaboration with patients. From the vocabularies in the narratives, we identify five institutional logics: a medical professional logic, a managerial logic, a commercial logic, and a consultation logic, and we recognize a new logic of patient-centeredness. The vocabularies and the connected logics were presented in Table 2. We have grouped the vocabularies to show the different aspects that connect to the logics. First, a *medical professional logic*. A primary source of legitimacy is the expertise of professionals (Blomgren and Waks 2015; Andersson and Liff 2018). It draws on instruments as medical education, peer review and clinical guidelines (Van de Bovenkamp, Stoopendaal and Bal 2017) to determine appropriate care for patients (Reay and Hinings 2009). Professionals are accountable for making the right judgments about their individual patients. The strong focus on expertise, medical issues, education, and individual patients matches the vocabulary of the *expertise narrative*. Second, a *managerial logic*. The introduction of business-like healthcare in the past decades brought with it that healthcare organizations have to behave and organize like regular businesses (Reay and Hinings 2009). Along this line hospitals have become motivated to adopt managerial practices, such as performance management tools and place emphasis on process control and cost containment (Bode, Lange and Märker 2016) and to improve organizational efficiency (Flynn 1999 in McGivern et al. 2015). State- and market-based healthcare regulation have brought along supervision and transparency of quality of healthcare (Van de Bovenkamp, Stoopendaal and Bal 2017). The focus on organization, performance, improvement, and quality of healthcare of *managerial logics* matches the vocabularies of the *quality improvement narrative*. Third, a *commercial logic*. Along with managerial logics, business-like healthcare is characterized by commercialism logics (Harris and Holt 2013), and organizations are expected to act like entrepreneurs. It emphasizes customer satisfaction (Reay and Hinings 2009) and competition (Beedholm and Frederiksen 2019). These aspects match the need for commercial behavior and the focus on competition in the *marketing narrative*. Fourth, a *consultation logic*. Civil association arrangements brought along consultation with a diversity of

partners, such as professionals, healthcare providers, patient organizations, insurers, and government (Van de Bovenkamp, Stoopendaal and Bal 2017). Steering takes place through negotiations between private and societal actors (Van de Bovenkamp et al. 2014). Consultation is the dominant governance mechanism of civil association (Van de Bovenkamp, Stoopendaal and Bal 2017). In the *partnership narrative*, consultation and contact with partners and the political agenda are most important. This fits within what we have termed *consultation logic* and which could more broadly be understood as a community logic (Thornton et al. 2012; Waardenburg 2020). Our analysis revealed *patient-centeredness* as a logic on the same level as the four institutional logics. We thus identify patient-centeredness as an additional logic to the multiple logics already described for the field of healthcare. This logic pronounces collaboration with patients as core to organizational processes and professional routines, for instance, through the formal accrediting of hospitals. It influences how healthcare professionals give meaning to patient collaboration.

Finally, we bring forward three considerations on how frontline professionals use institutional logics in their day-to-day work in an environment with multiple institutional logics. *First*, narratives play a role in the process of using multiple logics in day-to-day work. They help healthcare professionals to get to grips with a new principle in an environment with multiple logics. The narratives and the vocabularies of practice do so through different integrated ‘verbs’, which indicate processes of, e.g. coping with, activating, connecting, or subverting institutional logics. For example, narratives describe sequences, show and create change or stability (Vaara et al. 2016), simplify complexity (Czarniawska 2009), attribute meaning (Thornton et al. 2012), communicate about practices (Thornton et al. 2012), legitimate (Currie and Brown 2003), link meanings (Greenwood et al. 2002), and perform organizational processes (Vaara et al. 2016). The marketing narrative, for example, describes the sequence of the kickoff of a new center followed by a form of patient collaboration to promote this kickoff; it attributes the meaning of promoting to patient collaboration; and it legitimizes the organization of patient events. Narratives are thus vehicles (Currie and Brown 2003) by which

frontline professionals can use logics to give meaning to, in our case, patient collaboration.

Second, frontline professionals move fluidly between those narratives. In our case study, professionals used multiple logics to give meaning to patient collaboration, by moving through several narratives. One professional, for example, believed, among other things, that patient collaboration was an obvious part of delivering healthcare (patient narrative), that patient organizations are an important bridge to receiving patients (marketing narrative), that quality improvement with help of patients is important (quality narrative), and that patients’ professionalism is a vast issue (expertise narrative). This effortless assembling by frontline professionals shows they are not solving conflicts between logics or adhering to one dominant logic, as some scholars have focused on (e.g. Lander, Koene and Linssen 2013; Smets et al. 2015; Andersson and Liff 2018; Kyratsis et al. 2017; Grinevich et al. 2019). Instead, professionals seem to have different narratives and related logics to their disposal, as tools. The way they use these logics, resembles McPherson and Sauder’s (2013) idea of fluid negotiation. The authors argue that professionals in a drug court manage the existence of multiple logics by ‘drawing on a shared toolkit of logics’ (McPherson and Sauder, 2013: 186). They explain how the drug court professionals have the ability to draw on resources from different institutional backgrounds, as to validate these perspectives as legitimate, to stabilize the local organization. In our case study, healthcare professionals also use different narratives and logics fluidly as tools to give meaning to the principle of patient collaboration in their professional day-to-day work. This closely resembles the notion of identity scripts as described by Bévort and Suddaby (2016).

Third, frontline professionals use new logics in their day-to-day work and play an active role in the institutionalization of those logics. The patient-centered narrative is less ‘settled’ than the other four narratives. The vocabulary adopted in the patient-narrative expresses this. Words such as *new*; (*gaining*) *experience*; *quest*; *invent our own wheel*; *figure out*; and *chaotically* were rather common in this narrative. These words indicate that the logic of patient-centeredness has come to existence more recently. They further indicate that the logic of patient-centeredness

is in the process of theorization and diffusion (Greenwood et al. 2002). Another part of the vocabulary shows that this narrative is (at the moment) strongly connected to the work of, for example, nurses and physiotherapists, rather than medical doctors. Examples of these are *practical subjects; not wearing a white coat; discuss practical things*. The logic of patient-centeredness is in the midst of establishing itself as a legitimate practice for healthcare professionals' activities, vocabularies, and professional identities. Important for further institutionalization of this logic is in how far the frontline professionals will use and keep using this logic. This is related to the (political) space the different occupational communities (Abbott 1988) in healthcare give to *chaotically figuring out* and *experiencing* what patient-centeredness implicates for their profession. As Gustavsson and Andersson (2019) have argued, strong professional dominance has caused difficulties in organizing patient collaboration.

What follows from these three observations is that research on frontline professionals can benefit from a greater focus on process. While patient collaboration as an organizing principle might be considered an entity to deal with, the narratives identified in this study and the newness of the patient-centered logic show the importance of the processual aspect that comes along with working with multiple institutional logics for frontline professionals (Van de Ven and Poole 2005; Bakken and Hernes 2006). Thus, we argue that a process theoretical view (Langley et al. 2013) has the potential to further inform and develop knowledge on professionals' day-to-day experiences with multiple logics. One angle is the centrality of a temporal dimension in process studies. Taking time into account when analyzing the process and meaning of working with multiple logics for frontline professionals would add to a better understanding of the (changes in) flow of this process and how it is temporally connected to, e.g. occupational politics.

CONCLUSION

In this article, we posed the question 'how do frontline professionals in healthcare give meaning to a new principle – patient collaboration – in an environment with multiple institutional logics'. By

gaining insights into micro processes of meaning-giving, we aimed to contribute to a better understanding of how frontline professionals use institutional logics in their day-to-day work. Our case study has shown that frontline professionals in the field of healthcare give meaning to patient collaboration through five different narratives that relate to five different logics: a medical professional logic, managerial logic, commercial logic, consultation logic, and patient-centeredness logic. The narratives are vehicles through which frontline professionals use and make sense of the multiple logics. Furthermore, frontline professionals move fluently between the logics and use these logics as tools to give meaning to patient collaboration in their professional day-to-day work. Finally, new logics can be recognized by their narratives and frontline professionals play a role in the institutionalization of new logics when they use these logics. Our observations suggest that a processual view can help in gaining better understanding of how frontline professionals use logics in their day-to-day work.

Implications for research and practice

We suggest several angles for further research. First, we argued that narratives play a role in the use of multiple logics in the day-to-day work of frontline professionals. With verbs, we have suggested that the narratives are a vehicle to use logics. Further research might explore these micro processes related to narratives more in-depth. Secondly, we noticed how frontline professionals move fluently between logics. Further research might address questions on how these micro processes of fluent shifting between logics work. Besides implications for meaning-making, research may also focus on other aspects of day-to-day work of frontline professionals. This may, for example, include decision-making or collaboration with other professionals. Third, we noticed that the patient narrative is relatively new and not completely settled. Following the patient narrative over time and analyzing it in alternative healthcare contexts (e.g. regular hospitals, academic hospitals, and nursing homes) can reveal what this means for the development of the healthcare professions. Also, frontline professionals play an active role in the institutionalization of the patient-centered logic through this patient narrative. Following this process for a

prolonged period can provide understanding on how these micro processes of institutionalization work. In general, we argue that our case study emphasizes that research on multiple institutional logics benefits from a processual view and a stronger focus on micro processes in the professional frontline.

This brings us to a more practical implication. Concerning patient collaboration, there is a strong focus on tools and (communication about) concepts. The general idea is that solid tools and clear concepts will help professionals collaborate with patients. Strategy and structure gain much attention, while attention for meaning-giving and meaning-making processes is undervalued. However, our case study shows that these processes in the (institutional) professional frontline have a large influence on how a new principle is enacted in practice. It is paramount for practitioners to employ direct conversational methods that highlight these processes of meaning-making, such as the 'Whole system in the room' method (Shaw 2003). Such conversational practices assist in identifying and learning from different vocabularies of practice, related narratives, and how professionals make sense of working through institutional complexity in their day-to-day work. They potentially provide professionals with direction to navigate through and with new principles, and they open-up team, departmental, and organizational dynamics.

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