

From Logic Acceptance to Logic Rejection: The Process of Destabilization in Hybrid Organizations

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Abstract. We study the introduction of the private logic into a mature Italian hospital that was governed previously as a hybrid of professional and public logics. Intriguingly, the reconstituted hospital was for several years widely praised for its strong clinical and financial performance, but quickly and with little warning, it became riven by political differences that led to its demise. Through our case analysis, we develop a multilevel model that reveals the destabilizing process that can unfold when a new logic enters an established organization. We contribute to the hybrids literature by explaining the puzzle of how a new logic can become accepted and then rejected in organizations, emphasizing the critical importance of the interaction between the audience, organization, and practice levels. Crucially, we reveal that positive feedback from multiple audiences may be a mixed blessing for hybrids: although it offers resource and legitimacy advantages, it can induce internal tensions with severe destabilizing consequences. Our findings and model also run counter to two core assumptions within the institutional literature: that social endorsement is advantageous and that alignment with institutional expectations results in stabilization. We qualify these assumptions and indicate the circumstances under which they are unlikely to hold.

Keywords: institutional theory • qualitative research • public management • hybrid organizations

Introduction

Organization theory has long recognized that many organizations confront environments in which independent audiences make uncoordinated and inconsistent demands (D’Aunno et al. 1991). Recently, there has been a resurgence of interest in understanding how such competing demands can be reconciled—an issue defined within institutional theory as coping with multiple institutional logics. A particular focus of this work has been on “hybrid” organizations that incorporate two or more logics (Battilana et al. 2017) and that are often promoted as a means to address deep-rooted societal problems beyond the capability of traditionally arranged organizations (Jay 2013).

However, accommodating multiple logics within the same organization can be problematic, especially in situations where a new logic is introduced. Hybrids often display an inability to reconcile different audience expectations and have been shown to compromise anticipated benefits, leading to organizational paralysis or even breakup (Tracey et al. 2011). In light of these difficulties and given the growing importance of multilogic organizational forms in market economies, a critical question is how such organizations can combine

multiple logics and do so sustainably (Battilana and Lee 2014).

The initial motivation for this paper was to extend theory through an exploratory ethnographic study of an Italian hospital that, in 2004, added the private logic to its incumbent professional and public logics. By 2010, when we began data collection, the hospital was widely praised and declared a regional center of excellence. There were no obvious indications of internal struggles. Our intention, therefore, was to understand how the private logic became accepted in a hospital that belonged to a public health system where medical professionals had long been the dominant voice.

Four months after entering the field, however, the hospital was riven by political differences over arrangements initially perceived as instrumental to the hospital’s strong clinical and financial performance. This happened even though no changes were made to the hospital’s formal governance and management arrangements or the composition of its leadership team. As a result of the contestation that followed, the private logic was formally withdrawn, private investment ceased, and most hospital practices and decision-making processes reverted in 2015 to their earlier status.

These unexpected developments presented an unusual opportunity to explore both the adoption and the expulsion of a new logic in a mature hybrid. We therefore focused on the following research questions: How can a new logic be effectively introduced into a mature hybrid organization? What factors can disturb a well-functioning hybrid and lead to the subsequent rejection of a newly introduced logic?

In addressing these questions, we contribute to the literature on hybrids by developing a process model that theorizes the dynamics that unfold when a new logic enters an existing organization. Our model emphasizes the importance of the ongoing relationships between the audience, organization, and practice levels of analysis. Specifically, we show that when incoming actors engage in a strategy of *assurance* and are careful to ensure that incumbents maintain discretion over core practices, they can overcome audience skepticism and persuade incumbents that the role of the incoming logic is to support them. If all groups enjoy mutual gains, these mechanisms facilitate the smooth introduction of the incoming logic and the effective functioning of the new hybrid arrangement.

Counterintuitively, however, when audiences confer *acclamation* on the organization, standards of performance are compromised. This happens because the desire of organizational members to receive continued praise is powerfully seductive and leads to *narrower attention* as actors focus on audiences whose praise they deem most important. Crucially, this narrowing of attention prompts incoming actors to undermine incumbents' discretion over core practices in an effort to extend the influence of the new logic. *Criticism* from audiences that reveals deteriorating performance triggers *logic contestation* and fractures relationships between the proponents of the logics. At the same time, incumbents reassert their discretion over core practices in order to reclaim their authority. The result is that incumbents blame the new logic and reject it, and the original hybrid arrangement is restored.

Through our process model, we contribute to the hybrid organizing literature by showing that positive feedback from multiple audiences may be a mixed blessing: although it offers resource and legitimacy advantages (Scott 2008), it can induce internal tensions with severe destabilizing consequences. We also contribute to institutional theory more broadly. Specifically, our findings and model run counter to two assumptions within the institutional literature: that social endorsement is advantageous (Deephouse et al. 2017) and that alignment with institutional prescriptions results in stabilization (Greenwood et al. 2011). We qualify these assumptions and indicate the circumstances under which they are unlikely to hold.

Theoretical Context

Institutional logics are the socially constructed, historical patterns of beliefs and material practices that guide behavior, shape interactions and relationships, and provide meaning to social reality (Friedland and Alford 1991, Thornton et al. 2012). They convey the salience of particular issues in an institutional setting, specify the appropriate modes of organizing, and define the standards of success (Smets et al. 2012). As such, logics have a powerful influence on the direction and priorities of organizations. A feature of contemporary society is the increasing use of organizational forms—hybrids—that combine logics (Pache and Santos 2010). A notable example of this trend has been the incorporation of a private (market) logic within organizations where that logic was not only previously absent but considered anathema. For example, the private logic has been introduced into publicly funded hospitals and healthcare systems around the world (Maarse 2006); is now a prevalent arrangement for the delivery of educational services (Ball 2007), social welfare (Dowling et al. 2004), and transportation (Martimort and Pouyet 2008); and is even used in prisons (Yescombe 2011).

The growing interest in multilogic organizational forms is motivated by the possibility that combining logics will open up new ways of approaching intractable societal problems. A core assumption is that bringing apparently incompatible logics together will not only generate new ideas but also encourage organizational members to appreciate their complementarity (Jay 2013, McPherson and Sauder 2013, Smets and Jarzabkowski 2013, Dalpiaz et al. 2016, York et al. 2016). However, fusing logics is a complex task: hybrids are often a “locus of disorder” and signally fail to meet their aspirations (Battilana and Lee 2014, p. 398).

Tensions and disagreements between competing interest groups within organizations have, of course, long been acknowledged. For example, Burns and Stalker (1961) explicitly referred to organizations as political systems (see also Selznick 1949, Cyert and March 1963). Indeed, virtually all organizations operate with tensions arising from ideological differences, and researchers have explored how organizations cope with these tensions from various perspectives (Clegg et al. 2006). However, the institutional approach is distinctive in that such tensions are assumed to arise from two discrete challenges: the need to acquire legitimacy from external audiences and the need to reach an internal agreement between the organizational actors who promote the various logics (Pache and Santos 2010, Ramus et al. 2017).

Externally, hybrid organizations seek social endorsement from field-level advocates of each of the logics represented within the organization. Such endorsement

is crucial because it allows organizations to acquire the requisite resources to function effectively, and failure to do so can have serious implications (Deephouse et al. 2017). However, accommodating the tugs and pulls of disparate audiences can be a significant challenge (D'Aunno et al. 1991). Internally, the challenge is to construct an acceptable accommodation between those promoting the different logics, which is not straightforward, because tensions over core goals and their associated incentive systems often lead to competing claims about priorities and objectives (Jay 2013, Pache and Santos 2013, Ramus et al. 2017). Thus, hybrids have to reach a “settlement” (Rao and Kenney 2008) on the relative prioritization to be given to the constituent logics.

Scholars have identified several means by which these external and internal challenges can be addressed. This work has advanced our understanding of the coping strategies that allow hybrid organizations to attain their goals despite the risk of contestation (Lounsbury 2007, Kaplan 2008, McPherson and Sauder 2013, Pache and Santos 2013, Smets and Jarzabkowski 2013, Dalpiaz et al. 2016). Nevertheless, current research suffers from at least three weaknesses.

First, implicit in much of the literature is that multilogic organizations are “born” as hybrids. However, many organizations only become hybridized later in their life cycles. As Dunn and Jones (2010) suggest, integrating a new logic into a mature organization might be especially difficult, particularly if that logic has been vilified (Smets et al. 2012). Moreover, this challenge is heightened in organizations dominated by professionals, who can be highly resistant to change and often lack the requisite suppleness to accommodate new ideas and ways of working (Ferlie et al. 2005, Reay et al. 2006).

Second, most empirical studies have focused on hybrids in which constituent logics are integrated effectively (see Battilana et al. 2017 for a review) but give little attention to the temporal unfolding of hybridization and/or dehybridization (i.e., they do not consider how inherent political tensions might rise over time, and they do not take into account circumstances that might amplify or suppress them). As a consequence, we have limited understanding of the processes through which initially well-functioning hybrids might later unravel and why they might do so. This lack of attention is surprising in light of growing evidence that many hybrids are profoundly unstable (Hodge and Greve 2007) and that initially effective settlements are often unsustainable in the long term (Ball 2007).

Third, although research has recognized that the relationships between organizations and the fields to which they belong are of profound importance, most studies of hybrids tend to ignore the role of feedback—both positive and negative—from external audiences.

The interaction of the external and internal tensions confronting hybrids, in consequence, has been neglected—giving an incomplete account. This is problematic because the relationship between organizations and their institutional context is a central theme of institutional theory, and audience feedback plays a fundamental role in shaping that relationship (Scott 2013, Hinings et al. 2017).

In sum, we still know relatively little about how mature organizations can effectively introduce a previously alien logic and the circumstances that might subsequently undermine any settlement that is reached. Our purpose here, therefore, is to draw on a case study of an Italian hospital to explain how and why an incoming logic was embraced by incumbent members only to be abruptly rejected by them at a later point, precipitating the collapse of the new hybrid arrangement.

Methods

Given our focus on an unexplored phenomenon, we relied on an inductive research design based on a combination of ethnographic and longitudinal methods (Glaser and Strauss 1967). Our setting is particularly compelling because it concerns an attempt to introduce a third logic into a mature, professional organization. Moreover, it contains the puzzle of acceptance followed by rejection.

Research Setting

This study was conducted at R-Hospital (pseudonym), a rehabilitation hospital in Italy. Healthcare in Italy is deeply institutionalized as a publicly funded system based on the principles of universal coverage and access. Until recently, no hospitals in Italy were financed and governed from public and private sources. However, escalating costs prompted the search for a more efficient means of healthcare delivery (Jommi et al. 2001). One outcome was the “managerial experiment” that introduced private investment into the public system. This new kind of hospital immediately became the subject of controversy (Bonti 1997, Dugato 1998, Fiorentini 2000).

R-Hospital was converted into a managerial experiment in 2004. It acquired the legal status of a limited company, with 70% of its shares publicly owned and the remainder owned by private investors. The governing board included two representatives from the private sector and five from the public sector. In the senior management team, the chief executive officer (CEO), administrative director, marketing director, and their staff had business backgrounds, whereas the clinical director was a physician. When we entered the field in 2010, the hospital had 288 staff members, of which 80% were medical professionals providing orthopedic and neurologic rehabilitation services for brain-injured

patients. Funding was based on the international Diagnosis-Related Group (DRG) patient classification system, which specifies the appropriate fee and period of hospitalization for different services. For the treatment of patients with severe brain injuries, R-Hospital received a set daily fee irrespective of the length of hospitalization. For other services, however, it received a daily fee for a specified hospitalization period, beyond which reimbursement tapered to 50%. R-Hospital's overall funding thus varied based on the types of patients, the extent of bed occupancy, and whether treatment conformed to the DRG system.

We selected R-Hospital, because medicine is a “prototypical profession” (Hughes 1956) where physicians enjoy high status in the occupational hierarchy (Scott et al. 2000). Attempts to interfere with professional norms in hospital settings are usually strenuously resisted (Ferlie et al. 2005). Hence, R-Hospital offered a unique research setting because stakeholders considered it an especially effective example of a hospital that had combined professional excellence with strong financial outcomes achieved through private-sector involvement. However, in 2010, an accreditation assessment reported deteriorations in some professional standards, and there was a spike in patient complaints. The result was growing friction between physicians and administrative staff that became so acute that the hospital decided to abandon its multi-logic settlement—and expunge the private logic.

Data Collection

Our study centers on a 10-month single-site ethnography (2010–2011) complemented by the collection of rich, longitudinal qualitative data (2004–2013). We triangulated three sources of data—nonparticipant observation, interviews, and archival materials—from R-Hospital members and key audiences (Table 1).

Nonparticipant Observation. We collected real-time ethnographic data over a period of 10 months (2010–2011) for a total of 320 hours of observation. For seven months, we engaged in daily observation from 9 a.m. to 6 p.m., followed by one day each week for another three months. We collected two sets of observational data. First, we took part in informal and formal meetings (e.g., board meetings, clinical governance meetings, and budget and procurement meetings, as well as all public events organized by the hospital, for a total of 46 meetings)—in order to observe how professional, private, and public actors related to each other and their respective audiences. We observed not only what was said but also how it was said: we paid close attention to informants' tone of voice, patterns of speech, facial expressions, and body language to understand the meaning and emotions of what was being communicated (Putnam et al. 2016). Second, we systematically observed the work of medical professionals. The first author attended 20 weekly planning meetings and 20 interdisciplinary team consultations

Table 1. Data Sources

Data source	Detail
Observations (86 meetings, 1,468 pages)	
Organization-level decision making	<ul style="list-style-type: none"> Bimonthly board meetings (6 meetings) Meetings for the accreditation process (10 meetings) Meetings for monitoring of procurement activities, budget, and trade unions negotiations (5 meetings)
Professional activities	<ul style="list-style-type: none"> Other organization-level staff meetings (14 meetings) Weekly planning meeting (20 meetings) Interdisciplinary team consultations—first and follow-up visits (20 meetings) for a total of 140 patients over 6 months Daily informal exchanges
Public events	<ul style="list-style-type: none"> Local community events (11 events; e.g., open days at R-Hospital, town council meetings regarding R-Hospital, press conferences)
Interviews (131 interviews, 3,080 pages)	
Preliminary interviews	<ul style="list-style-type: none"> Preliminary interviews with senior managers and shareholders (16 interviews)
Semistructured interviews	<ul style="list-style-type: none"> Ethnographic interviews with employees (101 interviews) Informal exchanges on a daily basis Semistructured interviews with shareholders (4 interviews) Follow-up interviews with senior medical staff (10 interviews)
Follow-up interviews	
Archival documents (374 documents, 23 video)	
Organization-level decision making	<ul style="list-style-type: none"> Minutes of board meetings before field entry (2004–2010; 38 documents) All documents related to budget negotiation, code for procurement, agreements with trade unions (81 documents)
Professional activities	<ul style="list-style-type: none"> Internal procedures on patient management and ward activity planning (32 documents)
Public documents	<ul style="list-style-type: none"> Local, regional, and national newspaper articles 2003–2011 (223 articles) Video recordings of R-Hospital (23 video)

pertaining to the care of 140 patients. She acted as a “human camera” (Barley 1990), jotting notes verbatim with the support of an observation sheet. The notes were typed within 24 hours (Emerson et al. 1995) and reviewed each weekend, forming an “observation journal” of 1,468 pages. These observations were the basis for the mapping of the core practices from which we ascertained the relative influence of the three logics, as described below.

Open-ended and Semistructured Interviews. We conducted a preliminary round of 16 interviews at the start of the data-collection process in 2010 in which we asked organizational members to describe, from their perspective, the key events and decisions that characterized R-Hospital’s formative years so that we could properly contextualize our ethnographic data. All the interviews were recorded and transcribed, yielding 480 pages of transcript. Next, guided by the initial weeks of observation, we developed an interview protocol to elicit how medical staff at R-Hospital understood and invoked the public, private, and professional logics in their daily work. We then interviewed 105 organizational staff members (doctors, nurses, care assistants, therapists, and administrative staff) during 2010 and 2011. Again, the interviews were recorded and transcribed for a total of 2,300 transcript pages. To verify our emerging interpretations, we drew on multiple informal conversations and unstructured interviews. Finally, we conducted 10 additional follow-up interviews with senior personnel in 2013 and 2015, resulting in 300 pages of transcript.

Archival Materials. We accessed 151 organizational documents covering the lifespan of R-Hospital from 2004 onward. These included clinical professional documents, the minutes of all hospital board meetings, all documents related to budget negotiation and procurement activities, and agreements with trade unions. To systematically track audience perceptions, we analyzed local and national newspaper coverage from 2004 to 2011, yielding 223 articles and several video recordings. Because the source for these data was the communication office of R-Hospital, we asked a company specializing in media analysis to reperform the data-collection search. The sample was confirmed with a reliability of 90%. Furthermore, we collected public speeches, interviews, press releases, and external reports on R-Hospital by key external stakeholders. We continued to collect archival material after leaving the field.

Analytical Approach

We moved iteratively between the data, emerging theory, and relevant literature (Miles and Huberman 1994)

following an approach of gradual abstraction that moved from raw data to categories and themes (Barley 1990). Our analysis proceeded through four steps.

Step 1. Identification of the Institutional Logics in R-Hospital. Building on the works of Reay and Hinings (2005) and Thornton et al. (2012), we identified the higher-order institutional systems that characterized our context (i.e., the public sector, private sector, and medical profession) and then, based on an in vivo coding of our 105 interview transcripts, sought to capture how logics were interpreted “on the ground” (Reay and Jones 2016). For each logic, we identified its overarching goal, the group of actors inside R-Hospital who promoted it, and the corresponding audiences in the institutional environment (Pache and Santos 2010).

The professional logic that we observed in R-Hospital was that of “medical professionalism” (Reay and Hinings 2009, p. 630), where the overarching goal was the provision of medical care deemed appropriate for the patient and delivered by qualified professionals. Essential to achieving this goal was the physician–patient relationship and the exercise of professional judgment within this relationship. The main group who promoted this logic was the medical staff, especially physicians, and its audience-level referents were their professional associations. The private logic that we observed was akin to “business-like healthcare” in Reay and Hinings (2005, p. 358). Its overarching goal was financial self-sufficiency and market share, and a core aim was cost-effective treatment that meets essential patient needs at the lowest price. The main group that promoted this logic in our case included the CEO, the administrative and marketing directors, and the two members of the board appointed by the private investors. Its audience-level referents were shareholders and the Association of Private Hospitals. The goals of the public logic were similar to those of the professional logic in that they included the provision of high-quality health services. However, because the logic’s legitimacy rested on the political accountability of public officials to their electorate, emphasis was on the overall health system. The main group that promoted this logic was board members appointed by the Local Health Unit (LHU) and the local and regional governments.

Step 2. The Enactment of Institutional Logics: Practice-level Analysis. Through our interviews, we identified three practices within R-Hospital (McPherson and Sauder 2013, Smets et al. 2015) that were core to the role of physicians: “admission” practices, which centered on the criteria for the admission of new patients; “diagnosis and treatment” practices, which concerned the setting up of patients’ diagnosis and treatment schedules; and “discharge” practices, which referred to the criteria used to conclude the hospitalization

of patients and determine postdischarge care. These practices were central to the unfolding process that we observed at R-Hospital.

Implicit in each logic was a set of assumptions about how core hospital practices should be enacted. Actors promoting the professional logic believed that it was for physicians to decide whether to hospitalize a patient, diagnose appropriate treatment, and determine the time of discharge. Actors promoting the private logic emphasized the optimization of income and the need to align all three practices with the DRG protocol. Finally, actors promoting the public logic sought to ensure that the three practices were implemented on a “first come, first served” basis that optimized bed occupancy throughout the healthcare system as a whole rather than only in R-Hospital.

We triangulated our interviews and observations to understand how physicians enacted the three core practices in their everyday work. Mindful that our observational data were limited to the period in which the first author was embedded in R-Hospital, we collected additional data that provided a reliable indication of how the three practices had been enacted before our entry into the field. To do so, we triangulated archival data on clinical performance with interviews that retrospectively explored the enactment of core hospital practices from the introduction of the private logic to the start of our fieldwork. Because research participants may downplay ambiguity and conflict when reflecting on the past (Kimberly and Bouchikhi 1995), we triangulated the responses of informants from different logics. We also engaged with the same informants over time to help build trust (Cardinal et al. 2004).

For the period in which the first author engaged in daily observations, we coded all the discussions surrounding the decisions made by physicians in their weekly professional meetings with respect to the three core practices. Physicians treated 140 patients and took 1,005 decisions pertaining to these practices; 76% of the practice-level decisions in our sample (764 of 1,005) were routine, where physicians confirmed decisions made in previous meetings. By contrast, for 24% of the practice-level decisions (241 in total), one of the three logics was explicitly invoked by physicians and guided their decisions. It is this subset of 241 practice-level decisions to which we directed our attention. In doing so, we assessed which of the decisions were consistent with the professional, public, or private logic.

By analyzing longitudinally the qualitative evidence (i.e., retrospective interview data) and our observation of practice-level decisions by physicians in R-Hospital, we were able to examine how the relative salience of the three logics changed. Initially, physicians mainly invoked the professional logic in their clinical decision making; then they invoked the three logics almost equally; and

later they reprioritized the professional logic. We centered our analysis on explaining this dynamic. To do so, we began by examining the organization-level relationships between the actors who promoted each of the logics in R-Hospital.

Step 3. Analysis of the Effects of Audience Feedback on Organizational Relationships.

We coded excerpts of our field notes, interview transcripts, and documents and assigned first-order codes that meaningfully described the relationships between the three groups at the organization level by looking, for example, for expressions of suspicion, collegiality, and anger and for the behaviors associated with them. Examples of codes were “private actors portray themselves as supportive of professional goals,” “early benefits are distributed across public, private, and professional actors,” and “public, private, and professional actors increase the interactions with their audience-level referents.”

At this point in our analysis, we realized that informants promoting each of the logics consistently referred to the importance of feedback from external stakeholders. Thus, we turned our attention to the crucial role of audience evaluations. We triangulated media coverage at local and national levels as well as press releases, public speeches, and external reports from key stakeholders to elicit how the various audiences perceived R-Hospital from 2004 onward. We then interrogated our interviews and field notes to better understand how these changes in audience perceptions had affected the hospital’s internal workings and organization. Starting from the first-order codes, we scrutinized our data to capture verbal exchanges that explicitly related the organization-level dynamics (i.e., the behaviors and perceptions of the three groups) to feedback from specific audiences. For example, for the code “private actors become more assertive,” we analyzed all the passages where the CEO motivated his actions in light of the positive feedback received from the Association of Private Clinics; similarly, for the code “professional logic prioritized in work practices,” we analyzed all the passages where physicians related the change in professional behaviors to the negative evaluation expressed in the hospital’s accreditation report.

Step 4. Elaboration of a Process Model. We aggregated the basic codes identified in Steps 2 and 3 into higher-order constructs that captured the empirical dynamics in our case. This resulted in eight mechanisms spanning three levels of analysis: acclamation and criticism at the audience level (which captured stakeholder evaluations); assurance, narrower attention, and logic contestation at the organizational level (which captured relationships between

those who promoted each logic); and incumbents maintain discretion over core practices, incomers undermine incumbents' discretion over core practices, and incumbents reassert discretion over core practices at the practice level (which captured the enactment of intraorganizational practices). This allowed us to develop a process multilevel model that illustrates the relationship between our mechanisms over time and their effects on our focal organization. To do so, we "temporally bracketed" (Langley 1999) our analysis into three stages: a first stage in which the new logic is effectively introduced and accommodated by organizational actors (leading to mutual gains), a second stage in which those promoting the new logic become increasingly assertive (leading to the compromising of standards), and a third stage in which the new logic is rejected (leading to restoration of the original hybrid).

To ensure the trustworthiness of our analysis (Lincoln and Guba 1985), we triangulated across field notes, archives, and interviews to elicit core constructs. We also conducted internal member checks to verify our interpretation of events and collect follow-up data. Finally, the two coauthors carefully reviewed the field notes in which the first author had recorded her thoughts and feelings throughout the data-collection period. This combination of the authors' "insider" and "outsider" perspectives provided the benefit of "intimacy" with our research context as well as the opportunity for "distancing" (Langley et al. 2013, p. 6).

Findings

Our findings unfold over three stages. The first stage is the effective introduction of the private logic into R-Hospital, with all actors benefiting from mutual gains. The second stage is the increasing assertiveness of the private actors, with strong positive feedback from audiences supporting the private logic's growing influence but also compromising of professional standards. The third stage is the rejection of the private logic: criticism of the hospital led to internal conflict and prompted the incumbent actors to reassert the primacy of the professional logic, which led to restoration of the original hybrid arrangement. Tables 2–4 summarize the core constructs across the three stages, with additional supporting evidence for each one. We consider the stages in turn and emphasize that the core of our contribution lies in the interplay of three levels of analysis: evaluations at the audience level, relationships between different groups of actors at the organization level, and intraorganizational practices at the practice level.

Effective Introduction of the Private Logic (2005–2009)

Audiences were initially skeptical of private involvement in R-Hospital, in part because it had not been seen before in Italian healthcare. However, for

the first four years, R-Hospital seemed to cope well with the competing demands of the two incumbent logics and the incoming private logic, and R-Hospital established itself as a well-functioning hybrid. We found that this was owing to the effective introduction of the private logic into R-Hospital by means of two mechanisms: a strategy of assurance by the incoming actors at the organization level and incumbents' maintenance of discretion over core practices at the practice level. We first briefly consider the reactions of key audiences to the new hybrid arrangement and then examine the two mechanisms (Table 2).

Audience Level: Skepticism. Audiences did not expect the smooth incorporation of the new logic: they initially expressed widespread skepticism that a hospital with private-sector involvement could thrive in the Italian health system. They also exhibited much ideological resistance. For example, when the local government first considered the idea, "the opposition party was against the project. Private meant pirates to them" (LHU director, interview). Ultimately, however, local politicians recognized that if the hospital was to avoid closure, the *managerial experiment* "was the only viable solution" (LHU director, interview). Even so, many stakeholders had doubts about whether R-Hospital was an appropriate place to start, as evidenced by the low interest shown by private investors: "When the LHU issued the public tender for the selection of the private partner in 2003, only 3 private companies applied, and by the end of the procedure we were the only one left" (private investor 1, interview). Parts of the Italian medical establishment also questioned the choice of R-Hospital, noting its geographic and professional isolation, and pointed to its modest clinical reputation: "R-Hospital was a peripheral facility, most of the physicians were at the end of their careers, and no one sought to replace them; it was not an attractive place" (LHU physician 1, interview).

Organizational Level: Assurance. When the private actors first entered R-Hospital, they carefully signaled that they did not pose a threat to incumbents—that their intentions were solely to support healthcare delivery. This was a deliberate strategy on their part designed to smooth relationships with and overcome resistance from the professional and public actors. We were informed in the early months of our fieldwork that the incoming private actors—notably, the CEO, administrative director, and marketing director—had been aware of the need to gain acceptance and thus had openly portrayed themselves as supportive of the current professional and public goals of the hospital. They stressed that their efforts would be focused on supporting clinical performance and patient welfare—financial considerations would be secondary. As the

Table 2. Stage 1—Constructs and Illustrative Data

Constructs	Illustrative data
1. Audience skepticism	<p>“When we arrived, we did not find a sympathetic community. . . . indeed, the local population was skeptical about our chances of turning the old public hospital into an efficient health facility” (CEO, interview)</p> <p>“The new private management will have to prove itself in the next few months” (newspaper article 5)</p>
2. Assurance	
Private actors portray themselves as supportive of professional goals	<p>“The CEO and his staff were definitely supportive in the early years. They always remarked that the private investor had invested in the facility not to make profit but to support the consolidation of a specialized hospital in the local area” (physician 3, interview)</p>
Public and professionals actors accept this view	<p>“I knew very well that private investors in healthcare had traditionally very hard times in this Region. R-Hospital was a true ‘experiment’ in this sense and it would have been deleterious to enter the partnership with the idea of being the big boss” (CEO, informal exchange)</p>
3. Incumbents maintain discretion over core practices	
Professional logic	
Admission practices	<p>“At the beginning we compiled the patients’ admission list based exclusively on criteria of medical priority” (physician 4)</p> <p>“We respected the work of physicians. There was indeed little incentive for us to interfere in physicians’ work. We hardly complained on issues such as bed occupation or pushed for specific types of patients” (administrative director)</p>
Diagnosis and treatment practices	<p>“In the first few years at R-Hospitals we learned through our own day-to-day experience how to set up and improve patients’ treatments” (physician 3)</p> <p>“The transition from a generalist to a rehabilitation hospital—and the setup of the related treatment procedures—was done by the healthcare professionals” (CEO)</p>
Discharge practices	<p>“In 2006 we set up a discharge protocol detailing for each category of patients the average hospitalization length and the recommended time for discharge, based on the best international guidelines. We followed the protocol carefully with each patient” (physician 3)</p> <p>“When I arrived in R-Hospital in 2006 I had no say on physicians’ practices such as when and how to discharge patients” (clerk 2)</p>
Public logic	
Admission practices	<p>“Originally, we did not consider R-Hospital a hub of the public health network. Patients of our local health unit were primarily referred to other hospitals in the nearby area” (LHU member 6)</p> <p>“In the early years of R-Hospital, we had no formal agreements on the transfer of incoming patients with the public hospitals in our local health unit. Thus, the Local Health Unit did not exert any strong role as coordinator of the health network on us” (physician 3)</p>
Diagnosis and treatment practices	<p>“We had no voice in the treatment of patients. This was a physician’s task” (LHU member 1)</p> <p>“I cannot remember any systematic attempt by the LHU to interfere with our treatment procedures” (physician 2)</p>
Discharge practices	<p>“At the beginning we left R-Hospital grow up as an independent facility. I must acknowledge we resisted the idea of considering it at the same level of the other public facilities. Patients’ discharge paths in our LHU did not include R-Hospital” (LHU member 1)</p> <p>“Being a pretty peripheral facility, and with most orthopedic patients going back home after the discharge, we felt limited pressure to coordinate the patient postdischarge with other local public facilities” (physician 5)</p>
Private logic	
Admission practices	<p>“We had little voice in the decisions regarding patients’ selection” (CEO)</p> <p>“When the private actors entered our hospital, they did not force us to focus on specific categories of patients. Indeed, most of our patients were orthopedic (i.e., less remunerative patients) rather than neurological” (physician 1)</p>
Diagnosis and treatment practices	<p>“Physicians were originally skeptical about the new management and we were careful not to be overly present in their everyday work” (administrative director)</p> <p>“There was little interference by non-professionals over the choice of patients’ treatments. Administrators hardly entered into our business” (physician 2)</p>
Discharge practices	<p>“We introduced the DRG system. We did so through the involvement of external doctors who interacted directly with our physicians” (CEO)</p> <p>“The obsession to comply with the average hospitalization length set up by the remunerated DRG was not felt in the early years” (physician 2)</p>

Table 3. Stage 2—Constructs and Illustrative Data

Constructs	Illustrative data
4. Audience acclamation	<p>“The new hospital is exceeding expectations. It is quickly growing in the local area” (local newspaper 2009)</p> <p>“R-Hospital is a management model to be exported. This is demonstrated by the economic results, but also by the patient satisfaction feedback, that is constantly monitored by the regional Offices” (regional health councilor, 2009, public speech)</p>
5. Narrower attention	<p>Public, private, and professional actors increase the interactions with their field level referents</p> <p>“The Clinical Director announced he had been nominated a member of the National Commission on New Rehabilitation Techniques and, by doing so, all of them would have the opportunity to shape concretely the future of rehabilitation” (observation, internal meeting)</p> <p>“In the past three years we have moved from having no external engagements with the scientific community to having all physicians submitting abstracts to the national conference” (Clinical Director, interview)</p> <p>Limited concern about feedback from other groups, lack of reciprocal knowledge of accomplishments</p> <p>“In September 2010 the CEO received two visits from CEOs of foreign health clinics interested in learning the business model of R-Hospital” (R-Hospital 2010 Annual Report)</p> <p>Private actors become assertive</p> <p>“The success of this hospital derives from the managerial capacities of all of us (referring to the colleagues working in the administrative unit) who have been able to turn a dead facility into a vibrant hub” (administrative director, interview)</p>
6. Incoming actors undermine incumbents’ discretion over core practices	
Professional logic (43 decisions, 31%)	
Admission practices (11 decisions, 30%)	<p>“Mr. Casper (pseudonym) and Mr. Roger (pseudonym) are on our waiting list and they are both orthopedic patients type b. The former, however, has a higher rehabilitation potential and should be hospitalized first” (physician 8)</p>
Diagnosis and treatment practices (12 decisions, 44%)	<p>“Diagnostic test (anonymized) is essential for patient 69. Let’s plan it for early next week” (physician 11)</p>
Discharge practices (20 decisions, 27%)	<p>“Patient 62 has completed her rehabilitation path. We can discharge her tomorrow morning” (physician 7)</p>
Public logic (44 decisions, 32%)	
Admission practices (12 decisions, 32%)	<p>“We need two beds for Patients 54 and 55. They are exceptions to our admission rules, but the LHU hospital asked us to admit them” (physician 11)</p>
Diagnosis and treatment practices (8 decisions, 30%)	<p>“Whenever we need patients to take test (anonymized), we will send them to the nearby public hospital” (physician 7)</p>
Discharge practices (24 decisions, 32%)	<p>“Patient 62 has completed her rehabilitation path, but we should keep her in our ward an extra day until she is admitted to Hospice Alpha” (physician 10)</p>
Private logic (51 decisions, 37%)	
Admission practices (14 decisions, 38%)	<p>“We cannot lower the threshold of 100% of bed saturation and in redistributing beds, remember to keep at least 25 beds for type A patients (more remunerative patients)” (physician 9)</p>
Diagnosis and treatment practices (7 decisions, 26%)	<p>“We can avoid taking this extra diagnostic examination for patient 59” (physician 10)</p>
Discharge practices (30 decisions, 41%)	<p>“With this type of patients, try not to exceed the hospitalization length set by the respective DRG, as this would cut the reimbursement rate by 25%” (physician 3)</p>

CEO recalled, “When I arrived in R-Hospital, it was just me and many skeptical and demotivated clinicians. . . . I met with a few clinicians that I thought had the potential to lead the professional transition and asked them ‘what do you need? I am here to support.’ This is how we started to calibrate in a gradual way” (CEO, interview).

Consistent with this stance, the actors promoting the private logic were careful to discuss their ideas with their professional and public counterparts before making efforts to implement them. Furthermore, they consulted the clinical director on all decisions that had any clinical implications. This judicious

entrance was evident in the stories told to us about life during this early period:

I remember that in his first year the CEO invited physicians of the Italian Association of Private Health Clinics to teach us about their use of business practices, such as the DRG protocol. It was not the CEO who taught us directly, but someone from our profession. This was a smart move because we perceived them as being legitimate. (clinical director, interview)

Moreover, the private actors emphasized that the LHU was the “leading shareholder and the key organ of control of R-Hospital” (private investor, press release 6)

Table 4. Stage 3—Constructs and Illustrative Data

Constructs	Illustrative data
7. Audience criticism	<p>“Between 2009 and 2010 patients were hospitalized on average 20% longer, with decreasing rehabilitation improvements” (data retrieved for external accreditation report)</p> <p>“Patient 101 complained about the delay in the use of the rehabilitation gym. Apparently it was overbooked due to the increase in the number of outpatient patients” (observation, ward field notes)</p>
8. Logic contestation	
Professional and public actors realign and exclude private actors	<p>“It is time to reassert our role in R-Hospital” (clinical director, observation)</p> <p>“The CEO seems to forget that R-Hospital is still a public hospital operating within our LHU network. Hence, any decision should be discussed and agreed upon with us and with the professionals” (LHU director, interview)</p>
Private actors continue to be assertive	<p>“The outpatient budget will continue to increase next year” (2011 Outpatient Budget Plan)</p>
9. Incumbents reassert discretion over core practices	
Professional logic (86 decisions, 85%)	
Admission practices (17 decisions, 85%)	<p>“In planning next week admissions, let’s make sure we prioritize patients with high rehabilitation potential, regardless of the reimbursement level” (physician 13)</p>
Diagnosis and treatment practices (24 decisions, 83%)	<p>“We are entitled to plan the most effective treatments for our patients. If we believe patient 87 needs an extra diagnostic test, we will carry it out” (physician 12)</p>
Discharge practices (45 decisions, 87%)	<p>“The DRG should not be seen as a constraint, rather as a guideline for our work. Discharge happens only at the end of the rehabilitation path” (physician 2)</p>
Public logic (8 decisions, 8%)	
Admission practices (1 decision, 5%)	<p>“Let’s make an exception to the rule only for this time and hospitalize patient 101 coming from the local hospital” (physician 8)</p>
Diagnosis and treatment practices (3 decisions, 10%)	<p>“We will send patient 140 to take the diagnostic test in the LHU hospital only because we cannot run such a test here” (physician 13)</p>
Discharge practices (4 decisions, 8%)	<p>“I know we are not responsible for postdischarge, but we can support the LHU rehabilitation center with the discharge of patients 97 and 100” (physician 12)</p>
Private logic (7 decisions, 7%)	
Admission practices (2 decisions, 10%)	<p>“We will prioritize the admission of patient 89 on that of patient 92 only because they display the same level of rehabilitation potential” (physician 7)</p>
Diagnosis and treatment practices (2 decisions, 7%)	<p>“We have no certainty that this extra test would make a difference for patient 99. Let’s avoid making it for this time” (physician 9)</p>
Discharge practices (3 decisions, 6%)	<p>“For patient 92 we can keep the discharge date of 28 days set by the DRG. It is a good compromise and the patient will recover fully by that date” (physician 7)</p>

and would form a safety net against any overzealousness on the part of investors and managers who might be tempted to take cost-cutting measures too far. They also repeatedly stated that the commercial principles that they espoused were designed to help physicians deliver high-quality care. The CEO was quoted in the provincial newspaper (2005) as saying

I believe that the hospital can work properly only if it is supported by two key stakeholders: the city public hospital and the community of general practitioners. . . . Healthcare is public and it would be ridiculous to think that private actors could substitute for the State. The role of the private actor is to guarantee professional services in a better and more efficient way. (CEO, quoted in the provincial newspaper 1)

Later, he repeated the point: “When I arrived in 2004, I set out to portray the relationship with physicians not as contrasting but as collaboration. I gradually established a relationship of trust with the existing professionals working in the hospital and . . . with the local health unit” (CEO, interview).

This approach was confirmed by an interview with a key actor promoting the public logic—the former director of the LHU—who commented that “[t]he private actors came to R-Hospital with no expectations of taking over the lead of the hospital.”

Practice Level: Incumbents Maintain Discretion over Core Practices.

The private actors were careful not to place pressure on physicians with respect to their enactment of core hospital practices. Although they suggested changes, which were frequently adopted by physicians and resulted in the incremental integration of the private logic into core hospital practices, these suggestions were intentionally positioned in a way that did not impinge on physicians’ discretion over admissions, diagnosis, treatment, and discharge. Rather, the private actors presented alternative ways by which these practices could be enacted and sought to persuade physicians to consider them. For physicians, this respect for their professional discretion was of profound importance and significant in allaying their skepticism, even as

they incorporated ideas from the private logic into their decision making: “Being left alone in our work, this is what mattered to us” (physician 2, informal exchange). Evidence from archival and retrospective interview data supports this statement.

In terms of admissions, although the influence of the private logic was evident, physicians explicitly based their decisions on professional judgment. For example, senior physicians acknowledged the private actors’ request to maximize bed occupancy in order to support the hospital’s financial sustainability and searched for new ways to increase the number of admissions, such as by promoting the hospital in the local area and incentivizing colleagues to refer patients to R-Hospital. Yet, in the first four years, the hospital did not operate at its full capacity (it increased to 100% of capacity only in stage 2). Also, although the private actors encouraged physicians to admit more remunerative patients, they did not place pressure on them to do so, and the numbers were relatively small throughout this stage. As one physician put it, “In the first few years we had freedom to select the cases to be inserted in the waiting list for admission” (physician 4, interview). The prioritization of professional criteria in admission practices was also confirmed by private actors: “In the early days we did not interfere with the selection of patients entering the ward; we were busy in setting up all the administrative procedures and business relations” (CEO, interview).

Physicians exercised the same leeway for diagnosis and treatment. All physicians interviewed confirmed that they had exercised full discretion over patient care: “This was the time in which we experimented with many new rehabilitation techniques, some of which worked, some others did not” (physician 2, interview). The CEO also remembered “being very cautious in imposing any strict rule on how the physicians should operate in their daily work. . . . [This] was a delicate moment: entering an existing organization and being viewed with high suspicion did not facilitate our early acceptance” (CEO, interview).

In terms of the discharge practice, physicians agreed to the introduction of the DRG system—the core idea advocated by those promoting the private logic in R-Hospital—which had significant implications for hospital income. However, during stage 1, the physicians “found no major obstacles in discharge when the rehabilitation path was terminated” (physician 3, interview). Indeed, although private actors were clearly keen to integrate the DRG system in R-Hospital’s practices, they opted for “a bottom-up implementation, involving physicians and nurses in its early implementation” (administrative director, interview).

Thus, overall, we found that during stage 1, physicians maintained control over the extent to which the private logic influenced core hospital practices. In

other words, although the private actors promoted the private logic and the private logic was incorporated into core practices, this happened incrementally and critically, at the discretion of the physicians. The professional logic remained dominant.

Outcome: Mutual Gains. The private actors’ strategy of assurance combined with their respect for the discretion of physicians over core practices enabled the achievement of financial and clinical gains that tempered the concerns of physicians and indeed the public actors. Financially, the turnover of the hospital increased by 74% in 2005, 31% in 2006, 15% in 2007, 9% in 2008, and 16% in 2009. Gross operating margins were also positive—6% in 2006, 18% in 2007, 17% in 2008, and 16% in 2009. To support clinical performance, the senior management team used annual net profits for the purchase of advanced equipment (Annual Reports, 2005–2009), the renovation of the wards (Annual Report, 2008), and the training of nurses, care assistants, and physicians (Annual Reports, 2005–2009). Although each gain in itself did not radically alter the performance of the hospital, collectively they represented a cumulative step change both clinically and financially. Moreover, these gains resonated throughout R-Hospital: all occupational groups felt advantaged by them both materially (through new equipment and training) and symbolically (through the hospital’s strengthening reputation).

The upshot was a growing enthusiasm for the hospital. The private actors had overcome the reservations of the medical staff, and collegial relationships between medical and nonmedical personnel were apparent in formal settings (e.g., board meetings) and informally on the wards. The clinical director, who had 30 years of experience in publicly funded healthcare, declared, “We are now all perfectly integrated,” and, with a smile on his face, captured the sense of collegiality by saying, “We strategize all together while eating a sandwich.” One nurse nostalgically recalled: “We felt it was *our* hospital, *our* home. What do you do with your home? You give the maximum level of care” (nurse 11, interview).

Increasing Assertiveness of the Private Logic (2009–2010)

On the surface, R-Hospital seemed to be moving from strength to strength and was widely praised by key stakeholders, but internally, R-Hospital became volatile. Specifically, audiences’ widespread positive acceptance of R-Hospital turned to acclamation. Although this audience-level mechanism intensified the commitment of those within the hospital to sustain performance, it also precipitated and then exacerbated two mechanisms that destabilized the workings of the hybrid. First, at the organizational level,

narrower attention became evident as actors promoting different logics built relationships with particular audiences but showed less interest in the views of others. Second, buoyed by their role in R-Hospital's apparent turnaround, incoming actors undermined incumbents' discretion over core practices by pressing for their ideas to be adopted much more extensively in clinical decision making. At the same time, the public actors increasingly aligned themselves with the private actors while also pushing their own interests. In other words, the private and public actors came together to challenge the primacy of the professional logic in the functioning of the hospital (Table 3).

Audience Level: Acclamation. By 2009, a range of audiences recognized R-Hospital as a highly specialized provider of rehabilitation services. The change in status was reflected in a shift in the types of patients referred to it—the hospital treated relatively fewer orthopedic patients and focused instead on more challenging cases. The number of postanoxia and neurologic patients, for example, increased from 8 in 2004 to 120 in 2009 (R-Hospital official statistics). The media applauded these achievements. One newspaper referred to R-Hospital as “the optimal organizational model for delivering rehabilitation services,” highlighting that it could “maximize the synergies between the public and the private spheres” (provincial newspaper 4).

Physicians who had originally felt that working in R-Hospital would be less attractive than working in a city hospital now believed that the wider professional community respected them as highly competent and playing a valuable role in Italian healthcare. That respect was reflected in invitations to a senior physician to join the editorial board of an important academic journal and to the clinical director to join the national committee on clinical rehabilitation practice. It was also reflected in a research agreement signed with an elite university. Furthermore, more and more physicians from R-Hospital began attending regional and then national conferences, prompting the clinical director to proudly point out that “in the past three years we have moved from having no external engagements with the scientific community to having almost all physicians submitting abstracts to the national conference on rehabilitation” (clinical director, interview). Indeed, during 2009–2010, nearly 60% of physicians participated in national conferences, notably the Italian Society of Orthopaedic Rehabilitation Conference.

R-Hospital became an attractive employment option. Whereas many of the senior doctors had applied to the hospital because of the “lack of job market alternatives” (physician 3, interview) or for family reasons—“I knew they had recently opened a new

hospital close to home and wanted to stay nearby” (physician 1, interview)—many junior doctors hired in 2008–2009 applied because of the career opportunities that R-Hospital afforded. A junior physician reinforced this view: “I applied to R-Hospital because I thought it could give me the best professional training” (physician 12, interview).

It was not only members of the medical staff who were feted by the wider community. The CEO was invited to give a keynote speech at a national meeting of the Association of Private Health Clinics and was a guest speaker at a leading national business school. He also advised on how R-Hospital could be written up as a case study for graduate management courses. Executive directors of foreign hospitals and members of consulting companies visited in order to learn from the CEO how to make a public–private partnership work. Those promoting the public logic also benefited from the hospital's performance. In 2009, the secretary general of the regional government declared R-Hospital to be “a model to be exported, as confirmed not only by the economic results, but also by the high level of customer satisfaction” (press release 34). For them, customer satisfaction was expected to translate into electoral support.

Thus, R-Hospital was widely celebrated, with members of each of its constituent groups feted by audiences of their logic.

Organization Level: Narrower Attention. Acclamation had important effects on the relationships between R-Hospital and its key audiences. Physicians' interactions with their professional community were bolstered significantly by the increased conference attendance and recognition discussed earlier. Private logic proponents also appreciated the attention and respect that they received. For them, however, the “reference community is the Association of Private Clinics” (CEO, interview). The CEO and his colleagues—notably the directors of administration and marketing—expressed pride in the growing flow of visitors from foreign hospitals and consulting firms: “Next week we will host a delegation of hospital CEOs from Eastern Europe. This is a great achievement, we are honoured and delighted to be the only hospital they will visit in our Region” (marketing director, informal exchange). Advocates of the public logic also had their own key audiences—the electorate and politicians. For these audiences, R-Hospital was taking pressure off the public healthcare system by enabling more patients to receive timely care without the need for any additional public funding. As one LHU board member proudly recalled during a board meeting: “I talked to a group of citizens living in the city. All of them confirmed that they prefer driving 40 minutes to R-Hospital rather than going to the city hospital.”

An implication of these interactions between the three groups and their respective audiences was narrower attention on the part of all of them. Proponents of each logic developed attachments to audiences whose attention and positive reinforcement they valued. At the same time, they showed limited concern about feedback from “other” audiences—what mattered was validation from “their” peers. This was indicated in various ways, not least the relative ignorance of the others’ activities and accomplishments. For example, when the CEO gave a keynote speech at the Association of Private Clinics, none of the physicians—including the clinical director—were aware of it. Physicians were also surprised when foreign hospital administrators visited their wards.

This narrower focus of attention would later prove to be a destabilizing force, but in the short term, it boosted morale. We observed few complaints about work pressures. On the contrary, the following enthusiastic comment was more typical: “It is such a rewarding experience to be working here” (physician 8, interview). Advocates of the three logics also began to form their own separate informal groups for lunch (to which the first author was invited) and would meet for evening drinks and meals to celebrate with pride and optimism how things were progressing. This had not happened in the past. During a physicians’ dinner, one admitted: “I do not feel the distinction between ‘work life’ and ‘private life’ with my colleagues. For example tonight we are just hanging out together to celebrate the arrival of a new colleague.”

Actors’ narrower attention began to change the internal dynamics of the hospital. Crucially, incomers promoting the private logic became much more confident and assertive. They believed that the seemingly impressive clinical and financial performance of R-Hospital could be attributed to the ideas and practices that they had introduced. As the administrative director said to us in an informal exchange: “It is only thanks to our managerial skills that R-Hospital is the center of excellence widely recognized today.” This led to a shift in relationships between the three groups. The private actors began to attract support from those promoting the public logic who, after overcoming their initial skepticism, openly gave credit to their private-sector colleagues:

The competitive advantage of R-Hospital, I mean the reason for its success, is that it is always, always, always able to ensure a bed or a timely outpatient visit when needed. And this is because the private management has rendered it more efficient. I am not saying something which contradicts my role as a public representative, I always say what I think is the truth. (LHU representative 1, board meeting 2)

In effect, the public actors increasingly perceived the purposes and values of the public logic as aligned

with those of the private logic and began to reconsider their previously taken-for-granted close association with the professional logic.

Practice Level: Incoming Actors Undermine Incumbents’ Discretion Over Core Practices. A critical consequence of the assertive stance of the private actors and of the changing relationships between different groups was increased pressure on physicians to comply with prescriptions of the private logic. Proponents of the private logic began to emphasize the need to fill beds, the importance of strict adherence to the DRG protocol, and the benefits of bed occupancy by patients for whom the hospital received the highest reimbursement. In consequence, physicians were much more influenced than previously by the private logic in their admissions and discharge practices—and even, although to a more modest extent, in their treatment practices. All these changes were designed to contribute to the optimization of revenues. However, crucially, in doing so, they encroached on the discretion of the physicians who perceived the need to conform. These encroachments by the private actors were very deliberate:

I am now assuming a more restrictive behavior, which means that the Clinical Director cannot authorize any type of costs without the approval of the Administrative Directorate. Everything must be seen and pass through this office. (administrative director, interview)

Concurrently, the public actors increasingly appreciated that R-Hospital’s efficiency was contributing to the wider healthcare system by “processing” patients in a cost- and time-efficient manner such that resources could be reallocated elsewhere. As a result, the LHU also sought to influence physicians’ enactment of core practices, requesting R-Hospital to admit patients with lower rehabilitation potential in order to free up resources for other hospitals. Furthermore, because hospitals in the region were having difficulty handling the growing flow of patients discharged from R-Hospital, the LHU gave R-Hospital responsibility for postdischarge care. As the director of the LHU explained during an interview:

This hospital is like our young kid who’s now growing up. During his first years of life, we left him free to experiment with the new reality. But now we cannot have children walking at different paces. I mean, it would be extremely hard to justify why this hospital makes a profit, while the LHU as a whole is in deficit. The hospital must help the other public facilities, as elder brothers would do. (LHU director, interview)

The increased influence of the private and public logics resulted in more demands being placed on physicians—particularly with respect to the optimization of bed

occupancy and the admission of patients for whom the hospital would receive the highest reimbursement. One might have expected physicians to push back against such pressures, but in stage 2, they did not generate dissent. A key question is why.

Our analysis suggests that audience-level acclimation had raised performance expectations and that physicians were proud of the hospital's growing reputation, which outweighed potential concerns. We observed this pride in several conversations between physicians. As one said, "We are committed to this hospital, and we want to perform better and better." At another meeting, a physician explicitly commented on the importance of maximizing bed occupancy:

Have you read the newspaper article published yesterday? They point out how during the summer period hospitals work on average at 50% of their capacity. On the contrary, they emphasize that our hospital is always operative and work at 100% of its capacity. We should be proud of this. Make sure we continue keeping 100% of our beds full throughout the year. (physician 7, informal conversation)

We also found evidence of physicians justifying pressures arising from the public logic. After the public actors gave physicians responsibility for arranging patients' postdischarge care, one of them said:

On Monday I took part in a professional seminar with the most important physicians of the area. A colleague of ours, working in Hospice B (a postdischarge setting), openly said in front of all our colleagues that he strongly recommended our hospital because all the patients discharged by us and then admitted in Hospice B were happy of the service received. In their view, in no other hospital could they find physicians taking care so intensively of the postdischarge setting of patients. This is a source of advantage for us. (physician 4, informal conversation)

Physicians had internalized the narrative that the ideas associated with the private logic underpinned the hospital's "remarkable" turnaround and its burgeoning national profile—a narrative that was exploited by those promoting the private and public logics and that increased the workload of physicians. Thus, to cope with their increasing work pressures, physicians reinterpreted professional protocols and extended the application of private logic as well as the public logic more deeply into the three core practices. Whereas in stage 1 physicians' decisions with respect to admissions, diagnosis, treatment, and discharge were governed primarily according to the professional logic, in stage 2 the influence of the logics was more balanced. As shown in Table 3, of the 138 decisions analyzed during stage 2, physicians involved the professional logic in 31% of cases, the private logic in 37% of cases, and the public logic in 32% of cases.

More specifically, in their decisions on admissions, physicians selected patients with the greatest reimbursement potential in 38% of cases, a decision consistent with the private but not the professional logic, which emphasized patients' rehabilitation potential. This prioritization of the private logic is also illustrated in an exchange between two physicians who moved patients to the top of the list for admissions without regard for their rehabilitation potential.

Physician 2: (talking about the waiting list) How many cod.3 patients (i.e., highest earning category) do we have at the moment?

Physician 6: Twenty-six.

Physician 2: We must increase the number of patients. Let's put two of these patients on the top of the admission list of next week. (weekly meeting 4, observation)

Similarly, in 32% of cases, physicians gave priority to patients coming from the local area—again, irrespective of the patients' rehabilitation potential—thus giving priority to the public logic. When a physician asked which of two patients should be admitted ("patient A has a higher rehabilitation potential; patient B definitely has lower potential, but she comes from the nearby hospital"), he was told: "Take patient B first. Once we saturate the demand from local patients, we can admit patient A" (physician 8, interview) In contrast to stage 1, when the professional logic was dominant, in stage 2, in only 30% of cases did physicians invoke the professional logic and give priority to patients with higher rehabilitation potential.

In terms of diagnosis and treatment, a similar pattern can be observed, albeit in a less extreme form. Physicians prioritized the professional logic in less than one-half of the cases (44%). For example, physicians frequently made assertions, such as "[w]e should try to reduce the number of extra diagnostic examinations, unless strictly necessary" (physician 12). It was evident from the context of this particular statement that a treatment decision was being adjusted because of a perceived pressure to reduce costs (i.e., the private logic was overriding the professional logic). We observed other instances where the influence of the private actors was similarly brought to bear in clinical decision making, including the limiting of diagnostic examinations in order to reduce the costs of drugs.

Finally, with regard to the practice of discharge, physicians invoked the professional logic in only 27% of cases compared with 41% of the cases where physicians complied with the private logic emphasis on the DRG protocol in order to capture full reimbursement, thereby maximizing revenues. The reasoning behind such decisions was revealed in an exchange during a planning meeting.

Physician 11: The length of hospitalization of patient 38, according to his DRG, is 28 days. This means next week. We could potentially still work with him, but this would require exceeding the time limit. What shall I do?

Physician 5: I suggest keeping to the length of hospitalization set by the DRG. You can then write in the discharge letter that extra rehabilitation exercises are needed for a full recovery.

Physician 11: Okay, let's keep the time limit. (weekly meeting 5, observation)

In another 32% of cases, physicians' decisions to discharge were explicitly influenced by pressure from the public logic to delay discharges until arrangements for postdischarge care were in place, even though treatment had been completed. As an example, consider the following exchange between physicians:

Physician 8: Patient 43 has completed his rehabilitation project. The public hospice that will host him is full and has asked us to wait an extra week.

Physician 6: Let's wait for the availability of the public hospice then. We'll keep the bed occupied and show that we take care of the postdischarge setting.

Physician 8: I agree. (weekly meeting 4, observation)

Outcome: Standards Compromised. By mid-2010, it was clear that even though physicians were experiencing increasing work pressures, they largely accommodated the new arrangements. This was because, as we showed earlier, they were proud of R-Hospital's growing reputation—which reflected positively on their own professional reputations—and they believed that meeting the expectations associated with the private logic would help sustain it. However, as illustrated by our practice-level analysis, the increasing influences of the private logic and indeed the public logic led ultimately to a compromise of professional standards. Patients were being hospitalized for up to 20% longer than before, and physicians had become 50% less effective in achieving the rehabilitation goals defined by the Barthel Index, an internationally used scale that measures a person's ability to accomplish everyday tasks, such as eating, dressing, and washing.

Rejection of the Private Logic (2011–2013)

In 2011, there was a dramatic turn of events. For the first time, audiences subjected R-Hospital to criticism because of shortfalls in its clinical performance and standards of patient care, criticism that the physicians in particular—and, to a lesser extent, the public actors but not the private actors—perceived as reflecting badly on their conduct. This precipitated two mechanisms. First, logic contestation became widespread. Second, incumbents reasserted their discretion over core practices—physicians reappraised how they

conducted admissions, diagnosis, treatment, and discharge and, with the support of the public actors, abruptly reaffirmed the primacy of the professional logic. The result was the expulsion of the private logic and the restoration of the original hybrid (Table 4).

Audience Level: Criticism. In early 2011, an externally conducted quality accreditation of R-Hospital highlighted in a visible way the outcomes of stage 2 referred to earlier. Although much of the report was positive, the report clearly indicated instances where professional standards had been compromised. Physicians also learned of an increasing number of complaints from patients and their families. During our fieldwork, we observed for the first time patients expressing dissatisfaction to medical staff about “the time dedicated by the physicians to their patients” and the “quality of care provided by nurses and care assistants.” One patient commented angrily that “it is more a production chain than a hospital” (ward observations 34–36). Although the absolute number of patient complaints was relatively small, when coupled with the accreditation report, the complaints drew the attention of physicians and magnified their impact.

At first, the criticisms surprised physicians—they seemed taken aback by them. The accreditation report was the first negative evaluation that the hospital had received since the early days of R-Hospital, and we did not find evidence, either from our interviews or from our observations, to suggest that physicians had concerns about clinical performance. However, it quickly became apparent that physicians interpreted this negative feedback as threatening the respect they had gained from the audiences they most valued: as a consequence of participation in local and national conferences, they had become sensitive to even modest feedback that questioned their professional competence. Their immediate response to the accreditation report and the complaints from patients was to blame the pressures of work. As one put it: “It is hard to sustain these frenetic working standards, and patients' relatives now complain that we care more about quantity than quality” (physician 9, informal exchange). Another lamented that “patient 74 has a decubitus ulcer and is complaining about the way he is treated by the nurses. I know that our nurses have less time per patient now; it wasn't like this in the past” (physician 6, informal exchange). Expressing dismay and with a clear tone of anger, another physician commented: “This morning I intercepted a phone call of patient 120's relatives. They wanted to talk to the external relations office to complain about the quality of care provided” (physician 8, informal exchange). In addition, senior physicians increasingly voiced concern that their staff was demotivated: “I do

not know how to motivate my team. It is so disappointing” (physician 7, informal exchange).

Organization Level: Logic Contestation. In the weeks immediately after publication of the accreditation report, physicians’ discontent became ever more evident. A key moment happened when the clinical director suggested in an emotional meeting that it was pressures from “bureaucrats” that had led to the poor patient outcomes:

These data are drawn from the accreditation process. Now that the process has come to an end, we should make a decision: either file it as any other bureaucratic activity we carried out in the past or *use it as a way to improve our work*. I suggest we go for the latter and collect indicators both on the clinical and on the organizational side. (clinical director, weekly meeting 11 [italics indicate raised voice])

Senior clinicians followed suit, placing the blame squarely on the private actors. Increasingly, the physicians—regardless of seniority or length of service—began to attribute the compromising of standards and the rise in patient complaints to the business-like practices now portrayed as “imposed” on them. Physicians became visibly upset in their weekly meetings and began criticizing the private actors, referring to them as “interfering” and of “undermining” clinical work. They punctuated these meetings with statements, such as “*We are the one doing the ‘job’ here. . . . Without us, this hospital would close tomorrow*” (italics indicate a raised voice). Moreover, they dismissively referred to nonmedical managerial staff—whom they accused of claiming undue credit for the hospital’s past clinical achievements—as “them.” According to one physician: “I am so frustrated. I mean, treating 1 of 100 type 3 patients does not make a difference to them [pointing to the administrative team dining in the hall]. . . . I need to get gratification from the activities I carry out. I should be able to start and conclude a rehab path” (physician 11, lunch conversation between physicians).

At the same time, physicians insisted on greater involvement in important organizational decisions. In one notable meeting, the clinical director confronted the administrative director, announcing that any requests for increases in productivity would henceforth be rejected unless accompanied by additional resources. In the hospital wards, professionals became more forceful and excluded private actors from their daily activities. For their part, promoters of the public logic had also lost confidence in the private logic, and in a highly symbolic move, the CEO was forbidden to lobby regional politicians. Members of the LHU insisted that it was they, and they alone, who could do so. The implication was clear: the decline in professional standards was the fault of those

advocating the private logic; “they” were to blame. Hence, both the physicians and public actors started to withdraw their support from the private actors and push for a return to the original prioritization of logics in R-Hospital—the previously close relationship between the professional and public logics came to be reestablished.

Nevertheless, the private actors persisted in pushing for greater efficiency and complained about the inability of physicians to meet targets. They continued to promote the application of their logic as the appropriate way forward and seemed immune to the criticisms contained in the accreditation report. Crucially, their audience-level referents still applauded their efforts: visits from CEOs of foreign hospitals continued, the Association of Private Health Clinics still referred to R-Hospital as exemplifying best practice in the management of hospitals, and the CEO kept on being invited to roundtables on how to successfully manage public–private partnerships. As a result, the private actors sought to push their approach even further in response to this positive feedback. In frustration at the physicians’ sudden resistance to their initiatives, they reallocated resources from services that generated limited income (e.g., speech therapy) to those that increased hospital revenues (e.g., ambulatory services). In doing so, they neither informed the clinical director nor asked for his views, contrary to their previous behaviors. This proved counterproductive politically. Worsening relations between the private actors and the physicians as well as the private and the public actors became evident in the caustic interactions between the groups. Informal and social events—such as joint coffee breaks and the Christmas party—simply ceased.

Practice Level: Incumbents Reassert Discretion Over Core Practices. Our practice-level analysis shows that physicians not only reasserted themselves in organizational decision making but also took back control of core hospital practices. Senior clinicians insisted that any pressures that could compromise standards of care should be resisted. As shown in Table 4, of the 101 decisions analyzed during stage 3, physicians invoked the professional logic in 85% of cases, the private logic in only 7% of cases, and the public logic in 8% of cases.

Considering each practice in turn, we found that physicians based 85% of admissions decisions on the professional logic (up sharply from 31% in stage 2). The clinical director declared firmly:

From now onwards, we should select patients more carefully on the basis of their rehabilitation. We should try *not* to hospitalize patients in vegetative states, even though we might have pressure to do so. Be sure that patients have some type of rehabilitation potential. (weekly meeting 11 [italics indicate raised voice])

In terms of diagnosis and treatment, in 83% of cases (up from 44% in stage 2), physicians followed the professional logic, prioritizing patient care without regard for financial or capacity implications. For example, unlike in stage 2 when physicians had routinely complied with pressure from the private actors to limit patient referrals to other medical facilities, in stage 3 physicians frequently sent patients to other medical facilities for tests despite the costs of doing so.

Finally, with regard to discharge, physicians followed the professional logic in 87% of cases (up from 37% in stage 2). Indeed, the clinical director explicitly insisted on the application of the professional logic in discharge decisions.

You have frequently heard that patients “expire” as if they were a type of mozzarella cheese. Well, this is not true. It simply means that there is a tariff reduction, but we are not forced to discharge them. We do that because we deem it clinically appropriate to complete the rehabilitation project in this time span. (weekly meeting 11)

As a result, the proportion of orthopedic patients discharged within the strict time limits prescribed by the DRG system dropped from 41% to 6%, significantly curtailing hospital revenues. Moreover, physicians resisted taking responsibility for postdischarge care (they did so in just 8% of cases, down from 32% in stage 2), as advocated by the public logic, because it distracted them from looking after patients.

It is true that those patients we helped find a post-discharge setting for recommended our service. Yet, in reality they are not glorifying our professional skills in terms of our ability to cure them. Rather, they appreciate our . . . ability to find them a place to stay once they move out from our hospital. But this is not our duty: from now onwards we should not spend too much time in dealing with nonprofessional tasks. (physician 4, weekly meeting 13)

Outcome: Restoration of the Original Hybrid. In March 2011, frictions reached a head when the CEO and the administrative director announced that R-Hospital would be restructured into two subunits: inpatient services provided under a public payment scheme and outpatient services monitored against commercial targets. Again, this decision was taken without the clinical director’s involvement. The new structure, however, proved unworkable. After only two more years, the CEO resigned, followed a year later by the administrative director. The regional government formally announced that this particular managerial experiment was to be abandoned. The LHU bought back all privately owned shares, and the hospital became the publicly funded hub of the region’s rehabilitation services. In other words, the private logic was rejected. The multilogic experiment

had proved unsustainable and was replaced with a traditional public–professional hybrid.

Alternative Explanations

Through our analysis, we offer an account of how a new logic can be accepted into an established organization to create a well-functioning hybrid arrangement and how the arrangement can break down—with the incoming logic expelled and the original hybrid restored. At the core of our account is the role of audience feedback, which has specific effects on relationships between organizational members and the enactment of core practices. At the same time, and although we have confidence in our analysis, it is important that we interrogate alternative explanations for the events that unfolded in our focal case.

First, it could be that the incoming private logic was never accepted in R-Hospital—that incumbent actors decoupled by appearing to adopt the prescriptions of the private logic but did so only on the surface, which is why no tensions were evident in stage 1. This explanation would suggest that the meaningful adoption of the private logic did not happen until stage 2—the collapse of the hybrid stemming from the conflicting pressures that arose when the private logic came into direct contact with the professional and public logics. However, the evidence does not support this account in our case. Specifically, our data show clearly that the physicians enthusiastically adopted a number of ideas from the private logic in stage 1, most notably the DRG system, and that such ideas substantively affected physicians’ enactment of core practices at R-Hospital in its early years.

Second, it could be argued that our case can be explained much more simply in terms of diminishing returns. From this perspective, the introduction of a new logic provided the impetus to rethink ways of working in the hospital, which precipitated changes that increased organizational performance. Over time, however, after the straightforward changes had been made, the benefits of implementing the new logic declined, leading the public and professional actors to become frustrated and thereby creating tensions between the different groups, which ultimately destabilized the hospital. Again, the evidence indicates that this explanation does not apply in our case: our data show that the issues that led ultimately to the collapse of the hybrid arrangement were rooted in negative external audience feedback rather than in a perception among organizational members that the private logic had become less effective.

Third, another alternative explanation is that as the performance of R-Hospital improved, audience expectations moved ever higher, creating a destabilizing dynamic. This account would suggest that audience criticism of R-Hospital was not based on any

objective measure of performance but stemmed from audiences progressively raising the bar with respect to their conception of outstanding performance. This dynamic may have been evident to an extent in our case: our data show that, over time, audiences stopped being surprised at R-Hospital’s apparent accomplishments. However, the physicians were very clear—both in their comments to us and in their interactions with one another during stage 3—that clinical standards had deteriorated, and therefore, we do not believe that this explanation adequately accounts for what happened in our case.

Discussion

Our findings support three contributions. First and most important, we present a model of a previously neglected process, which allows us to explain the puzzle of how a new logic can be accepted and then rejected in hybrid organizations. Second, we deepen our understanding of the challenges of hybrid organizing by showing the critical importance of the interaction between the audience, organization, and practice levels. Finally, we connect to the broader institutional literature by challenging two of its widely held assumptions.

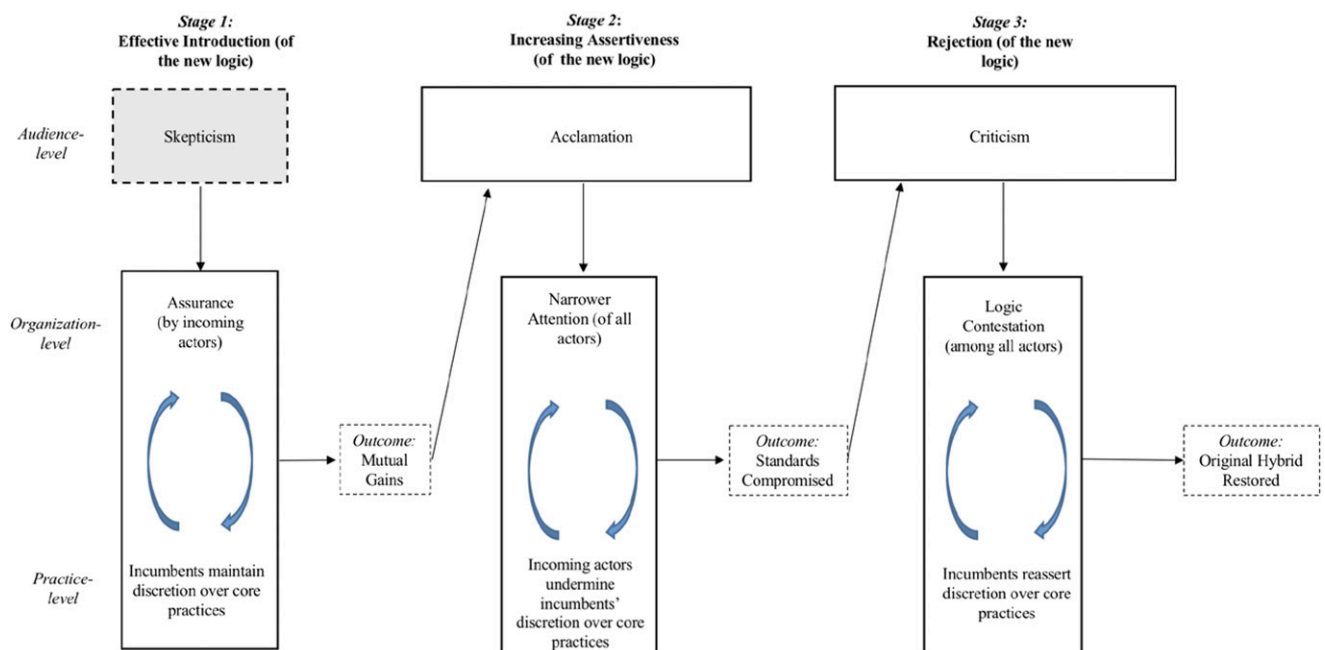
A Process Model of Logic Acceptance and Rejection in Hybrid Organizations

The case of R-Hospital features a mature hybrid organization that introduced a new logic in a seemingly effective manner—despite that logic initially being viewed with considerable skepticism. However, suddenly and with minimal warning, the hospital became

riven with infighting, leading to the collapse of the revised hybrid arrangements. Drawing on our findings, in this section, we elaborate the overarching process (see Figure 1). Our model comprises three discrete stages and cuts across the audience, organization, and practice levels of analysis.

The first stage in our model is the effective introduction of a new logic. A key task facing actors promoting this new logic is overcoming the skepticism of key audiences as well as resistance from incumbent organizational actors, especially if the logic is viewed as alien or even dangerous (see also Selznick 1996, Hardy and Maguire 2017). Note that audience skepticism is not a mechanism in our model but represents a common scenario when novel hybrid arrangements emerge (Tracey et al. 2011). Our model presumes that incoming actors promoting the new logic recognize that in order to gain acceptance from incumbents, it is strategically advantageous to present the new logic as an opportunity to further organizational priorities. Hence, they adopt a strategy of assurance by emphasizing that the primacy of incumbent logics will not be affected, thus signaling that the incoming logic is not a threat; on the contrary, the new logic is portrayed as a means to advance existing organizational goals. Moreover, to make this entry strategy work, incomers are careful to ensure that incumbents maintain discretion over core practices. In other words, incomers make the new logic available but do not insist on its implementation in core organizational decision making—they persuade incumbents to adopt it rather than mandate its use.

Figure 1. (Color online) A Process Model of Logic Acceptance and Rejection in Hybrid Organizations



Taken together, these mechanisms indicate that at the heart of an effective entry strategy for an incoming logic perceived as hostile by incumbents is a portrayal of “deference”—a strategic behavior designed to nurture relationships with others who are reluctant to engage (Jourdan et al. 2017). Deference encourages incumbent actors to favorably appraise an incoming logic despite their initial fears. An important outcome of this strategy in our case was the achievement of mutual gains stemming from notable performance improvements that signaled that the new multilogic settlement was working. These improvements energized incumbents and captured the attention of external audiences, providing the impetus for the transition to stage 2.

The second stage of our model is the increasing assertiveness of the new logic. Although stage 1 sees the effective introduction of the incoming logic and the emergence of a well-functioning hybrid, the move toward destabilization begins in stage 2. This is the stage where the role of audience feedback becomes apparent: as performance improvements are recognized, leading to acclamation by audiences, incumbents become encouraged and feel empowered to look at the means by which the incoming logic might be further used. Performance improvements become particularly influential if they are widely seen and acknowledged as arising from the changes made by the incoming logic and if the benefits are mutually shared. These criteria are especially important where the incoming logic is regarded with high suspicion and where the incumbent logic has high status. As such, acclamation can have positive effects for the functioning of the hybrid and the enactment of the new logic settlement. However, the potential for destabilization arises when audience feedback nurtures two mechanisms: narrower attention and efforts by incomers to undermine incumbents’ discretion over core practices.

Narrower attention occurs when logic proponents court and respond to praise from audiences of particular relevance to them. For example, the relevant audience for professionals is that of the profession (the association and peers), and it is feedback from that audience to which they are expressly attentive (Freidson 1986, Greenwood et al. 2002). Such praise, moreover, can motivate groups to become correspondingly “deaf” to the feedback and concerns of other audiences; they become consumed with “their” world. Narrower logic attention, in other words, contains a measure of hubris—a sense of exaggerated self-confidence (Hayward and Hambrick 1997)—that encourages those promoting a particular logic to advocate their logic as deserving of greater priority and to push for its further application.

By itself, narrower logic attention can provide benefits because audience-level praise enhances the

receptivity of actors to newly introduced ideas and provides the motivation to adopt further changes (cf. McPherson and Sauder 2013). However, our insight is that acclamation can push the benefits of familiarity toward dysfunctional levels by encouraging proponents of logics to become overly assertive. Buoyed by their acclaimed role in the organization’s performance, incoming actors can go beyond the careful persuasion of others to a more confident and forceful advocacy of their worldview. Acclamation, in other words, can trigger a second mechanism, which sees incomers seeking to undermine incumbents’ discretion over decision making, leading to significant changes in the enactment of core practices.

However, this deepening of the new logic into core practices may not immediately be resisted. Indeed, applications of the incoming logic may be accepted because they are assumed to underpin the performance improvements garnering praise among audiences. Acclamation from important stakeholders, in other words, influences the behaviors of incumbents as they come to enjoy, even relish, the praise they receive—especially, as in R-hospital, if the praise is unexpected. The glow of “success” can flatter incumbents into complying with recommended changes—even though doing so weakens the very autonomy and discretion that were earlier regarded as sacrosanct. Thus, acclamation can, at least temporarily, subdue the risk of contestation that might otherwise arise from narrower logic attention and the growing influence of the incoming logic on core practices.

The result is a relative reprioritization of logics in favor of the incoming logic as that logic becomes acknowledged as a positive and important influence on organizational performance and therefore deserving of greater involvement in organizational decision making. The incoming logic thereby extends further into core organizational practices, which, crucially, may compromise the standards of incumbent logics—a potentially dangerous outcome for the organizations concerned. However, this outcome is not associated with the contestation that would have occurred in stage 1. Instead, that potential for contestation is held in check by the enjoyment of audience-level acclamation.

The third and final stage of our model is the rejection of the new logic. The lack of contestation evident in stage 2 depends on sustained audience-level acclamation. If that feedback turns from praise to criticism, as it did in our case, and those promoting the incumbent logics interpret the negative feedback as reflecting on their competence, these actors will question the changes that have been introduced. Specifically, criticism triggers two other mechanisms that fracture relations between the proponents of the different logics. First, logic contestation emerges as

the different groups feel the shock of negative feedback and seek to attribute blame. When incumbent actors realize the implications of what has happened, their earlier fears about the new logic are resurrected, and they turn against the incomers: they will support change only as long as their own legitimacy is not jeopardized, but after their integrity is impugned, they will distance themselves from the newly introduced arrangements. Those promoting the incoming logic, however, will ignore or downplay that criticism if “their” audiences continue to convey praise. For them, the hubris associated with narrower logic attention continues to drive their behavior.

Second, incumbents reassert their discretion over core practices by resisting the influence of the incoming logic and reclaiming control over core practices, actions that are designed to affirm the prioritization of the logic they embody and marginalize the influence of the incoming logic. The consequence is an escalation of tensions and disputes. Hubris on both sides—exacerbated when some audiences are critical, whereas others remain positive—prevents an easy compromise. In these circumstances of extreme conflict, it is difficult for the revised “settlement” to survive. Instead, the outcome is the restoration of the original hybrid organizational form as incumbents push out the incoming logic.

In sum, our process model reveals a cycle of gains, compromise, and restoration. Positive audience feedback leads incumbents to support changes in practices, even beyond the point at which it becomes clear that the changes are not viable; however, signals of disapproval precipitate rapid withdrawal of that support followed by political strife and rejection of the incoming logic.

We believe that R-Hospital provides an excellent context for building new theory about the dynamics of logic acceptance and rejection in hybrid organizations. At the same time, it is based on the case of a single organization, and it is therefore important that we consider the boundary conditions of our model and the extent to which it can be “transferred” (Lincoln and Guba 1985) to other settings. In this regard, we highlight several features of our case. First, we focused on an established organization, and the dynamics that we identify may not apply directly to newly formed hybrids. Second, the incoming logic in our case is a private logic—a logic that exerts particular influence in market economies (Kitchener 2002) but was alien to our focal organization. Again, the dynamics of our case may not hold exactly in situations where the incoming logic is of a different kind. Third, the dominant incumbent logic in our case is the very high-status medical professional logic in which promoters are especially protective of their autonomy (Chreim et al. 2007). One might imagine a

different set of dynamics if the incumbent logic is of lower status than the one being introduced. Fourth, acclamation in our case was driven by significant performance improvements after the introduction of the new logic. Without these major improvements and the associated gains, the organization may not have progressed beyond stage 1. Fifth, our case is of a hospital in Italy, a country with a long tradition of publicly funded healthcare and no tradition of private investment in the public system. Thus, although our findings are likely to resonate in contexts with similar funding arrangements (such as Canada, Australia, the United Kingdom, and elsewhere in Europe), they may do so less strongly in countries such as the United States, where private actors have long been deeply implicated in healthcare delivery.

More broadly, given that other hybrids have avoided the fate of R-Hospital, it is important to consider whether the outcome observed in our case was inevitable. Could it have been avoided? Several studies highlight the critical role of managers capable of holding multiple value sets and enacting them in practice (e.g., Besharov 2014, Smith 2014, Battilana et al. 2015). The implication is that supportive hierarchical arrangements within an organization are necessary if an appropriate settlement between logics is to be sustained. In our case, there was an absence of such “pluralist managers” (Besharov 2014, p. 1497), and after the internal balance began to be lost, there were no countervailing pulls for its restoration. Also absent were “spaces of negotiation” (Battilana et al. 2015, p. 1658) that might have encouraged the working through of tensions and differences by bringing contesting parties together. On the contrary, in our case, the physicians withdrew from exchanges with proponents of the private logic. Finally, there was an absence of supportive structures in the institutional environment, such as those noted by Purdy and Gray (2009) and Smith et al. (2012). It is difficult to assess the extent to which this absence contributed to the rejection of the private logic at R-Hospital, but a more mature institutional context may have tempered—at least to some extent—the forces of destabilization that we observed.

Contributions to Research on Hybrid Organizing

Our model highlights that the introduction of a new logic is not an event but an unfolding process. It also emphasizes that the relationships between external audiences and actors promoting different logics within an organization are fundamental in shaping that process. After an alien logic has been introduced, the defining influence on how events unfold is audience-level feedback—both positive and negative. Acclamation triggers narrower logic attention and the growing application of the incoming logic to core

practices—even if doing so results in some compromise of standards. Acclamation across audiences also lowers the risk of resistance or even the expression of concern about the deterioration in performance. Criticism, in contrast, leads to disruption. As our case shows, the introduction of change, however careful, generates only a tentative settlement, and the turn from praise to criticism reignites the earlier concerns of incumbents about an alien logic. This sequence of acceptance followed by rejection runs counter to the suggestion of McPherson and Sauder (2013) that growing “familiarity” will promote logic compatibility and enable additional inclusion of the incoming logic. In contrast to that study, our case shows that the bumping of logics can work against stabilization rather than for it, even after an initial period of effective adoption and implementation.

Our study is not unique in showing that hybrid organizations can oscillate markedly between their constituent parts—work on hybrids from the perspectives of institutional theory, identity, and paradox has revealed this dynamic. For example, Ramus et al. (2017) show how a radical change in the environmental conditions facing work integration social enterprises in Italy dramatically increased the importance of the “commercial logic” relative to the “social logic,” which created internal tensions (see also Jay 2013, Pache and Santos 2013). From an identity standpoint, Ashforth and Reingen (2014) show how “oscillating decisions and actions” (Ashforth and Reingen 2014, p. 475) in a natural food cooperative shifted power between groups who had different perspectives about the appropriate balance between social and business purposes (see also Besharov 2014, Wry and York 2017). From a paradox perspective, Smith and Besharov (2019, p. 7) show how a Cambodian social enterprise shifted from a focus on “helping the most disadvantaged” to “building a sustainable business” (see also Smith et al. 2012, Bednarek et al. 2017). Crucially, what our study adds to this important stream of work, which builds theory about how such oscillations can be managed and contained, is a theoretical explanation of hybrid disruption that is so severe that the organization cannot adequately function, leading to the rejection of a logic.

Our model provides a second important insight for understanding hybrid organizations: namely, that for a new logic to be incorporated effectively into a mature organization, incumbent discretion over core practices should not be disturbed. The introduction of a logic perceived by incumbents as fundamentally challenging to their values can only be accomplished if the incoming actors work to support existing organizational goals. Even after its effective adoption and in the face of demonstrated benefits, attempts by incomers to undermine incumbents’ capacity to enact

core practices in accordance with their logic is likely to result in contestation because doing so risks the compromising of standards. In particular, the effective introduction of an alien logic requires organizational members to avoid the seductive influences of narrower logic attention. However, as our case suggests, this is a difficult requirement to meet. Narrower attention is a profound mechanism that can outweigh political astuteness and drive an organization toward internal conflict. In our case, the mechanism was displayed in the behavior of the private actors as they pushed the application of their logic without regard for professionals’ (previously sacrosanct) discretion over core practices and in their insistence on doing so even in the face of sudden and aggressive opposition. Yet these same actors had shown by the manner of their entry into R-Hospital considerable political astuteness. Their failure to retain their political sensitivity indicates that the destabilizing effect of narrower attention can prevail even in the case of actors who might be expected to be immune to its influence.

Contributions to Institutional Theory

The preceding discussion speaks to the literature on hybrid organizations. However, insights provided by our case also have relevance for institutional theorizing more broadly. In particular, the process model that we have developed calls into question two core assumptions within the institutional literature: that social endorsement is advantageous and that alignment with institutional prescriptions results in stabilization.

Contrary to current theorizing, which assumes that organizations aligned with their environment are institutionally advantaged (Scott 2013, Deephouse et al. 2017), our study suggests that positive signals of social legitimacy may, over time, prove to be problematic and, ultimately, impede performance. Specifically, organizations that meet institutional demands may invoke audience praise and endorsement, but that praise may arouse the disruptive mechanism of narrower logic attention. Alignment, in other words, is a double-edged sword that, as well as promising positive outcomes (such as protection from institutional scrutiny and better access to resources; Scott 2008), can lead to dysfunctional outcomes. These outcomes transpire not simply because of conflicting expectations on the part of different audiences, as suggested in existing work (Greenwood et al. 2011), but because high levels of audience praise distort organizational priorities and decision making.

A second assumption in the institutional literature is that after organizations have achieved alignment with their context, organizational arrangements will stabilize and endure (Greenwood et al. 2011, Hardy and Maguire 2017). This assumption, however, is based on a portrayal of organizations as homogeneous.

A more nuanced depiction would recognize that occupational communities within organizations are selectively attentive to audience-level referents of “their” logic. Yet, despite appreciation within organization theory more broadly that complex organizations are heterogeneous, institutional analysis has “neglected the intra-organizational level” (Battilana and Dorado 2010, p. 1435; also see Binder 2007, Souitaris et al. 2012, and Raffaelli and Glynn 2014). Our contribution to this debate is that the degree of alignment between an organization and its institutional context is not a fixed arrangement but a dynamic arrangement shaped by the organization’s multiple relationships with audiences and the pattern and tone of feedback received from them. Settlements, in other words, can be very tentative rather than solidly entrenched, which means that destabilization—not stabilization—may be the likely trajectory and outcome of institutional alignment.

Conclusion

Organizational forms that bring together ideas and practices from multiple institutional logics are often positioned as a panacea for the most deep-rooted social problems for which there are no obvious solutions. The effective management of such organizations is bound to be challenging because they are predicated on institutional contradiction. Moreover, as our case shows, the apparently smooth adoption of a logic may be temporary and fleeting. The dynamic that we observed between logic acceptance and logic rejection may be a core feature of hybrid organizing, and we have developed a framework to account for why multilogic organizations can switch quickly and with little warning from one to the other. Although we have analyzed a single case, we believe that the insights we offer have broader applicability and hope that others will build on our findings to extend understanding of this important area of inquiry.

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