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Organizing as becoming
Contradictory isomorphic pressures in a university hospital setting

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Abstract

Studying a university hospital undergoing radical organizational change, the paper discusses the creation and constitution of new leadership roles. The discussion focuses on how responses to isomorphic pressures are related to local variations of organizational structures and patterns of institutionalization. Variation occurs in terms of two different discourses, creating different types of legitimacy, and is explained by combining an institutional approach and the becoming perspective based on the notion of timespace, thus bridging realism and social constructivism. Theoretically, the paper points to how realism and social constructivism can be bridged by focusing timespace within a qualitative methodology. Practically, the paper lends more support to new public governance than to the prevailing discourse of new public management.

Keywords: Timespace, isomorphism, institutionalization, becoming, new public governance

1. Introduction

Throughout the industrialized world, pressures for increased expenditures on health care are growing and, at the same time, budgetary constraints on health care are increasing (OECD, 2013). The combination reflects the interplay between increasing life expectancy, improvements in avenues for treatment, and higher costs of medicine. In consequence, increasing expenditures and cost reductions occur simultaneously as political governance enforces demands for efficiency.

In Denmark, the focus on efficiency has been part of a roll-out of New Public Management, which has more or less turned out to be a general pattern of public sector restructuring in the industrialized world. However, the type of roll-out has varied across countries, spanning from the radical surge of privatization in New Zealand and the UK to a more incremental approach adopted by the US and the Nordic countries (Kettl, 2000). As recounted by Kirkpatrick et al. (2009), the focus on new public management stems from the governmental focus on productivity in hospitals during the 1980ies (Ejersbo & Greve, 2005), which at the management level led to the formation of the so called Troika model, i.e. “with a doctor, a nurse and a general manager at the hospital level and a system of joint management involving only doctors and nurses at the clinic level” (Kirkpatrick et al., 2009: 649). The dominant nature of this process was that the medical profession increasingly became engaged in managerial activities in an attempt to control how management structures were organized, involving a recurrent struggle between doctors and nurses on collective interests, especially regarding the division of labor between leading physicians and head nurses. While new public management in general has aimed at reducing the influence of incumbent professions on managerial activities (Hood, 1991; Kettl, 2000), the opposite effect occurred in Denmark, positioning doctors as dominant managerial figures in hospital governance (Jespersen, 2005; Kirkpatrick et al., 2009). This happened irrespective of the variations in organizational structures that have occurred across the Danish counties, which are the main bodies responsible for the Danish hospital sector.

However, during 2010-2012, the county of North Denmark initiated an organizational innovation of the hospital sector, aimed at instigating relational coordination (Gittell, 2009) as the dominant organizational principle of hospital activities. Existing organizational centers, which were organized along functional lines, were supplanted by clinics which combine various specialties that to some extent are interrelated in the sense that they, in most cases, will share patients who suffer from more than one disease. As part of the change process, the Troika governance was substituted by various new managerial roles at the hospital level. At the level of clinics, three roles were formed, i.e. the roles as head of clinic, deputy of human resources, and deputy of horizontal patient processing, i.e. a boundary spanner focusing on how activities across clinics are coordinated. The roles were described generically in a way which emphasized knowledge of hospital activities, but not necessarily based on the medical and nursing professions. In effect, at Aalborg University Hospital, which is the object of our study,

three out of eight positions as head of clinic were filled by economists and one by a nurse, while doctors only occupied the remaining four positions. Furthermore, a dominant part of the deputy positions were filled by nurses. Simultaneously, the organizational role as head nurse was substituted by a new role as nurse ward manager, meaning that an entire organizational layer among nurses disappeared. In effect, the old collaboration/conflict relationship between leading physicians and head nurses vanished and was replaced by a new organizational structure, where leading physicians and nurse ward managers alike refer to the clinic management. This organizational structure is organized in ward management teams and is supported by professional teams “of specialist physicians, nurses and other professionals who are working within or between the different medical specialties” of the clinics, and patient teams which coordinate the processing of patients across specialties and clinics (Axelsson et al., 2014: 5).

As the organizational roles at the level of clinic management were described in generic terms, and as well-established boundaries between various hospital activities became blurred or even disappeared, the organizational members filling the new clinic management positions embarked on a journey, where they simultaneously had to make the new organization function while defining their new positions along the way. The process was to some extent complicated by problems of recruiting specialized medical staff, which meant that each clinic had to construct its own solutions to various problems of patient processing. Furthermore, as the new organization took off, the hospital was recurrently met with demands for budget cuts in the face of increasing costs of health care. In effect, what at the outset had been designed as a more or less uniform way of organizing turned out as a set of organizational structures which differed across clinics.

The present paper discusses how the leaders in question create and constitute their organizational roles in circumstances of radical and institutional changes involving contradicting pressures of isomorphism. The discussion reflects an ongoing case study of the profound changes of organizational and managerial structures which has just been described. While hospitals are often compared to the kind of professional bureaucracies originally described by Mintzberg (1979), we argue that the change process may be characterized more as a search for legitimacy than as a search for operational rationality.

The reason for this point of view is that the forty interviews, which we conducted with ten leaders on four consecutive rounds during the period of Spring 2014 to Spring 2015 across four clinic managements, continuously touched upon how the new leaders could establish themselves as legitimate and respected leaders while being the core actors of ongoing radical organizational change. It occurred from our interviews that legitimacy had to be based on an intricate balance between leaders being seen by the medical and nursing professions as someone who are preoccupied with serving the needs of patients, and simultaneously being seen by the political system as someone who pay sufficient attention to demands for productivity increases and budget cutting.

In order to argue our point of view we take, as our point of departure, the institutional idea advocated by Meyer & Rowan (1977) that organizations are molded by the need for achieving contextual legitimacy, and that organizations are influenced by strong isomorphic pressures (DiMaggio & Powell, 1983). Especially, we will argue that the leaders in the present case find themselves in circumstances of coercive, mimetic, and normative isomorphism which tend to be contradicting. While section 2 expands on legitimacy and isomorphic pressures, and relates these concepts to our case study, section 3 describes our ethnographic case study method as combining an institutional approach with the ideas of timespace (Schatzki, 2009) and organizational becoming (Tsoukas & Chia, 2002; Larsen & Rasmussen, 2013). Section 4 presents the case study in terms of four narratives, and section 5 concludes by summing up the findings and readdressing the issues of legitimacy and isomorphic pressures.

2. Legitimacy and isomorphic pressures

The basic stance of an institutional approach to organizational analysis is that organizations are much more than mechanisms for achieving certain goals, as envisaged by a rationally founded functionalist approach (e.g. Parsons, 1956a, 1956b). Instead, organizational behavior is molded by cultural context-specific expectations which need to be met in order for the organization to achieve legitimacy which can attract and command resources (Meyer & Rowan, 1977; Pfeffer & Salancik, 1978). While this does not exclude rationality and goal seeking behavior from entering the scheme, where legitimacy may occur as a kind of pragmatic legitimacy derived from stakeholder goal attainment, legitimacy does to an important extent rest on moral sentiments and taken-for-granted values of behavior (Suchman, 1995). This implies that there are limits to the variation of organizational behavior, as argued by DiMaggio & Powell (1983) who hypothesize that isomorphism arises from resource dependency, attempts to reduce ambiguity, and the degree of the professionalization of key staff, including managerial positions. Especially, homogenous patterns of action and interaction are expected to occur in circumstances where an organizational field is structured around “stable and acknowledged centers, peripheries and status orders” (DiMaggio & Powell, 1983: 156).

According to DiMaggio & Powell (1983), the isomorphic pressure from *resource dependency* occurs because the dependent organization needs to comply with the requirements of the sources of supply. In the case of isomorphic pressures arising from *ambiguity*, the main source of isomorphism is the search for credible solutions which are assumed to work in practice, e.g. like the satisficing processes originally described by March & Simon (1958). Regarding *professionalization*, academic and professional training leads to patterns of behavior and decision making which are more or less uniformly applied across a variety of organizational settings, and, in effect, reduces the sources of variety in organizational processes and

structures. Finally, isomorphism in *structured organizational fields* occurs because frequent interaction among actors tends to create increasingly routinized behavior and decision making, and it becomes stronger when the organizational field is transparently organized in terms of power structures and decision making bodies, e.g. dominant coalitions, and when the complexity of information processing requires actors to adopt common standards and procedures.

The idea that frequent and structured interaction lends itself to isomorphic pressures can be found in a variety of theoretical settings. For instance, within network theorizing, it is argued that variety is excluded in cases where interaction is tightly coupled (Granovetter, 1973), and within industrial analysis we find the argument that actors tend to pursue similar strategies in similar circumstances (Porter, 1980), and that actors comply with behavior that is broadly accepted across a business community, e.g. sharing industry recipes (Spender, 1989), industry mindsets (Phillips, 1994), or cultural-cognitive frames (Geels, 2014). These cases resemble the argument by DiMaggio & Powell (1983) that actors within an organizational field tend to develop a sense of belonging to the same group and sharing professional identities. The same argument applies to the intraorganizational level, e.g. where performance criteria are enforced as part of goal achievement and coordination, and it can be argued that isomorphism is a latent property of intraorganizational coordination which becomes manifest to the extent that coordination relies on variety-reducing routines.

Isomorphic pressures are prevalent in settings where performance and quality standards play a prominent role for execution and outcomes, e.g. as in health care. As touched upon previously, the Danish health care sector has for more than two decades experienced an increasing use of performance management associated with new public management. The basic idea of new public management (Hood, 1991; Christensen & Lægreid, 2010) is to increase efficiency by replacing policy-based governance with market mechanisms, supplemented by performance control and benchmarking. As part of this, the role of managers in the public sector is changing from that of servants within bureaucracies to a new role as managers of market-oriented organizations (Farnham et al., 1996). However, solely relying on market forces or market proxy arrangements fail to provide efficient or socially desirable results in complex settings where actors and organizations must rely on knowledge sharing and “thick” information. Although this has long been recognized within economics (Coase, 1937; Williamson, 1975) and innovation theory (Lundvall, 1985, 1992), it has had less impact on the new public management discourse. Recently, there has been a growing awareness that goal achievement and social development in the modern welfare state requires cross-organizational cooperation and networking. In effect, scholars are advocating that new public management should be substituted by new public governance (Osborne, 2010; Torfing et al., 2012) where performance and innovation are pursued through networking and public-private partnerships, and cross-departmental activities and cooperation. These interactive arrangements must be supported by decreasing the operational involvement of the political system, empowering employees, and

creating a closer cooperation between the public and the civic sectors (Osborne, 2006), including co-production across traditional sectors (Osborne, Radnor & Nasi, 2012).

The new public governance idea that performance and innovation within the health sector can be strengthened through interdepartmental activities and cooperation is a guiding principle of the type of relational coordination that is pursued in the university hospital case which is the object of study in this paper. The project of instigating relational coordination was initiated by the regional government of North Denmark in 2010 as a top-down initiative, including the formation of committees comprising administrative and health care staff which drafted designs for the new organization. The undertaking was informed by the work on relational coordination by Jody H. Gittell, who also gave a seminar on the topic the same year to members of the committees and other related staff.

According to Gittell (2010: 15-16), relational coordination is different from coordination in the sense that while “coordination is the management of interdependencies between *tasks*, relational coordination is the management of interdependencies between *the people* who perform those tasks”. The management of relational coordination works through “relationships of shared goals, shared knowledge, and mutual respect” (Gittell, 2010: 13) and can, from an institutional perspective, be characterized as comprising the types of pragmatic, moral and cognitive legitimacy described by Suchman (1995). In effect, relational coordination serves the purpose of instigating a sense of belonging and joint action which is at the core of the isomorphic pressures described by DiMaggio & Powell (1983). Thus, although Gittell (2010) pays her respect to contingency and organization design theorists like Thompson (1967) and Galbraith (1973), and combines the principles of relational coordination with the principles of high performance work systems (Gittell, 2003), the idea of relational coordination carries affinity with institutional theorizing.

The basic working of relational coordination within high performance health systems is based on careful organization design comprising activities which can be monitored and measured, and in order to make interdependencies work communication needs to be frequent, timely, accurate and problem-solving (Gittell, 2010: 53). This line of organizing is designed to overcome the classic weakness of performance systems being reactive and blurring accountability between individuals and teams. However, we may add that it also serves as a mechanism for creating shared meaning and understanding, which is especially sensitive to complex organizations like university hospitals that often encounter cases of multiple diseases involving a variety of specialties, a problem frequently aired in our interviews. As described by Weick, Sutcliffe & Obstfeld (2005), sensemaking takes place as retrospective reflection that happens both during and after action has taken place, and it takes the form of enactment which involves the simultaneous processes of selection and action (Weick, 1979). Sensemaking is essentially a social phenomenon which is created by the interplay between act, inter-acts, social commitment and committed interpretation (Weick, 2001), where action emerges as a collec-

tive obligation leading to socially shared interpretations. As these interpretations assume the role of shared understandings of why and how action takes place, they serve as strong mimetic and normative isomorphic pressures on behavior.

So, the position that we argue here is that in order to grasp how relational coordination becomes the guiding principle of an organization, we need to supply the contingency and organization design approach to relational coordination with an understanding of how relational coordination institutionalizes organizational behavior through the creation of shared meaning and legitimacy. Shared meaning and legitimacy are created as organizational actors enact isomorphic pressures within structured organizational fields, where resource dependency, coping with ambiguity, and professionally socialized patterns of behavior are dynamic forces of institutionalization. As actors create meaning while searching for meaning through action, institutions are created and become patterns of behavior.

The implication of this position to relational coordination is that while relational coordination may be designed top-down, it will essentially become a reality bottom-up. What we mean by this is that organized behavior grows out of the acts and inter-acts of the organization members. As argued by Tsoukas & Chia (2002: 573), the organization “is both a given structure (i.e. a set of established generic cognitive categories) and an emerging pattern (i.e. the constant adaptation of those categories to local circumstances)”, implying that isomorphic pressures are translated into local variations of response and creation. The emerging patterns occur because “organizational actors can exercise discretion in adopting organizational change, innovating in response to external pressures” (Quirke, 2013: 1678). In consequence, the “organization is a secondary accomplishment” in the sense that the organization emerges from local application of the social rules that constitute the organization, implying that while “organization aims at stemming change, it is also the outcome of change” (Tsoukas & Chia, 2002: 570).

3. The ethnographic approach of the case study

In order to detect how isomorphic pressures are translated into local variations of response and creation, we adopt an ethnographic approach, implying that we as researchers attempt to experience the complexities of everyday organizational life (Kott, 1995; Yanow, 2006; Ybema et al., 2009) in order to achieve practice-driven theorizing (Orr, 1996, 1998; Nicolini, 2009). The core assumption of this research method is that the understanding of organizing requires the understanding of how social and material practices are ordered across time and space (Giddens, 1984; Nicolini, 2009), where organizing becomes manifest as a texture of interconnected practices (Schatzki, 2002, 2005; Reckwitz, 2002; Czarniawska, 2004, 2007; Nicolini, 2009). Interconnectedness of practices are uncovered by studying how they become

connected through time and space, and how they are constituted and maintained through social agency (Czarniawska, 2004, 2006, 2007; Czarniawska & Hernes, 2005; Nicolini, 2009). The study focus on social agency in terms of *timespace*, which we understand as the process where an organizational actor “when acting, comes towards a way of being departing from certain states of affairs” (Schatzki, 2009: 37). Thus, what we are looking for in our recurrent conversations with interviewees is how they are giving sense to their leadership roles through time while creating the leadership space in a setting of relational coordination. In doing so, we especially focus on “teleoaffective structures, which contain enjoined and acceptable ends, enjoined and acceptable projects and actions to carry out for those ends, and enjoined and acceptable emotions” (Schatzki, 2009: 39).

For the purpose of the present paper, we have singled out two of the four clinics that we have studied, one of which comprises a number of specialties belonging to a coherent group of various diseases, and one of which comprises a number of specialties that are intricately linked to the activities of many other clinics. In effect, the study covers both vertical and horizontal aspects of the relational coordination setting in question with a focus on real-time practices as they are expressed through the actions and wording of the interviewees. The actions and wording of the interviewees are interpreted within a becoming perspective (James, 1909; Chia, 1996; Weick & Quinn, 1999; Tsoukas & Chia, 2002; Larsen & Rasmussen, 2013), focusing on the micro-processes which constitute organizational change and lead to the establishment of organizational routines.

Routines are understood as the outcome of how ideas and actions interconnect (Feldman, 2000) as part of the organizational members’ interaction and wording during the change process (Orlikowski, 1996; Tsoukas & Chia, 2002). The implication is that behaviors are repeated and cognitive representations are shared, thus creating patterns of institutionalization (Weick, 1979). These patterns vary across clinics, because routines are subject to variation. While routines guide action, they are also molded by action and developed through the enactment of them, and while routines are enacted multiple times people shape connections which themselves are subject to variation during time (Feldman & Rafaeli, 2002; Feldman & Orlikowski, 2011). This means that routines are altered by being reproduced (Feldman, 2000, 2003; Jarzabkowski et al., 2011), and that patterns of institutionalization may vary across clinics.

In the present study, patterns of institutionalization are uncovered by detecting the stories that the interviewees tell about their organizational life, assuming that “in order to understand their own lives people put them into narrative forms – and they do the same when they try to understand the lives of others” (Czarniawska, 2004: 5). We detect the stories through “a process of inquiry in which practitioners become co-researchers, and researchers become co-practitioners, as each articulates what they have been ‘struck by’ in the unfolding process” (Shotter, 2006: 601). During our interviews, we create timespace by engaging with our inter-

viewees in reflections on what has been going on, what is going on right now, and what will be going on, aiming at a dynamic dialogue, or thinking-from-within as Shotter (2006) puts it, which during recurrent encounters has the potential to change not only the epistemological, but also the ontological state of the organizational actors (Shotter, 1984). Consequently, we exercise “practical authorship” (Shotter, 1993) in order to uncover the emerging patterns of institutionalization, and as the narrative unfolds, researchers and interviewees become entwined in co-enactment.

The creation of patterns of institutionalization becomes especially important in the present case, because organizing by relational coordination is still unfolding, and despite the existence of routines and codes of practice the actors have to negotiate and renegotiate their understandings and actions through in-practice interaction (Feldman, 2002; Feldman & Pentland, 2002). As routines are developed, applied and exercised, variety occurs, thus gradually changing the everyday practice and the way in which the organization organize (Orlikowski, 1996; Orlikowski & Hofman, 1997). In effect, the organization is in a state of becoming.

The state of becoming are complicated by the fact that the new positions within the clinic management teams are predominantly filled with actors with deep knowledge of specialties and processes at the university hospital, meaning that the organizational and managerial experience attached to the new positions mainly reflects the type of organization which the relational coordination setting has abolished. Consequently, the occupants of positions at the clinic management teams have experienced the challenging situation of employing existing skills and understandings in order to make the new organization work while at the same time struggling with understanding and defining their new roles. Although the design of the organization has been supported by extensive organizational layout and job descriptions, the actors have had different interpretations of layout and job content, especially since layout and job descriptions are of a general and generic nature. The reason for this is that no one has been able to create a clear roll-out of relational coordination and the interfaces between clinics. In consequence, the organization has been in a process of continuous creation and recreation as the actors have been preoccupied with creating the new organizational reality based on simultaneous and retrospective sense making (Weick, Sutcliffe & Obstfeld, 2005; Cunliffe & Eriksen, 2011).

4. Stories of management learning and institutionalization

In the following, the state of becoming is addressed in terms of four narratives that cover the experience of four members of the clinic management teams in the two clinics mentioned previously. Each clinic is represented by two members of the management team, denoted as interviewee 1 to 4, respectively. Four interviews with each interviewee, or more precisely, di-

alogues were undertaken during a period of twelve months, with the exception of interviewee 2 who instead of interview 3 took part in a focus group séance (which is not part of the data for this paper). In sum, these interviews reflect a longitudinal process of learning and institutionalization in which the interviewees have involved.

Quotations have been translated from Danish into English to the best of our ability. In some cases, the spoken word has been slightly changed in order to make the quotations readable. A couple of times, the abbreviation FLO occurs. FLO is the Danish abbreviation for relational coordination.

4.1. "I am the organization"

During our first interview with interviewee 1, two main points of understanding is co-created. First, the new organization is experienced both as a *process* in which the organization members find themselves en route to a state of relational coordination, and as a *structure* in which the organization members have to find a meaningful space. Second, each clinic constitute an distinctive organizational field within which the actions and organizational understanding of the organization members are confined, thus implying that the organizational members are inclined to be intra-departmentally oriented rather than cross-departmentally oriented. In effect, the structure of relational coordination is characterized by an organizational variety which slows down the process of relational coordination, and the main impression is that the new organization is continuously being defined and redefined as the organizational actors encounter new situations that call for negotiation of meaning.

This is a challenging situation, since interviewee 1 not only has to navigate and help others navigate in the process of creating the new organization, but also has to define and create her leadership position along the way. In consequence, she is focused on creating a *raison d'être* for her actions and decision making. It appears during the dialogue that the *raison d'être* comprises a point of departure and a heuristic for individual behavior. According to interviewee 1, the point of departure is simply that relational coordination is a condition of organizational life, and based on this condition she develops a clear definition of herself as a leader:

...I identify myself with the organization. The organization is the core business, and to me the core business is the patient. [...] I am a searching problem-solver for the sake of core business. [...] I am the organization. (Interviewee 1: 13, 14)

Interviewee 1 navigates by a strong identification with the organization, but since the organization is in a state of flux, and organizational fields tend to become blurred, she equates patient needs with the organization. The identification itself becomes a driver for leadership because the need of the patient is generally accepted within the organization as being important, and presented with the idea that the identification is a process of enactment and of creating shared understandings, interviewee 1 reflects that

...it is not difficult, I think, to communicate what we have to do. It is not difficult to communicate all this about the need of getting patients discharged, and that they are not supposed to be operated outside the region in private hospitals or the like. Especially, since it is the core business. (Interviewee 1: 15)

However, she also reflects on problems of relational coordination in practice. As organizational members' identification along intra-departmental lines seems often stronger than identification along cross-departmental lines, she advocates for organizational overlapping, i.e. structures and processes which supports relational coordination along matrix lines.

The idea of overlapping organizational fields is further elaborated during the second interview where it appears that interviewee 1 has become more critical towards the new organization since the first interview. She calls for action and argues that leaders within the organization are not sufficiently focused on horizontal processes, despite a high level of employee commitment to the new organization. As the dialogue carries on, she gradually arrives at the conclusion that it might reflect a process of learning where she, alongside other leaders with whom she interacts frequently, are creating a leadership role which is more focused on horizontal processes, and that this process makes her more aware of boundaries between activities, teams, and clinics. The awareness of the boundaries is further stimulated by the fact that all clinics are met with political demands for budget cuts, which tends to create a situation where each clinic tries to protect its own resources and staff at the expense of other clinics. Antagonizing as this might be, she copes with it by defining budget cuts as a condition of organizational life which can be dealt with by creating organizational overlap which she by reference to a specific example describes in terms of a cooperative organizational culture:

...they can do it because it is, like, a cooperative culture. And about overlapping (the attitude is): That's why we are here, we are here because we are a part of you, even though we physically are located somewhere else.

Interviewer: This means, you think of overlapping more as a way of relating to one another, but some would say that overlap calls for slack resources in the organization.

Interviewee: No, I don't see it like that.

Interviewer: No, you see it more like a specific type, or a way of relating to one another.

Interviewee: A way to relate to one another (...) the less the resources, the more important it is that we overlap. (...) It is an opportunity for things being smoother, and we have greater understanding and do not need so much time in order to move on. In some way a positive integration. (Interviewee 1: 44-45)

Situations like this are important to her, because she fuels energy from activities and situations that are not linked to must-do tasks. Challenged if she still perceive herself "as the organization", she reflects in the affirmative, but arrives at the conclusion that she often becomes part of the informal organization of staff in order to move forward.

The third interview is predominantly characterized by the fact that a new head of clinic has arrived. In contrast with the previous head, who was an experienced physician, the present head

is an experienced economist who has occupied several leadership positions, both at the level of regional policy and as hospital CEO. Interviewee 1 is frustrated in the sense that she experiences the political level as someone who is constantly demanding results, but at the same time she experiences the new head of clinic as someone who is able to demarcate clear lines of responsibility and create transparency regarding the process of political prioritization. In essence, she finds that the demands for budget cuts and increasing efficiency is a condition of organizational life where she constantly has to prove something to the political system, but at the same time she experiences herself and her colleagues as becoming more focused on which tasks to prioritize in order to make relational coordination work for the sake of the patient. On the other hand, she still finds that the conception of reality differs considerably across clinics, and that there are cultural clashes in terms of how and when to act. However, the main impression from the dialogue is that she is increasingly coping with ambiguity, because she is arriving at patterns of behavior which cope with uncertainty.

The main theme during the fourth and final interview is her sense of living in a new organization that is unfolding along a steady pattern.

...it is a great challenge, but now we are protecting FLO, and indeed we are not going to do something else, dear me. [...] Good networks with nurse ward managers, in the beginning they said: "For what do we need each other? Why, you are somewhere else than me?" It was very much like "hmm". And then suddenly, we had a theme day a month ago, you know, it was such a super day. "We would like more of those, we do need each other". (...) Someone like you must know how long time it takes to become "we". Now we are "we". The other clinics etcetera, now we are "us", this is an amusing experience. (Interviewee 1: 72)

However, the extent to which relational coordination is being realized and experienced appears ambiguous, for two reasons. First, integrating the patients in the core business has still a long way to go. Second, there may be limits to the expansion of relational coordination.

Dear me - the way we integrate patients in our sector - coming to think about all that has been written about it, it appears ridiculous. Because, we have created a structure, previously and also to some extent now, where it is like this about patients: "Oh my God, are you here too?" [...] The patients are posing demands, but we must also make demands to the patients. [...] And all this about breaking down silos, we need a different picture, because the silos must not really be broken down. We need professional professionalism, we are a university hospital, and for that reason we must go deep-deep in individual specialties. (But) we lack the overlap between silos. [...] (However) matrix is good, but there can also be too much matrix. (Interviewee 1: 75, 76, 77, 79)

So, relational coordination is still in a state of becoming. However, it seems that while budget cuts are being met in various ways, new patterns of behavior and routines are institutionalizing, and in the organizational life of interviewee 1 this is experienced as an increasing focus among organization members on shared understandings. As she is extensively preoccupied

with realizing relational coordination, her perception of herself as “the organization” becomes stronger as a heuristic for organizational behavior.

4.2. “I like to get involved”

Like in the first interview with interviewee 1, the first interview with interviewee 2 took, as its point of departure, the existence of organizational variety and how to include that as part of creating the new leadership role. However, while the heuristic of interviewee 1 is one of identifying herself with the organization, the heuristic of interviewee 2 is one of staging the leadership level below the level of clinic management, which she sees as the greatest challenge of the new organization. According to her, relational coordination is about decentralizing tasks, and

...there are so many fields we need to work with, like quality, accreditation, work conditions, innovation, our specialties, I mean, all sorts. You know, the employees have to assume responsibility in order to make it work, and in some areas this is something new. In some places, it was natural that employees had some responsibilities in various fields, but in other places it is...it has been the nurse ward manager and maybe a small team surrounding her/him who has been in charge. (...) All this about creating involvement and decentralizing responsibility and competencies in specific fields so you free time for being a leader at the ward level...Because, the problem during this transition is management. Leading and caring for personnel has been really important, but it has often been overruled by operational affairs. (...) They don't have much time for being leaders. (Interviewee 2: 4)

Staging ward management becomes important, because relational coordination in the present organization requires the continuous bridging of gaps, which in a relational coordination context is especially challenging:

I mean, interfaces we know, but how do we make interfaces become overlaps, so people work together, so people can be flexible in their approach... (Interviewee 2: 6)

Being an experienced leader, her approach to these matters is flexible and hands-on.

So, maintenance and stability that is not like my great force. Not that I don't think that things must be stable, but I like to take on new things (...) I like to get involved. [...]

Interviewer: I wonder what is the time perspective when you reflect on yourself as a leader, when you are involved in something? Especially in an organization like this?

Interviewee: Well, I think it is all about phases. (...) You can't plan everything in the long run, but you can have some long run goals about getting it working across, secure patient processing and curing, optimize time of admission as part of the offerings and options there are. However, in one-two years from now we ought to be in control of our budget and the things we have initiated by now. (Interviewee 2: 3, 12)

Her heuristic on these issues is intriguingly simple:

...do the things the best you can and say “now is the time” and have the courage to say it. This is what I have experienced; don’t be afraid to talk to your associates and those with whom you are with. And, you know, be open, too, and do not yield to authorities; this is awkward if you have the courage to embrace the situation. (Interviewee 2: 13)

The idea of staging next level management is further elaborated during the second interview, however from a slightly different angle. First, budget cuts have become an issue of the utmost importance, pervading most of the activities going on. Second, it appears that next level management has improved on leadership, leading interviewee 2 to focus on improving the awareness of next level management of strategic challenges. How to combine these two issues is addressed by engaging the situation.

...I mean, it is the one who leads that is close, extremely close, and have to communicate that we are a “we” and continuously support growing a culture of cooperation and help. [...]

Interviewer: How do you support them? How can you support directly from here?

Interviewee: But, I talk with them about how I think they could do this and that. (Interviewee 2: 25, 27)

In order to improve the ability of the clinic to participate in relational coordination, interviewee 2 has designed a new organization chart that has been approved, and according to which specific nurses involved in innovation of activities are referring directly to interviewee 2. This is part of her efforts to create bridges between interfaces, but at the same time she acknowledges that her efforts contribute to organizational diversity in a way which may complicate overlaps between organizational fields. In essence, the evolution of institutionalizing discourses on budget cuts and on improving the role of the patient in patient processing might lead to isomorphic pressures which decrease variation within organizational fields while increasing variation across organizational fields.

During the fourth interview, interviewee 2 touches upon the advent of the new head of clinic which has led to a more clearly defined leadership role, as expressed by interviewee 1. She argues that the organization appears more stable, and that relational coordination seems to unfold. However, the focus on budget costs seems to drag the attention of leaders away from relational coordination in favor of optimizing what goes on along functional lines and within clinics. As focus on improving the conditions of the patient is still a dominant discourse, the economic pressures enforced by the political system implies that next level management in some cases dissociate themselves from the clinic management.

We feel it at once, when we are the bad guys. That if we make some agreement, the managers go back to their organization and argue, well, it is all about that clinic management, they don’t understand a damned thing of what we are saying, but we have to do it, if they say so. And this results in a terrible cooperation. However, it’s all about if you are a leader in this system; you back the decisions that are made and have to be loyal. This is what you have to learn. (Interviewee 2: 47)

The main impression from the dialogues with interviewee 2 is that while shared understandings are unfolding regarding how relational coordination assist the need of the patient, shared understandings on budgetary issues are less developed and more likely to be perceived as extra-organizational coercion. This reflects that institutionalization takes place as part of a process creating organizational variation.

4.3. “We have been through a lot”

While interorganizational variation played an important role in the first interviews with interviewees 1 and 2, the point of departure in the first interview with interviewee 3 is intra-organizational. However, the intra-organizational perspective reflects that the activities of the clinic to which interviewee 3 belongs are intricately linked to the activities of many other clinics, so, in effect, organizational and relational issues are strongly influenced by cross-clinic activities and matrix processes. This pervades how discourses unfold within the clinic. As the activities of the clinic to a large extent are driven by demands from other clinics, the clinic management focuses on flexibility and how to develop a cooperative culture. However, as recruitment problems have been severe, continuous organizational change has been necessary.

We have been through a lot of organizational stuff. [...] I don't know if it is part of the specialties, part of their nature, that people reach out, that people try to change things, assuming responsibility. This is probably the most visible (...) you assume responsibility, and you try to change the conditions in which you find yourself. We have just had an organization review, and we can see that we...that it is on these parameters that we positively differ from the rest of the university hospital. (Interviewee 3: 5, 6)

Interviewee 3 does not have a background within the medical and nursing professions, which he consciously articulates in terms of having a role as facilitator, so his understanding of the state of becoming is to a lesser extent rooted in the practicalities of specialties. Instead, he focusses on governance regimes and how they interact with different kinds of political and organizational pressures. However, during the dialogue it appears that two main points of departure drive the operation of the clinic in a way which is similar to the *raison-d'être* of other clinics.

...within this health system which is, eh...it has a long, long, long academic history. Everything to do with patients is pervaded by a means and ends rationality. It is based on evidence. [...] It has been a process with high uncertainty concerning my leadership role and ability, and...it has been so not only for me due to my background; it has been so for all heads of clinic. It has been a year characterized by creating new structures, new ways of cooperation. Some has been more challenged than others regarding the complexity of fields they have to cover and how much they knew about them in advance. Including; is it fields with huge operational problems, is it fields with huge recruitment problems? But how we communicate about FLO and the principles, the principles of leadership inherent in the structure, has been a mutual task for all of us. (Interviewee 3: 8, 9)

Interviewee 3 responds to the challenges of the clinic by adopting a strategic approach where he tries to solve problems by organization design and by creating new cooperative structures within the clinic. A new team among doctors has been created, and doctors are more engaged in the leadership of the clinic than is the case in other clinics, and, consequently, also more engaged in cross-departmental activities. In effect, the focus on relational coordination appears to be quite strong in the everyday life of the clinic.

During the second interview, it appears that recruitment problems are now being solved, and the organization is not bound to change in a while. However, budget cuts are forced upon the clinic, which is extremely challenging since the activities of the clinic are primarily driven by demands from other clinics. In this situation, interviewee 3 turns his attention to the leadership role as such.

I mean, the narrative that I present to you, is of course the narrative that I must use elsewhere in my capacity as a leader, in dialogue with ward management, and there we speak about it again and again: How nice, we got through the challenging winter because we had a leadership of specialties which focused on helping each other, focused on understanding the challenges of each other as they occurred, and that we have workable coordination. It is, of course, this narrative that contributes to uphold...well, legitimacy of decision making, but also supporting the thinking and understanding of how to manage specialties and create an image of positively moving forward. (...) If I focused on the individual saying that “you have not kept your budget – what’s up” (...) then I would not experience this kind of thinking. (Interviewee 3: 21-22)

Creating narratives has been important to him, since he does not find the narrative accompanying the original top-down decision on instigating relational coordination convincing. In his point of view it lacked legitimacy and to some extent relevance, so it is important to develop narratives that create legitimacy, especially by creating new ways of practice, which he exemplifies by a couple of recent cases.

Interviewer: However, this is in order to find out what works...

Interviewee: Yes, of course. But I mean, thinking about FLO is less pervasive.

Interviewer: Well, but in some way it sneaks in.

Interviewee: It is a classic organizational practice that has always been around.

Interviewer: To me, it sounds like your approach to FLO is becoming increasingly pragmatic.

Interviewee: Yes, but pragmatic meaning that we continuously focus on patients.

Interviewer: Yes.

Interviewee: The power of that image is not to be underestimated. (Interviewee 3: 28)

Creating powerful images of relational coordination becomes increasingly important, especially since the clinic is facing severe budget cuts. This is also the overriding theme of the third interview, where interviewee 3 reflects on how the organization has developed, and ar-

rives at the conclusion that relational coordination is increasingly at the core of how the organization members think and talk about organizational activities. However, while relational coordination is increasingly being taken for granted by organization members, budget cuts are on the brink to overrule the current state of affairs, as clinics focus on internal optimization, because economic incentives are based on individual budgets and not on cross-departmental activities.

So, the discourse is pointing in the right direction. But not as fast as originally expected in regional government. (Interviewee 3: 43)

These themes are resumed in the fourth interview where interviewee 3 calls for a new system of economic incentives and a reevaluation of the principles of governance. It appears during the interview that the clinic in question is running out of options for new budget cuts. However, interviewee 3 seems surprisingly relaxed. While previously stating in the third interview that budget cuts are part of the job description, interviewee 3 now goes one step further.

You also get used to the fact that you in particular are in that space all the time. The space of conditions and options is as it is. (Interviewee 3: 55)

While focusing on how the guiding principles of relational coordination becomes taken-for-granted values within the clinic, interviewee 3 is also pursuing the course of budget cuts which in the present system of economic incentives works against relational coordination. In effect, his leadership role is continuously balanced between two very different lines of institutionalization.

4.4. "I believed that more risk-taking would occur"

As compared to the previous interviews, organizational variation was more explicitly addressed in our first dialogue with interviewee 4, who is an extremely experienced leader continuously reflecting on her leadership role. She defines herself as a leader who is becoming less and less focused on practicalities within the clinic and more and more focused on interdepartmental coordination. In consequence, her attention is increasingly preoccupied with barriers to relational coordination, which she perceives in terms of clashes between professional identities and problems of transcending from traditional silo management to network management. Especially, she finds that the use of existing solutions in combination with budget cuts blocks organizational innovation.

If you want to reuse (existing solutions), you must, eh, you need to do it properly. I mean, it must be thought through what you are doing. And I think it is really okay to be, basically, chocked. Even if it is not pleasant in the current situation, it is not a bad thing. [...] I mean, the rest of the organization has not changed. (...) Then, the whole organization enters cutting mode, and that means that if we as relational coordinators have a good idea, then it is stopped in a classic fashion: Does it cost money? How much does it

cost? (...) I find it troublesome, because I believed that more risk-taking would take place. (Interviewee 4: 2, 3)

In effect, she calls for the development of a new system of economic incentives, which are not enforced top-down but based on dialogue. While there is a need for investing resources in developing organizational overlap and culture, pressures of inertia blocks new initiatives.

Interviewer: I am thinking that you, actually, put yourself in a difficult position, because you call for risk-taking in a culture which essentially is a zero mistake culture. (...)

Interviewee: But you might say that if you look at medical research and so on...I mean, in this case you also have...there you are, essentially, in risk conditions, aren't you? But it is true that in the relation between patient and caring, there we have a zero mistake culture, but I am just thinking that to be organizationally risk-taking does not mean that you take risks in caring and treatment. (Interviewee 4: 13)

The second interview elaborates on these issues, and during the dialogue the interviewee recounts some organizational experiments that she has undertaken and arrives at the conclusion that organizational innovation in terms of relational coordination is beginning to function in cases where empowerment is undertaken, and network management is organized by setting up new arenas of cooperation. She feels that the basic requirement for this kind of leadership is to constructively engage in learning about differences between professions and organizational cultures, and to be cautious in choosing organizational battles. It becomes clear that while legitimacy regarding top-down demands for economic optimization is created, legitimacy regarding everyday cross-functional coordination and integration of the treatment of patients is simultaneously building up. This theme pervades the third interview, where a number of specific examples from everyday practice is touched upon, all characterized by actors co-creating sense guided by a focus on the treatment of patient, while severe economic problems is dealt with by management.

In essence, interviewee 4 is engaged in a process where relational coordination is being increasingly shaped. At the outset of the dialogue in interview 4, she explains how relational coordination is becoming widespread among doctors and nurses who appear more and more able to meet the challenge. Regarding leadership, conflicts between traditional management and relational coordination still occur, but relational leaders seem to gain legitimacy by combining involvement in specialties with cross-functional activities. At this point of our dialogue, she is quite optimistic.

...it is awesome when you experience that it is not just caused by some of the things which you have initiated yourself, but that things are happening in the surroundings... Then I think that it will happen and that it will be the patients' health sector at some point of time. [...] ...it is a process of negotiation, but it is also an approach to the patient. (Interviewee 4: 53, 58)

5. Conclusion

The present paper has discussed how leaders in a university hospital undergoing radical organizational change create and constitute their leadership roles while facing contradictory pressures of isomorphism. The individual and organizational processes of becoming were illustrated by four narratives that carried examples of coercive isomorphism in terms of top-down enforced budget cuts, mimetic isomorphism in terms of sustained professional cultures and practices, and normative isomorphism in terms of the powerful image of the patient as core business. As the organizational actors, serving as co-researchers in this case study, enacted the isomorphic pressures within structured organizational fields, two main discourses appeared as the outcome of social agency, i.e. a discourse creating legitimacy in relation to political stakeholders, and a discourse creating legitimacy in relation to how core business is generally perceived within and across clinics. The outcome of enactment differed across our co-researchers, reflecting how isomorphic pressures are being discretionary translated into local variations of response and creation. To some extent, the differences reflect differences across the group of co-researchers as to how they approach organizational challenges and institutionalization, thus emphasizing that the process of becoming depends on the timespace in which the actors find themselves and are in the process of creating. As their background, experiences and local context differ, they are departing from different states of affairs. In effect, while contributing to institutionalization, the process of enactment also contributes to organizational variation and variation in the patterns of institutionalization.

The practical authorship which we have undertaken in this study points in two directions. First, it shows that adopting an institutional approach within a becoming perspective is a fruitful combination when analyzing processes and patterns of institutionalization. From an ontological and epistemological point of view, the combination is challenging since it implies a mix of realist and social constructivist paradigms. During the case study, this has been a complicated process, especially since the authors originally approached the case study from, respectively, a realist and a social constructivist point of view. In the present study, qualitative methodology has served as the main bridge between the paradigms. Second, it shows that relational coordination at the university hospital in question may have serious implications for the exercise of new public management. The narratives on local variations of routines and patterns of institutionalization reflect that coordinating cross-departmental activities in extremely complex circumstances depend on network and empowerment reaching out for the patient. In effect, the organizational challenges revealed in our case study lend more support to new public governance than to new public management.

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