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Translating to Maintain Existing Practices

Micro-tactics in the Implementation of a New Management Concept

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Translating to maintain existing practices: Micro-tactics in the implementation of a new management concept

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Keywords:	Translation, Editing, Institutional logics, Decoupling, Value-based healthcare, Interpretive analytical framework,, Micro-tactics, Collaborative translation work
Abstract:	Research has demonstrated how the translation of a new management concept into organizational practices is impacted by the translators´ engagement with their local context. We expand this literature by demonstrating how a heterogenous institutional context prompts translators to create practice change but also practice maintenance. Building upon an interpretive analytical framework we offer a way

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	forward to examine relationships between societal institutions and distributed collective work in change processes. Our longitudinal qualitative study based upon interviews and observations examines how the concept of value-based healthcare was translated at a hospital. The translators developed three micro-tactics: disregard, maintenance, and displacement, grounded in their narration of practice changes. Translators enacted institutional logics differently at the levels of meaning and practice when they framed, rationalised, and contextualised the potentialities of a new concept, and this complexity provided the possibility of various practice outcomes. We contribute to the understanding of translation by demonstrating how a heterogenous institutional context encourages translators to change selected practices but also to decouple and maintain most of the existing practices due to their enactment of institutionalised rationalities. Moreover, we discuss how translation outcomes are impacted by collaborating actors' shared interpretations of their institutional context. Collaborating translators need to agree on whether and what practice change is valuable for the organization, and change is only possible when they interpret that they have the leverage to align a new idea with dominant institutional logics.

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Translating to maintain existing practices: Micro-tactics in the implementation of a new management concept

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Introduction

Implementing management ideas and models to create organizational change is an everyday task for most organizations. In the last decade translation research has become a vibrant field for analysing how the local organizational context becomes important not only as a venue for change but also in terms of how it plays an active role in the outcome of the change. Studies on Scandinavian institutionalism have provided noteworthy insights into the ways in which the fit between diffusing ideas and adopting organizations (Ansari, Fiss, & Zajac, 2010; Mazza, Sahlin-Andersson, & Strandgaard Pedersen, 2005) is affected by strategic actors and entrepreneurs who are particularly influential within their context (Czarniawska, 2009; Gondo & Amis, 2013; Morris & Lancaster, 2006; Røvik, 2011), and by structural and material aspects of the local context (Gond & Boxenbaum, 2013; Kirkpatrick, Bullinger, Lega, & Dent, 2013; Theulier & Rouleau, 2013).

The actors' interpretation of their *institutional* context is crucial to the unfolding of the translation processes. Studies explicitly examine how translation processes are impacted by societal meanings providing the ground rules for what would be comprehensive translation outcomes (Lamb & Currie, 2012; Lawrence, 2017; Pallas, Fredriksson, & Wedlin, 2016; Waldorff, 2013), and by institutional fields shaping how actors and organizations interact in translation processes (Heinze, Soderstrom, & Heinze, 2016; Nicolini, Lippi, & Monteiro, 2019; Nielsen, Mathiassen, & Newell, 2022).

However, a growing number of translation studies has begun further exploring the micro-tactics that translating actors develop within their institutional context. The research demonstrates how translators actively seek to relate a new concept to dominant institutionalised meanings and practices. Some translators develop formal organizational change strategies and execute various

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translating activities (Heinze et al., 2016; Ritvala & Granqvist, 2009; Spyridonidis & Currie, 2016), and others invest their own commitment, social positions, emotions, and identities to facilitate the adaption of a new idea (Cassell & Lee, 2017; Lawrence, 2017; Lok, 2010; van Grinsven, Sturdy, & Heusinkveld, 2020).

Yet, while studies have primarily investigated the translators' promotion and contextualisation of a certain idea leading to its institutionalisation, the research has devoted less attention to conceptualising what is actually meant by institutional context. We know truly little about how institutions impact translation activities, especially in acknowledging the more heterogenous context (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011) that provides various rationales for the translators' sensemaking of meanings and practices and enables them to develop a variety of micro-tactics. Translators are given the task of making a new idea fit their local context and, when doing so, they need to create strategies that allow them to balance between established institutional structures but that also allow them to deviate from the current ones.

We focus on the translation of the concept of value-based healthcare (VBHC) at a Danish hospital. VBHC defines value as health outcomes that matter to patients, divided by cost (Porter & Lee, 2013). The concept resonates with a broader welfare reform agenda in healthcare, asking how the sector can make a profound difference in the lives of patients. The hospital setting is particularly interesting and relevant because of the highly institutionalised context that national policies and managerial and professional standards and norms regulate in detail, and yet this setting has a multitude of actors engaged in sensemaking. The following research question guided our study: *What micro-tactics do translators develop, and how do translators use them to navigate their heterogeneous institutional context?*

Our analytical framework and ethnographically inspired methodology allow exploration of the process as a continuous effort by multiple translators (Czarniawska, 2009) who create not only

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change but also stability. We draw upon rich qualitative data, including archival materials, interviews, and observations. We interviewed hospital directors, health professionals, and collaborating partners three times between 2016 and 2018, a timespan of three years that allowed us to follow how the translation unfolded in real time. Our theoretical framework combines the concepts of editing (Wedlin & Sahlin, 2017) and institutional logics (Friedland & Alford, 1991; Thornton, Ocasio, & Lounsbury, 2012), permitting an examination of translation as a process in which interacting actors who interpret and enact institutional logics edit both the meaning and practice of an abstract concept. We found that the translators—hospital directors, clinical managers, administrative staff, and health professionals—developed three micro-tactics: disregard, modification, and displacement to make the VBHC concept fit the meanings and practices of the hospital's existing financial model, integrated care, and patient orientation.

We make three contributions to the translation literature and other micro-level-oriented institutional approaches such as practice-based institutionalism. Building upon an interpretive analytical framework (Zilber, 2016) we offer a way forward to examine relationships between societal institutions and distributed collective work in change processes. First, we advance the concept of micro-tactics to clarify how actors navigate heterogeneous institutional contexts leading to not only practice change but also practice maintenance. Translators enact institutional logics differently at the levels of meaning and practice when they frame, rationalise, and contextualise the potentialities of a new concept, this complexity opening up the possibility of various practice outcomes. Second, our study contributes to the concept of decoupling by explaining that the context of multiple institutional logics prompts translators to enact and safeguard not only organizational efficiency but also various other legitimate rationalities. We explain that practice change is difficult in highly institutionalised organizations, but possible in less precarious areas where the translators interpret that they have the leverage to align a new idea with dominant institutional logics. Finally,

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we contribute to discussions of collaborative translation work by explaining that translation outcomes are impacted by the actors' shared interpretations of their institutional context. Collaborating translators need to agree on whether and what practice change is valuable for the organization; thus change is only possible when they interpret that the new practices are aligned with dominant institutional logics, and when they have leverage in changing them.

Translation within a heterogeneous institutional context—the theoretical framework

In the following we review research on translation and institutional logics to build our theoretical framework for analysing actors' development of various micro-tactics to make a new managerial concept fit their heterogenous institutional context.

Actors' development of responses in translation

Scandinavian institutionalism investigates the process of translation by which ideas—such as managerial concepts—become popular at field level, how they spread and travel, and how they change as they are translated within organizations by actors who create localised meanings and practices (Czarniawska & Joerges, 1996; Czarniawska & Sevón, 1996; Drori, Höllerer, & Walgenbach, 2013; Røvik, 1998; Sahlin-Andersson, 1996; Wedlin & Sahlin, 2017). A significant contribution was the move beyond the narrow understanding of diffusion in neo-institutional theory as a push of ideas at field level (DiMaggio & Powell, 1983; Meyer & Rowan, 1977) that takes into account that organizations are not passive recipients but actively seek and transform new concepts (Boxenbaum & Strandgaard Pedersen, 2009; Wæraas & Nielsen, 2016).

Actors translate ideas "to fit their own wishes and the specific circumstances in which they operate" (Sahlin & Wedlin, 2008, p. 225). Thus, organizational actors interpret and make sense of ideas, and although not always conscious and strategic, institutionalised beliefs and norms

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implicitly govern translation processes (Czarniawska & Joerges, 1996; Czarniawska & Sevón, 1996; Sahlin-Andersson, 1996; Wedlin & Sahlin, 2017). One stream of studies examines the impact of societal meanings such as rational myths (Zilber, 2016), fashionable ideas (Eriksson-Zetterquist & Renemark, 2016) and discourses (Gondo & Amis, 2013; Lawrence, 2017; Outila, Piekkari, Mihailova, & Angouri, 2021) that pave the way for the translation of an idea into the organization. Another stream focuses on how the institutional field impacts translation through its institutionalised practices (Nicolini et al., 2019; Ritvala & Granqvist, 2009) and its actors, who together shape the morphing of ideas (Nielsen et al., 2022) or actively survey the field to promote new models locally (Heinze et al., 2016; Sahlin & Wedlin, 2017). In general, these studies provide a strong grounding for understanding institutions as key aspects of translation.

Focusing on the responses, translation studies have begun further exploring the micro-tactics that translating actors develop. Actors translate global field-level ideas at multiple levels of society through active contextualisation and entrepreneurship work (Andersson Malmros, 2021; Gond & Boxenbaum, 2013; Ritvala & Granqvist, 2009), as well as through various linking activities to pave the way for adherence in local organizations (Heinze et al., 2016; Outila et al., 2021). The translators themselves also affect the translation responses because of their considerable vigilance and commitment, in addition to their reflections and emotions connected to expressions of institutionalized beliefs (Cassell & Lee, 2017; Lawrence, 2017; Thøgersen, 2022). They may also use their social positions in organizational hierarchies to direct the translation outcomes (Nicolini et al., 2019; Spyridonidis & Currie, 2016) and their agency to choose influential language in decision-making (Piekkari, Tietze, & Koskinen, 2020). Some translators even re-construct their identities to accommodate institutional change and simultaneously protect their own integrity (Lok, 2010; van Grinsven et al., 2020). Thus translation studies demonstrate that actors' interpretation of their institutional field and personal agency is crucial to their development of responses in the translation

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processes. We nevertheless still lack insight into how the translators navigate in a more heterogenous institutional context that provides different rationales for sensemaking. The translators may develop not only shared responses but also a variety of micro-tactics, and the translation process may not result in the institutionalisation of a new idea.

Furthering this, we believe that the micro-level-oriented editing approach (Sahlin-Andersson, 1996; Wedlin & Sahlin, 2017) is well-suited for analysing the translation process as embedded in a heterogenous institutional context. Sahlin-Andersson (1996) and Wedlin and Sahlin (2017) point out that translators use specific editing rules within an organization: formulation, logic, and context. Formulation means that an idea is framed in a catchy, commonly accepted way to attract attention and support; logic stresses how the idea is promoted with a specific rationale, e.g., as a legitimate solution to a given problem; and, finally, context underscores the local setting's impact, e.g., its specific history, traditions, and organizing on the translation. In particular we welcome that Sahlin and Wedlin (2008) include both the programmatic aspect referring to the ideas, aims, and objectives of a certain practice, and the technological or operational aspect referring to the concrete tasks or routines that this practice consists of. This means that the focus in translation studies should be on not only how new concepts are framed rhetorically, but also on the ways in which the organisational practices may change.

Enacting a heterogeneous institutional context

We understand institutional context as comprised of various co-existing institutional logics, defined as: "supraorganizational patterns of activity by which individuals and organizations produce and reproduce their material subsistence and organize time and space" (Friedland & Alford, 1991, p. 248). Institutional logics, in other words, operate as guidelines for how actors are to recognise what is appropriate and legitimate behaviour in a given context. In practice, the logics may conflict with

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each other because they are based upon different rationales and beliefs, but they may also co-exist and even reinforce each other in some situations (Currie & Spyridonidis, 2015; Goodrick & Reay, 2011; Smets, Jarzabkowski, Burke, & Spee, 2015; Waldorff, Reay, & Goodrick, 2013). Institutional logics have symbolic elements that communicate taken-for-granted meanings and beliefs, guiding what is legitimate (and what is not) when a management concept is to be translated into the organization. Equally important, however, is that institutional logics also have associated practice elements. Thornton et al. (2012) emphasise that logics are socially constructed values *and* material practices.

Institutional logics provide a theoretically interesting lens to explore how overarching societal principles influence healthcare practices. Existing studies have empirically shown how institutional logics impact the form and purpose of healthcare organizations (Kitchener, 2002; Scott, Ruef, Mendel, & Caronna, 2000; Waldorff & Greenwood, 2011), as well as how the work of health professionals has changed to become much more focused on organizational efficiency and performance (Dunn & Jones, 2010; Goodrick & Reay, 2011; Kirkpatrick et al., 2013; Reay & Hinings, 2005; Waldorff et al., 2013). Although the identified logics come with different labels these studies emphasise the enduring prevalence of primarily the state and professional logics in Western healthcare. Corporate logic enters the picture, with national reforms promoting neo-liberal ideologies through new public management incentives.

Recently, a variety of studies have begun exploring the practice elements of institutional logics, and our study is well-placed within the emerging practice-driven institutionalism perspective (Smets, Aristidou, & Whittington, 2017; Smets et al., 2015). This new research mainly draws upon ethnographic methods showing for example how local actors interpret and employ institutional logics to implement a management concept (Currie & Spyridonidis, 2015) or how everyday practices at the micro level enact the institutional complexity of more logics (Jeschke, 2022; Smets

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et al., 2015). The perspective reconnects institutional theory with its practice-theoretical roots to "foreground the collective performance of institutions through situated, emergent and generative practices" (Smets et al., 2017, p. 366). Thus, institutional logics are not to be understood as static structures (Lounsbury, Steele, Wang, & Toubiana, 2021) but as constantly interpreted and enacted by social actors who produce and negotiate meaning. Zilber (2016) emphasises that this type of ontology reflecting a processual orientation and a distributed understanding of agency offers a new balance between structure and agency in our understanding of institutions. Instead of overstating the power of institutions, the impact of individual and collective actors on the institutions is highlighted.

This interpretive and micro-level-oriented approach to capturing institutional logics building upon a social constructivist ontology fits well with the concept of translation. As Lawrence and Suddaby (2006) noted translation offers both a conceptual and methodological way for institutional theory to move beyond the static, encompassing view of institutions and institutional outcomes. Despite these similarities, however, the two approaches differ in the focus of their attention. Where practice-driven institutionalism explains the everyday work done to enact broader institutional arrangements, the concept of translation explains an idea's journey from one context to another. Thus, by combining the concepts of translation and institutional logic we add to practice-driven institutionalism by explaining in detail what happens when an idea is deliberately translated into an institutionalised context involving micro-level practices.

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Empirical case—translating value-based healthcare into healthcare

Our empirical case is the local actors' translation of the VBHC concept into a highly institutionalised hospital setting. The concept was developed at Harvard Business School by economics professor Michael Porter and strategy professor Elizabeth Teisberg (2006), who argued

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for directing the healthcare sector's attention away from *input* (activities) and towards *outcome* (value). They asserted that patient preferences and satisfaction should be assessed to facilitate their return to employment or education. Later, Porter and Lee (2013) developed a model presented as a strategy that would fix healthcare and that defines value as health-related outcomes that matter to patients divided by the overall cost of their treatment.

Although seemingly well-defined and easy to grasp, VBHC does not contain clear-cut strategies to reform the healthcare system (Pedersen, 2017). Fredriksson, Ebbevi, and Savage (2015), who reviewed the growing VBHC literature, found that understanding of the concept is superficial and the processes so abstract that it may be undergoing a process of dilution rather than diffusion. In this sense we find that VBHC represents an abstract idea with a catchy label (Wedlin & Sahlin, 2017), and despite the lack of guiding strategies and practical examples—or maybe because of the lack thereof—VBHC is being spread as a fashionable management model (Czarniawska & Sevón, 2005).

VBHC travels to Denmark

The Danish healthcare system is predominantly public and funded by taxes. Five geographic regions have political and administrative responsibility for local hospitals. The state is responsible for collecting taxes, and the government and regions negotiate an annual economic agreement that defines the regions' budgets. The hospitals are regulated on a detailed level through national laws and policies on patient rights, medical treatment, health professionals' authorisations, accounting systems and economic incentive structures. The plurality of standards and norms of managers and professionals also plays a role.

Until 2019 the healthcare budget consisted of both a fixed and an activity-based framework, with a minimum 2% annual increase required for the level of activity. However, in recent years,

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politicians and health professionals have blamed this activity-based model for creating undue attention to levels of activity, instead of quality and patient outcomes (Burau, Dahl, Jensen, & Lou, 2018; Pedersen, 2017). The interest organization of the five regions, called Danish Regions, introduced VBHC as a possible solution to the problems identified. The Boston Consulting Group and the Institute of Value Based Research in Sweden (Pedersen, 2017) were especially active in promoting the spread of VBHC in Denmark, for example, by co-organizing a talk by Porter for stakeholders in the Danish healthcare sector in November 2014. Thus prominent consultancy firms acted as carriers (Sahlin and Wedlin, 2008), broadcasting and promoting the international dissemination of VBHC.

From theory to local VBHC experiments

The 2016 Economic Agreement stated that the regions had to develop new management and accounting models based on value-based management. In the Capital Region of Denmark one hospital and various hospital departments were appointed to serve as laboratories for experimenting with value-based management, as stated in the Capital Region's 2016 Budget Agreement:

> The parties agree (…) to establish an experiment with a new economic governance model that can strengthen the hospitals' framework conditions to create the greatest possible value for patients within the given budgets. It could, for example, be better quality, service or coherent care pathways. (p. 14)

Bornholms Hospital, a small island hospital geographically isolated from the rest of the Capital Region, was selected to serve as an organizational laboratory in a three-year experiment called Development Hospital Bornholm (DHB).

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According to the hospital directors they received no further formal guidelines regarding the content of the project. Moreover, only a brief amount of time was available to define the project protocol. The local managers organized two workshops for staff, clinical managers, patients, relatives, and regional politicians to discuss patient preferences, goals, and needs. Based on input from these workshops and political interests, eight sub-projects were established.

Methods

The study, designed as a longitudinal ethnographically inspired case study, involved an in-depth exploratory investigation from 2016 to 2018 of the translation of VBHC into meanings and practices.

Data sources

The study draws upon archival materials, interviews, and observations. We collected archival materials related to the translation of the VBHC concept, including international books, academic presentations, video presentations, Danish national and regional policy reports, governmental budget agreements, and Bornholms Hospital's planning documents.

We conducted three rounds of interviews during the three-year period as part of an ongoing evaluation led by the Danish Center for Social Science Research and structured in alignment with the progress made in DHB (Figure 1). Interviews lasted 30–90 minutes, were audio recorded, and transcribed verbatim.

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The first round of interviews took place one year after the hospital was appointed as an organizational laboratory. We chose to interview nine people directly involved in the project at that point (two hospital directors, six clinical managers, and one administrative member of staff). The interviews provided a unique opportunity to explore the actors' initial reflections about VBHC. The second round of interviews took place halfway through the project and included 21 people (the hospital director, the DHB programme manager, seven project managers, three clinical managers appointed to the sub-projects, six clinical staff, two local general practitioners, and the manager of the local healthcare authority). In the third round of interviews, 65 people (hospital managers and staff, managers and staff from the municipality, and general practitioners) were asked about their reflections on and experience with the three years spent as an organizational laboratory and the process and outcomes of the specific projects. We were particularly interested in their descriptions of changes in day-to-day practices at the hospital.

Finally, we observed selected meetings related to the DHB project, including eight initial meetings during which the programme and project managers discussed and developed the aims and activities of the sub-projects. We observed two planning meetings on the specification of the activities to be developed and implemented, one session in a teaching programme promoting the provision of service at the hospital, and one conference in spring 2018 with presentations on processes and results. At these meetings the project's intentions, status, and challenges were discussed. We took detailed notes at the meetings, which allowed us to analyse the actors' statements in a manner similar to interview statements.

Combined, the ethnographically inspired case study served to provide in-depth insights into the translation process, especially the actors' underlying thoughts and the project's impact as it unfolded over time.

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Data analysis

We conducted an abductive and iterative process, constantly moving between our empirical data and theory, just as we refined our theoretical framework during the research process.

The analysis was performed in four steps. The first step explored how VBHC was specified into areas of change at the hospital. More specifically we looked for emergent patterns across the eight sub-projects. We found that the local actors—hospital directors, clinical managers, administrative staff, and health professional (primarily physicians, nurses, and secretaries)—highlighted three areas of change, including the financial model, integrated care, and patient orientation.

In the second step we explored how the actors defined and articulated the meanings and practices of VBHC within the three areas of change (Appendix A). We applied the concept of editing rules (Wedlin & Sahlin, 2017) to search for and identify key phrasing (ways of framing the VBHC concept as catchy and commonly accepted); logic (ways of rationalising VBHC); and context (ways of linking VBHC to the local history, traditions and organizing) in accounts by interviewees. When explaining and rationalising the local translation process the interviewees argued in similar but not unified ways.

Thus, in the third step we explored the potential institutional pattern underlying the actors' translation. We followed the "pattern-inducing" technique in which "researchers commonly follow a grounded theory or ethnographic methodology, within an interpretivist tradition grounded in the assumption that meaning is tightly intertwined with context" (Reay & Jones, 2016, p. 449). Thus, we scrutinised our interviewees' accounts looking for the ways in which they legitimised the meanings and practices of the new VBHC concept in their local context. They expressed their understandings of how VBHC would impact the hospital's focus on attention, responsibilities, and practices. In our coding of the data we identified the actors' interpretations and enactments of three

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institutional logics (Appendix B). The welfare logic emphasises that the hospital should take responsibility for the entire care trajectory of patients and for adjusting treatment to each patients' life situation, which makes patient involvement an imperative in medical treatment and healthcare organization; the corporate logic emphasises that the hospital must be run efficiently, satisfy patients´ needs and optimise its position in the region; and the health professional logic emphasises that the hospital should facilitate high-quality treatment provided by trained experts. Similar logics have been identified and described in previous studies on Western healthcare (see the "Institutional logics" section). It should be mentioned that our data also indicate that the actors enacted other types of logics, e.g. logics of distinct medical specialties and health professions. However, we determined that these logics were less influential in this particular translation process.

In the second and third steps we paid attention to the divide between meaning and practice. This divide was not only noticeable using the lens of institutional logics but was also a facet of the editing rules. An analysis of the reflections of interviewees at various hierarchical levels in the organization allowed us to explore the meanings and practices they ascribed to the areas of change promoted by the programme.

Finally, in the fourth analytical step we considered how the translators' use of editing rules and their interpretation and enactment of institutional logics gave rise to the simultaneous development of micro-tactics. We identified three micro-tactics by paying specific attention to what happened in the translation process within each of the three areas of change, and more specifically the translators' various ways of relating meanings and practices (the translators' interpretations of logics at the programmatic and operational levels, target of change, own leverage, and practice change narrative). We labelled these: disregard, modification, and displacement, to emphasise their differences. Figure 2 shows the steps in our analysis.

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……. Insert Figure 2 about here …….

Our case is a critical one, which is defined as "having strategic importance in relation to the general problem" (Flyvbjerg, 2006, p. 14). Coding reliability was ensured through a rigorous process in which one author coded the empirical data before discussing the codes with the co-author to ensure that data were relevant for answering the research question and that interpretations were transparent. We relied on both interviewee statements and statements made at workshops and meetings about current and changed practices, just as we included interpretations by more than one person or group of actors, "allowing the story to unfold from the many-sided, complex and sometimes conflicting stories" (Flyvbjerg, 2006, p. 21). In the analysis section we link interview excerpts with interviewees (e.g. Physician #8) to provide these subtle details.

Translation of value-based healthcare at the hospital

Our analysis begins just after Bornholms Hospital was appointed an organizational laboratory for experimenting with VBHC. We identified the hospital directors, clinical managers, administrative staff, and health professionals' development of three types of micro-tactics when translating the new concept at the hospital. These micro-tactics were constituted differently due to the translators' interpretations of logics at the programmatic and operational levels, target of change, own leverage, and practice change narrative. Table 1 provides an overview of the constitutive elements.

….Insert Table 1 about here….

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I) Disregard: translation to financial model

In the *micro-tactic of disregard,* the actors framed the new financial model as a way to improve value for patients, to strengthen treatment quality, and to efficiently prioritise treatments. Yet, in terms of actual practices, the actors interpreted their leverage regarding inter-organizational practices as constrained, and they decided to disregard the purpose as too unrealistic and to not develop an alternative financial model. We explain this as due to the translators' enactment of various co-existing logics adding meaning to the new concept, but also that the existing financial practices were deeply rooted in a dominant logic, where it was crucial for the hospital to continue measuring activity levels (and not patient outcomes).

Translation into meaning: improving financial practices. Early in the process we saw that the clinical managers responsible for the hospital wards expressed an ambitious attitude towards the hospital's new status as a laboratory. As one clinical manager explained: "This project might teach us something new about how to manage a hospital" (Clinical manager #1). The clinical managers framed the concept as an alternative to the existing financial system, which they considered as predominantly focused on productivity levels rather than high-quality professional patient care—a rationale we find is the enactment of welfare and health professional logics. The clinical managers were particularly keen on framing VBHC as providing space for professional judgement:

> Anything about ways to make sure that we had the best pay-off has been very important to us, and now we're exempted from that. It makes sense, and I'm looking forward to immersing myself in something that makes sense for patients and for me: how many visits do you need in here, and who should you see? (Clinical manager #1)

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The hospital directors responsible for overall administrative management framed VBHC in a slightly different manner. They argued that the existing model worked well as a way to distribute the budget and maintain high productivity, though it needed redefining. In their view, the downside of the existing financial model was that public resources were spent on repeated or unnecessary activities because each organizational unit (hospital, department, ward) became too preoccupied with maintaining their own activity levels. As one hospital director stated:

> It will be interesting to find out if we can plan so that we can pay attention to entire systems and to coordination [across intra-organizational boundaries and sectors]. By doing that we can eliminate duplicate activities. I think we spend a lot of money on repeating activities across all sectors. (Hospital director #2)

Hence, the hospital directors argued for the rationale of effectiveness to ensure that the hospital could maintain the ability to deliver a sufficient amount of care in light of an ageing population and an increasing need for healthcare services. Effectiveness was, in other words, rationalised as a pre-condition for the hospital's ability to provide value for all patients, which is an argumentation we assess is the enactment of welfare and corporate logics.

Translation into practice: maintaining the monitoring of activity levels. Interestingly, at the operational level of translation, we found that clinical managers continued to be aware of their own department's activity levels. Weekly departmental reports produced by the financial department continued to indicate activity levels. One financial consultant explained that: "We have to monitor our activity. What I used to say is: 'We're not benchmarked according to our activity levels, but we have to keep track of them.' And that's what we do; we keep track of our activity".

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This reaction was related to the hospital's context, i.e. its status as a laboratory hospital, where being exempt from activity-based budgeting was, according to clinical managers, only seen as temporary:

> We talk about how we can't stop measuring our activity. Because when the project is over, then what? We don't know. And how will we be able to compare ourselves to others on how we're doing, what patients we have etc., if there's no documentation of any kind? Will that have any importance? We just don't know! (Clinical manager #1)

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The clinical managers described the reports as a constant reminder of the dominant financial framework in the regions. Moreover, the hospital directors continued to receive updates on the departments' activity-based performance and still had the option of interfering in the event of unusual activity levels. Maintaining activity levels continued to be seen as a way to protect the hospital from external interference, e.g. economic reductions or the closure of departments, and accordingly, the clinical managers talked about how they continued to pay attention to their activity levels. In line with the editing rule stressing the importance of context and the dominance of a corporate logic, the clinical managers emphasised the relevance of the existing financial model, which legitimised the organization's efforts to optimise its conditions.

Thus, the hospital directors decided to omit the development of a new financial incentive structure, even though it was stated in national and regional agreements. They reasoned that they, employed in a relatively small hospital, would have limited power to completely redefine the entire financial model:

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> Very early in the process we decided that we shouldn't develop a new financial model. Rather we should use Development Hospital Bornholm as a chance to develop better treatment and care for patients. (…) We were more interested in demonstrating another way to care for patients. (Hospital director #1)

Consequently, the hospital directors and health professionals agreed to disregard the initial purpose of defining new indicators of value to replace the current, influential indicators of activity. Maintaining activity levels was seen as crucial and in line with the context's dominant corporate logic. The translators viewed the development of new financial practices as unrealistic.

II) Modification: translation to integrated care

The actors emphasised the rationale that providing efficient, integrated care could improve patient welfare. They believed that they had some leverage to modify selected intra-organizational and inter-organizational practices; however, the coordination of patient treatment across established professional specialities and units was viewed from the perspective of the organization instead of from that of the patient. We relate this to a *micro-tactic of modification*, and we explain this as the actors' way of modifying what was possible within the regional context and to safeguard health professionals' areas of expertise and responsibilities legitimised by co-existing logics.

Translation into meaning: creating value for patients. The clinical managers and health professionals framed integrated care as a legitimate purpose that the hospital had been neglecting. In April 2018, the hospital's website presented the following overall aim: "Value-based healthcare means paying stronger attention to the patient's entire care trajectory across the municipality, the hospital and the general practitioner, resulting—in the end—to constantly improving patient satisfaction and the quality of patient care". As one clinical manager explained:

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> We have many patients with multiple diseases, and they visit the hospital repeatedly, at the outpatient clinic for cardiology, for diabetes, and so on. It's not hard to see that it's irrational from the patient perspective to visit different outpatient clinics on different days. (Clinical manager #3)

Other clinical managers similarly used the patient perspective as an argument for reconsidering the organization of care to think differently about which patients should be treated here, when, and by whom.

Thus a widespread understanding among hospital directors, clinical managers, and clinical staff was that well-coordinated care was an important way to help patients experience their care as safe and well-planned. We determined that this translation represents an enactment of not only a corporate logic but also a welfare logic, stressing that public organizations are obliged to consider the preferences of citizens.

Translation into practice: focusing on selected practices. Project managers, clinical managers, and clinical staff attempted to accommodate integrated care. Yet the perspective changed, so instead of viewing integrated care with the eyes of the patients, it became the perspective of the professionals and the administration. In the medical department a weekly meeting for physicians representing different medical specialties was introduced to discuss specific patient cases. The physician presenting the case would receive input from colleagues on a possible diagnosis or further relevant diagnostic tests. One physician noted a clear pay-off:

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> These meetings have a clear positive outcome; I learn something and I'm able to finish up with my patients in a positive way. (…) you avoid the ping-pong of patients bouncing between me and my colleagues, and the patients' disappointment when we're not able to give them a clear diagnosis. (Physician #1)

The meetings were set up as a continuation of an already existing meeting practice, which meant that no additional coordination was required, allowing physicians to concentrate on patients in their own field of expertise and to manage their own daily workload without being disturbed by (new) integrated care tasks relating to patients in other departments.

Another modification in practices was the improved coordination of individual patient visits to the hospital to ensure that check-ups and diagnostic tests in different outpatient clinics were carried out on the same day. However, like all other Danish hospitals, Bornholms Hospital comprises smaller units based on medical sub-specialties. Each unit is staffed with specialised physicians and nurses who provide patients with treatment plans within their own area of expertise. A noticeable translation of VBHC into practices would require profound adjustments in the organizational structure and resource allocation. Thus, the existing organizational boundaries of the context remained. To minimise the drawbacks, nurses and secretaries were asked to pay more attention to patients' other appointments in the hospital when booking new ones. One nurse described her response as follows:

> There's some coordination going on. Our secretaries coordinate patient appointments if possible. I have become more attentive towards asking if patients are interested in coordinating their appointments. (Nurse #1)

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Accordingly, the translation within this area became a modification of physicians' meetings and delegating coordination tasks to secretaries and nurses to improve the efficiency of planning, which is the enactment of a corporate logic but also represents a way for the health professionals to avoid major changes in existing practices and organizational structures, where they assess what is high-quality treatment, as aligned with a health professional logic.

III) Displacement: translation to patient orientation

Finally, in the *micro-tactic of displacement* the hospital directors framed the rationale of patient orientation as the improvement of patient preferences and the hospital's service. Yet, despite the actors' interpretation that they had leverage to create change, these intra-organizational practices remained unchanged. The health professionals sparked a conflict between logics by emphasising that the focus on service provision was illegitimate and should be displaced by a continuation of the already existing practices of professionals taking patient values into account.

Translation into meaning: tensions between hospital and hospitality. As part of the project, a formal purpose turned out to be strengthening patient voices and involvement in decisions about their own treatment trajectory. One clinical manager emphasised that: "(…) people need more influence than they currently have. We are well aware of what we want when we're hospitalised. We don't like to be a number, placed in a hospital room with a lot of other patients" (Clinical manager #8).

Yet, the rationalisation of patient orientation fuelled a debate about how to find a balance between patient preferences and professional judgements in decision making. The aim was to develop a culture in which all staff paid attention to the individual needs and expectations of patients and then acted accordingly—or as a clinical manager framed it:

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> We need to focus on the soft values. Until now we have defined the success of the operations from the surgeon's perspective. Obviously, we do have a dialogue with the patient, but we have never been especially attentive towards the patient's expectations (…). How can we teach the patients to make the best choices? (Clinical manager #4)

As an extension of the intention to include the individual preferences and needs of patients, the programme manager arranged a series of workshops with a renowned Danish hotel manager who trained managers in the service-profit chain (Heskett, Jones, Loveman, Sasser, & Schlesinger, 2008). Emphasis was put on patients feeling welcomed and well taken care of at the hospital. Some clinical managers and staff members embraced this rationale, one clinical manager noting:

> (…) we're a service organization. We have to see ourselves as a large hotel. The hospitality should be similar to when you arrive as a tourist, when you enter a place and say, 'Wow, this is nice!'. You know that somebody is able to answer your questions and that it matters to them to be around. (Clinical manager #4)

This emphasis on hospitality and service raised questions, however, about what patients actually value and what constitutes the core purpose of a hospital. As one clinical manager explained: *"Is it a value to be welcomed if you leave the hospital with a leg that was put together wrong? Or is it value when you're welcomed and everything works, and the quality is okay too?" (Clinical manager #1).* This debate captured a struggle between institutional logics: a welfare and corporate logic's emphasis on patient involvement and satisfaction with the hospital's treatment and services, and a health professional logic's weight put on professionals as experts and decision-making authorities. Who has the greatest authority, and who has the final say in the balance between service and medical treatment? The clinical managers and healthcare staff argued that, while the hospital

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directors promoted inclusion of patient preferences and hospitality, it would be better to focus on the hospital's provision of high-quality care.

Translation into practice: appreciating existing practices. The health professionals expressed a continued struggle when it came to the translation's operational level. The dilemma was how to avoid patients making decisions that the health professional's saw as wrong. One clinical manager stated:

> It involves what constitutes the best for the patients, and how the patient can make the best choices. What if the patient chooses training over surgery, and I—if I were the surgeon—think that it's the wrong choice. Helping patients make the right choices will definitely be the hardest! (Clinical manager #4)

The health professionals acknowledged the importance of inviting patients into the decision-making process but felt that it challenged their role as being responsible for providing the best patient care possible, which was an established, legitimate role in the hospital context.

In one subproject the project manager and health professionals developed a leaflet to be used in speaking with patients and their relatives on subjects related to living with a chronic disease, e.g. asking patients where they would prefer to die in the hospital or at home. Would they like to be resuscitated in the event of cardiac arrest? Health professionals argued, however, that the leaflet's focus and language were too direct and did not induce hope. One physician stated: "I find [the leaflet] offensive, insensitive, and counterproductive, so I haven't used it. But I've had many conversations about these issues, as required" (Physician #8). The health professionals struggled to use the leaflet in a way that suited their individual understanding of how to speak with patients.

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They preferred more, not less, space to incorporate their individual professional judgment. Further, they described themselves as already being patient oriented and capable of addressing the specific needs of patients. Instead of pushing for a way to improve patient orientation practices, they emphasised their existing practices as already being patient oriented, displacing the need to focus on this issue.

Thus, in terms of developing new patient involvement practices, the health professionals claimed that they as trained professionals were already taking patient preferences into account, a stance that involved the displacement of a delegitimised new purpose. To do so, they strived to translate the rationale of patient orientation with a health professional logic to maintain space for their individual judgment and an emphasis on medical treatment.

The micro-tactics used to maintain existing practices

Our analysis shows how multiple actors translated the concept of VBHC into a highly institutionalised hospital organization. We identified three micro-tactics. In the *disregarding micro-tactic,* the purpose of a new model is narrated as meaningful in line with multiple logics, but practice change is unrealistic due to a few dominant institutional logics at the operational level. This tactic developed because the translators interpreted the existing financial model for healthcare as rigid and in need of replacement. They did not believe, however, that decisions about abandoning the model were in their hands, causing them to disregard this purpose.

The *modifying micro-tactic* also narrates the purpose of a new model as meaningful in line with multiple logics, but practice change is viewed as possible in selected areas compatible with dominant institutional logics. We saw that the translators supported the intention to develop more coherent and integrated care for patients. Organizationally, however, the division of work in the sector is spread between various medical specialties, and health professionals are trained to focus on

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their own area of expertise. As a result, the translators interpreted that it was only possible to modify a few intra-organizational administrative practices without having to involve the whole region.

Finally, the *displacement micro-tactic* narrates the purpose of a new model as encompassing conflicting institutional logics, and the solution to relieving this tension is to displace the new idea as illegitimate and maintain existing practices legitimised by one of the dominant logics. We saw that the managers and health professionals agreed about involving patients but disagreed about whether service – and not primarily health professional expertise – was a legitimate purpose for the hospital. So instead of changing practices, the translators maintained the existing methods for health professionals to involve patients.

Taken together, the three micro-tactics emphasise the importance of the interpretations translators make of their institutional context and own agency to leverage influence in changing inter-organizational or intra-organizational practices.

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Discussion and conclusions

We contribute to the translation literature and other micro-level-oriented institutional approaches in various ways. Building upon our interpretive analytical framework (Zilber, 2016) we offer a way forward to investigate the relationship between societal institutions and distributed collective agency in change processes. Similar to the practice-based institutionalism approach (Smets et al., 2017), we understand micro-level processes as unfolding through actors' linking of meanings and practices to broader institutional arrangements such as institutional logics.

First, using theory and analysis, we advance the concept of micro-tactics to explain translation as a multi-layered process by which actors navigate their heterogeneous institutional context and create various outcomes, in this case the maintenance of existing practices and change

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of practice in less precarious areas. By uncovering how translators enact different institutional logics when they frame, rationalise and contextualise the potentialities of a new concept, we developed a repertoire of micro-tactics that could potentially be applied to other translation processes. A common feature of these tactics is that translators enact some institutional logics as particularly influential at the level of meaning (programmatic) but enact others at the level of practice (operational). The conflicts between levels are resolved or navigated through the creation of narratives of practice change as unrealistic, possible, or illegitimate. A few studies have also addressed translation outcomes as situated within a heterogeneous context of institutional logics. However, these studies did not explore the variety in outcomes, showing instead how an idea creates organisational practice change and is institutionalised through actors' mobilisation of specific logics (Lamb & Currie, 2012; Lok, 2010; Pallas et al., 2016; Waldorff, 2013; Waldorff & Greenwood, 2011).

The institutionalisation of an idea is in fact the focus of many translation studies that carefully examine how a new idea is copied, specific aspects subtracted, and local traditions added or radically altered (Gond & Boxenbaum, 2013; Lamb & Currie, 2012; Nielsen, Wæraas, & Dahl, 2020; Røvik, 2011, Wæraas & Sataøen, 2014). In addition, the impact of an idea's characteristics on its own implementation has caught the attention of researchers (Ansari et al., 2010). However, only few studies consider other translation outcomes such as rejection and non-adoption. They emphasise that translation is impacted by the perceptions of influential actors that the idea has limited desirability and feasibility (Kirkpatrick et al., 2013) or by old routines that hamper the diffusion of knowledge (Saka, 2004). Seeking to conceptualise the variety in translation outcomes, Mazza et al. (2005) describe homogenising and heterogenising empirical tendencies at the field level, leading to different forms of adoption of a new management model internationally. Similarly, Røvik (2011) provides a typology of ten adoption processes leading to various implementation

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outcomes, including rejection that occurs due to unsatisfactory results and incompatibility with institutional norms, logics, and complex practices. Yet, while these studies describe different translation processes and outcomes, they offer less analytical guidance as to why and how translation processes may result in these different outcomes. Thus, we add to the field by developing a novel framework focusing less on whether and how an original idea (or parts hereof) is changed, and more on how translators' enactment of various institutional logics impacts the translation in multiple directions.

Second, our study contributes to the notion of decoupling (March & Olsen, 1976; Meyer & Rowan, 1977; Weick, 1976). We clarify how a heterogenous institutional context prompts translators to voice different rationales and to simultaneously develop practice change *and* maintenance depending on how they interpret how a new idea fits into dominant institutional logics. In the classic neo-institutional literature on decoupling, actors intentionally neglect the implementation of practices that are considered harmful, inefficient or inconsistent with the aims of the organization, thus shielding the organization's core tasks against change (Boxenbaum & Jonsson, 2017). Or alternatively, according to Bromley and Powell (2012, p. 489): "Decoupling also occurs in the relationship between means and ends, when policies are implemented but the link between formal policies and the intended outcome is opaque." The point is that decupling is a deliberate strategy for dealing with external pressures and protecting organizational efficiency. Decoupling may not last in the long run because increasing external pressures for transparency reveal inconsistencies between idea and practice, and "efforts will be taken to close the gap – either by letting the idea drop, or by more whole-hearted attempts to implement it" (Røvik, 2011, p. 642). Our analysis nevertheless shows a more nuanced picture. The organization may still exhibit its (symbolic) adoption of a new idea to the outside world, but decoupling emerges unintentionally, guided by the translators' ambiguous institutional context, stemming not only from the outside but

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also from within (Brunsson, 2002; Selznick, 1949). They protect practices relating to plural logics, including organizational efficiency, but also professional expertise and citizen welfare, as shown in our case. This means that the translators' narrations of practice changes as unrealistic, possible or illegitimate are their enactment of various institutional logics resulting in both organizational stability and change. This compels us to propose that researchers use the concept of translation to achieve greater depth concerning the complex micro-level organizational processes and to explore how some practices are decoupled while others are changed due to the translators' diverse interpretations of their heterogenous institutional context and own agency to leverage influence.

Finally, our study contributes to discussions on the notion of collaborative translation work (Czarniawska, 2009; Heinze et al., 2016; Kirkpatrick et al., 2013; Nielsen et al., 2020; Pallas et al., 2016; Wedlin & Sahlin, 2017). We find that collaborating translators need to agree that changing practices will be valuable for the organization; thus change is only possible when they believe that the new model aligns with existing logics, not to mention that they have leverage in changing related practices. Other studies claim that collaboration will lead to adoption of a new model, such as Nielsen et al. (2020), who explain how translators' collaboration across organizational and field levels connects the 'official' management idea with adopting organizations and thereby strengthens the chance that the idea will have the desired effects. Our study, however, shows that collaboration may not necessarily pave the way for organizational change. Our findings indicate that in highly institutionalised contexts the translators may, despite their possible differences, interpret and enact their institutional context similarly. As Ansari et al. (2010, p. 78) note the already established norms and routines of an organization create the rules of the game: "New practices and ideas do not diffuse into a cultural void but, rather, into a preexisting cultural universe that delineates the roles and responsibilities of its respective actors and the boundaries of appropriate behaviour". In our case we saw more alliances across groups of actors than disagreements in terms of how they

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interpreted practice change and their own agency to leverage influence. For example, our findings show, perhaps counterintuitively, that the health professionals perceived the corporate logic as important and legitimate, and that the managers perceived the health professional logic similarly.

Our exploration of a specific hospital's experimentation with VBHC makes it clear that policy implementation is not a scripted translation of plans into reality but an uncontrollable process in which policies and plans are twisted from below (Zapata & Zapata Campos, 2015). This was the case with this project, which was initiated in response to disapproval concerning the existing financial model's overly heavy focus on efficiency. But, as the translation unfolded, it became evident that despite the project's positive connotations, only selected practices were modified in the heterogeneous institutional context.

Directions for future research

We studied a translation process within healthcare. Studies of less mature, institutionalised contexts might show that collaborating translators believe that they possess greater leverage, allowing them to deviate from dominant logics and develop other translation outcomes besides mainly practice maintenance. Another possible avenue of future research is to explore how the dynamics between meanings and practices evolve over time. Although our longitudinal study allowed the exploration of changes over a three-year period, we are curious about whether and how discussions and work related to implementation of VBHC would impact the organizational practices in the longer run. Finally, an interesting line of research beyond the focus of our study is to include the patient perspective. When the aim of a new concept being translated is to focus more on patient values, it would be relevant to explore what institutional logics patients enact and whether these facilitate patient inclusion and involvement.

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Table 1. Constitutive elements of micro-tactics in translation

Micro-tactic	Disregard	Modification	Displacement
Interpretations of logics at programmatic level	Co-existing	Co-existing	Conflicting
Interpretations of logics at operational level	Dominating (one logic)	Co-existing	Dominating (one logic)
Interpretations of target of change	Inter-organizational	Inter-organizational/ Intra-organizational	Intra-organizational
Interpretations of translators' leverage	Constrained	Some	Enabled
Practice change narrative	Unrealistic	Possible	Illegitimate

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Figure 1. Timeline of interviews

Timeline	***February 2016***	***February – September 2016***	***September – December 2016***	***January – August 2017***	***September 2017 – December 2018***
DHB project	Hospital exempted from activity-based budgeting	Development programme prepared; approved by the Regional Council	Detailed planning of eight sub-projects, redefinition of goals and activities	Start-up and adjustment of goals and activities	Further implementation
Interviews			2 hospital directors 1 economic consultant 7 clinical managers ***10 interviewees***	1 hospital director 1 programme manager (head of DBH project) 7 project managers 3 clinical managers 6 clinical staff (physicians, nurses and secretaries) directly involved in sub-projects 2 general practitioners directly involved in sub-projects 1 manager from local municipality ***21 interviewees***	2 hospital directors 1 programme manager (head of DBH project) 7 project managers 7 clinical managers 6 team managers 1 service manager 1 quality manager 30 clinical staff (physicians, nurses, medical laboratory technicians, physiotherapists and secretaries) 3 general practitioners involved in sub-projects 7 managers and staff from local municipality ***65 interviewees***

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Figure 2. Identifying actors' micro-tactics by examining editing rules and institutional logics at the programmatic and operational levels of translation

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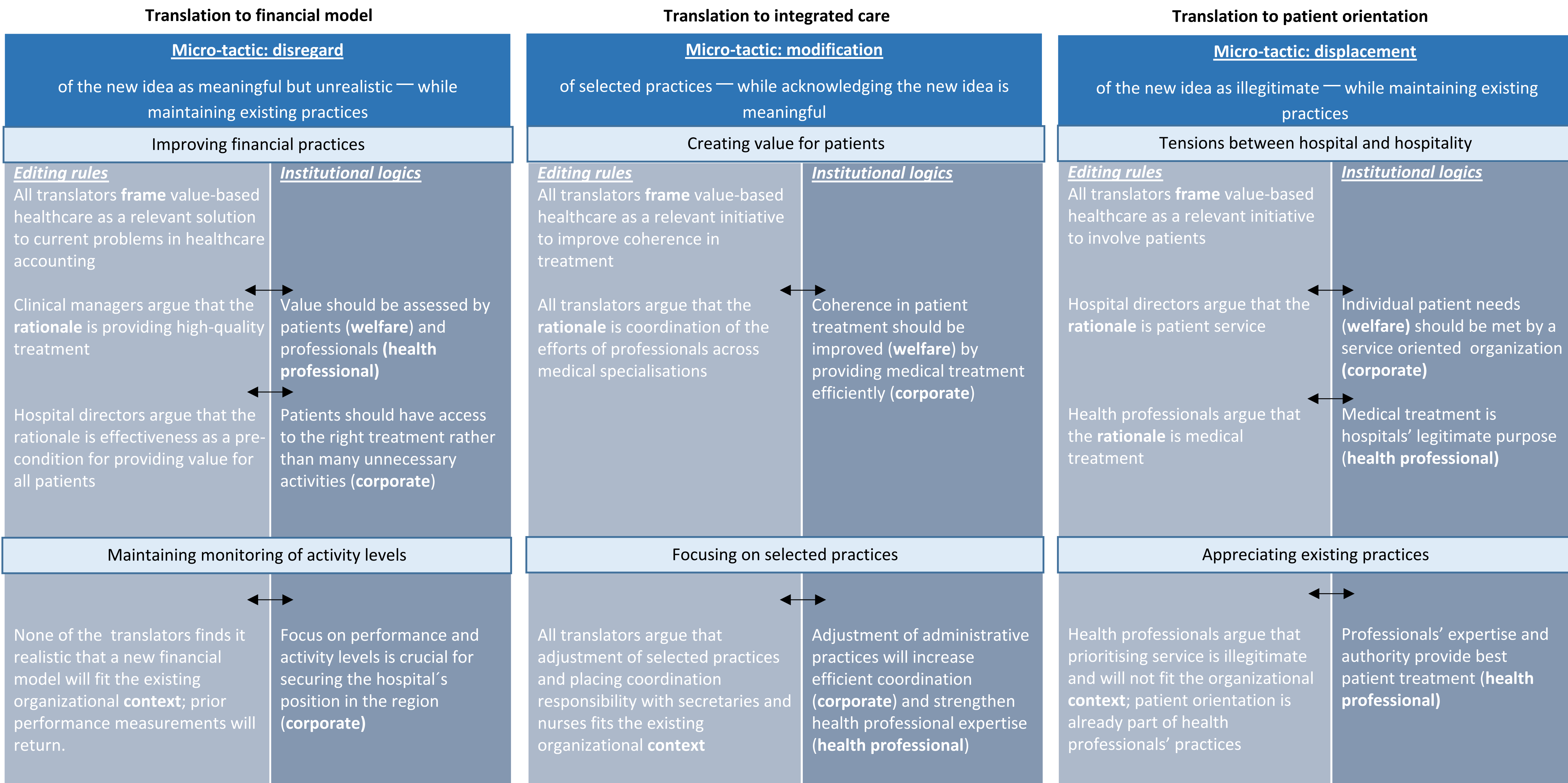

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Appendix A: Editing of value-based healthcare – additional illustrative quotes

Editing rules	Illustrative quotes
Translation to the financial model	
Translation into meaning	
a. Formulating	"We've been preoccupied with productivity numbers [as part of the old financial model] measured as DRG [diagnosis-related groups]. We don't have other types of measures, even though other measures would be logical." (Clinical manager #1)
b. Rationalising	"It's about defining value as something that's not just about the patient but also about the health professionals. (…) That would be great if we could connect the patient experience of excellent treatment at the hospital with the staff's experience – clinical outcomes for instance." (Clinical manager #1) "The message that I communicate to my organization is that if we need to be able to accommodate 500 new patients with multi-morbidity per year within the same system, then we need to cooperate more and be more effective than we are today." (Hospital director #2)
Translation into practice	
c. Contextualising	"Even though we're exempted [from activity-based funding] for three years, I'm sure they're [regional administrators] looking at our activity levels anyway. (…) It's my responsibility for us to be able to explain a reduction in productivity." (Clinical manager #3)
Translation to integrated care	
Translation into meaning	
a. Formulating	"I consider it as a journey. As something that addresses patient needs before and during hospitalisation, and as something that focuses on patients being discharged from the hospital and so on. We address the entire journey." (Hospital director #2)
b. Rationalising	"If [a patient] has two appointments in the medical outpatient clinic, they should be planned as in extension of one another. (…) We could work smarter, think differently about who's coming in and why." (Clinical manager #1)
Translation into practice	
c. Contextualising	"You can consider it a challenge. You could also tell the patient, 'I can't promise you that all your appointments will be on the same day, but I can try my best'. And then get back to the patient and say, 'Four of your appointments are lined up, though we have to wait with your cardiologist appointment, but we're doing as much as we can'." (Nurse #8)
Translation to patient orientation	
Translation into meaning	
a. Formulating	"Do whatever makes sense, what is reasonable, and what the patient asks for. Use your common sense and do whatever is meaningful." (Hospital manager #2)
b. Rationalising	"A culture [current one] in which physicians – especially surgeons – only find it meaningful to deal with patients whose operations went well is a challenge. (…) I would rather that they spent time on patients who have a problem after surgery. I want them to determine whether a patient needs surgery and what the patient wants." (Hospital director #2)
Translation into practice	
c. Contextualising	"It was a common understanding [in a project group] that this is what we do already. And it's very difficult … the patient perspective is not a strong argument in itself, even though you can say that patient experiences are different [from the health professionals']." (Project manager #8)

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Appendix B: Institutional logics enacted in the translation of value-based healthcare - additional illustrative quotes

Key aspects of identified logic	Illustrative quotes
Welfare logic	
Focus of attention is patient welfare. Patients have legally defined rights of informed consent and must be appreciated as individuals with unique experiences, needs, and preferences. Hospitals must take responsibility for entire patient care trajectory, involve patients in own treatment, and adjust treatment to each individual life situation. Several practices relate the hospital to a broader societal system providing welfare.	"We need to place the patient on the centre stage, no matter what. I hope that we can obtain consensus about how to do what's best for patients – that we become more attentive." (Clinical manager #4) "We cannot be sure that our version of what's best for the patients is the same as their version. From my point of view – working with palliative care – this is a useful reminder." (Physiotherapist #8)
Corporate logic	
Focus of attention is organizational performance, including: political goals, organizational structure, strategies, financial performance, and the satisfaction of patient needs as customers. Hospitals must take responsibility for organizing and providing services efficiently. Several practices register and account for the hospital performance (activity levels).	"Patients should be more satisfied with this hospital; that's this is about (…) It's necessary for us to save money, to appreciate our diagnostic capabilities, and to avoid patients showing up when it's not necessary. And also that it doesn't take an undue amount of time because we're send patients all over the place from colleague to colleague." (Physician) "We're measuring absence due to illness, patient satisfaction, employee satisfaction, and all sorts of other regional goals." (Hospital director #2)
Health professional logic	
Focus of attention is professional authority and expertise. Hospitals are responsible for providing high quality and best possible treatment defined by professionals' standards and judgements. Several practices support professional expertise and experience in the provision of treatment and care.	"We must not forget to talk about the quality of our treatments. It's not enough to devote yourself to the availability of televisions and bottles of cold drinking water in the wards." (Clinical manager #1) "Some physicians are very preoccupied with their own area of specialization and they find it difficult to give thorough answers to patients about examinations performed in another specialty. They prefer to make a referral to a colleague instead of doing it themselves. It's the result of a development going on for decades." (Physician #1)

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