CENTER OR PERIPHERY?: IDENTIFYING THE LOCUS OF DIFFERENT TYPES OF
DIVERGENT ORGANIZATIONAL CHANGE

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ABSTRACT

This study examines the relationship between actors’ social position and the likelihood that they will initiate two different types of divergent organizational change in a field of activity, namely changes that diverge from the institutionalized model of organizations’ role division and changes that diverge from the institutionalized model of social groups’ role division. I explore this relationship using data from 93 change projects conducted by clinical managers at the National Health Service in the United Kingdom. My findings show social position to be a determinant of the type of divergent organizational change an actor might undertake. This result suggests that treating divergent organizational change as a uniform phenomenon might mask important idiosyncrasies associated with the different types of divergent organizational changes likely to be undertaken by actors with different profiles in terms of social position.

Keywords: Divergent organizational change; institutional change; social position.
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INTRODUCTION

Institutions are social structures characterized by a high degree of resilience (Scott, 2001). Actors tend to take for granted and reproduce beliefs and practices that have become institutionalized (Zucker, 1977). But institutional change occurs despite institutional pressures towards stasis. Over the last decade, research in organization studies has examined the enabling conditions for divergent (also called radical) organizational change, that is, organizational change that diverges from, or breaks with, the institutionalized model for organizing in a field of activity (D’Aunno, Succi and Alexander, 2000; Greenwood and Hinings, 1996; Amis, Slack and Hinings, 2004).

Actors’ social position has been found to be an important enabling condition for initiating organizational changes that diverge from the existing institutions (e.g., Leblebici et al., 1991; Palmer and Barber, 2001; Sherer and Lee, 2002; Greenwood and Suddaby, 2006; Cliff, Jennings and Greenwood, 2006). But findings of recent research regarding the enabling role of actors’ social position appear to be contradictory. Specifically, some institutional studies have found low status actors, who are said to be at the periphery of a field (Shils, 1975), to be more likely to diverge from the existing institutions (e.g., Hirsch, 1986; Leblebici et al., 1991; Kraatz and Zajac, 1996), whereas other institutional studies have found high status actors, who are said to be at the center of a field (Shils, 1975), to be more likely to diverge from existing institutions (e.g., Greenwood, Suddaby, and Hinings, 2002; Sherer and Lee, 2002; Greenwood and Suddaby, 2006).

The present study suggests that this variation in whether actors at the center or at the periphery are more likely to diverge from existing institutions can be explained by the existence of different types of divergent organizational change. Whereas institutional research thus far has considered divergent organizational change to be a uniform phenomenon, I propose that organizational changes might diverge along different dimensions of the dominant institutionalized template for organizing within a field of activity thereby corresponding to different types of divergent organizational change.

The institutionalized template for organizing, often referred to as an institutional logic (Scott,
is a field’s shared understanding of the goals that are to be pursued (desired ends) and how they are to be pursued (appropriate means) (see Figure 1). The latter specify actors’ appropriate role division in a field, that is, what activities they should engage in and how they should interact with one another (Rao, Monin and Durand, 2003; Kraatz and Block, Forthcoming). Since organizations and social groups (e.g., professional or occupational groups) are two main categories of actors in fields (Battilana, 2006), means specify the appropriate model of social groups’ as well as organizations’ role division. Organizational changes might thus diverge from the means or ends or means and ends specified by the dominant institutional logic in a field. When diverging from the means, changes might diverge from the institutionalized model of social groups’ or organizations’ role division. In this study, I focus on these two latter types of divergent organizational change, namely changes that diverge from the institutionalized model of organizations’ role division and changes that diverge from the institutionalized model of social groups’ role division.

I explore the relationship between actors’ positional characteristics and their likelihood to initiate the two different types of divergent organizational change using data from 93 change projects conducted between 2003 and 2004 by 93 clinical managers in 80 different organizations within the National Health Service (NHS) in the United Kingdom. The NHS is a public, state-funded healthcare system made up of more than 600 organizations that fall into three broad categories: administrative units; primary care service providers; and secondary care service providers. In 2004, the NHS employed more than one million people, including healthcare professionals and managers.

Professional groups are the most salient social groups in the NHS, and the dominant institutional logic is that of medical professionalism, which prescribes a model of organizations’ role division that places hospitals (i.e., secondary care service providers) at the heart of the healthcare system and a model of professionals’ role division predicated on physicians’ dominance over all other categories of professionals. I developed a measure of the degree to which change projects in my sample diverged from the logic of medical professionalism concerning (1) the role division among
organizations, and (2) the role division among professionals.

My results show social position to be a determinant of the type of divergent organizational change an individual actor is likely to undertake. These findings suggest that treating divergent organizational change as a uniform phenomenon might thus mask important idiosyncrasies associated with different types of divergent organizational changes that are likely to be undertaken by actors with different profiles in terms of social position.

SOCIAL POSITION AND DIVERGENT ORGANIZATIONAL CHANGE

Most of the studies referenced earlier, although they have contributed to a better understanding of the enabling role of actors’ social position, have been conducted at the organizational level of analysis thereby not accounting for the role of individual actors in divergent organizational change. Such neglect is surprising given that it is these individual actors who will initiate changes that diverge from the existing institutions (Berger and Luckmann, 1967; DiMaggio and Powell, 1991). In order to have a more fine-grained understanding of the enabling role of social position for initiating different types of divergent organizational change, it might thus be necessary to account for the influence of individual actors’ social position (Battilana, 2006).

Within organizational fields defined as recognized areas of institutional life (DiMaggio and Powell, 1983), individual actors are embedded in organizations and social groups (e.g., professional and occupational groups) that transcend organizational boundaries (see Figure 2). Hence, individual actors’ social position is determined both by their position in the organizational field, which is dependent on their organizational and social group memberships, and by their position within their organization. Their position in the organizational field (i.e., center vs. periphery) is determined by the status of both the organization and social group to which an actor belongs (Shils, 1975). Status defined as “an effective claim to social esteem in terms of positive or negative privileges” (Weber, 1978: 305) is the unearned ascription of actors’ social rank (Washington and Zajac, 2005). As for individual actors’ position within their organization, it is largely determined by their position in the organizational hierarchy. The social position of a nurse in charge of a ward in an NHS hospital, for example, is determined both by the status of the organization (i.e., hospital) and the status of the social
group (i.e., professional group of nurses) to which she belongs as well as by her position in the hierarchy of her organization (i.e., the hospital in which she works).

Building on the few studies that account for the enabling role of individual actors’ social position (Maguire, Hardy and Lawrence, 2004; Cliff, Jennings and Greenwood, 2006), Battilana (2006) developed a model of the influence of individual actors’ social position on their likelihood to initiate divergent organizational change. This model, although it contributes to a more fine-grained understanding of the enabling role of individual actors’ social position by accounting for the influence of both their position in the field (center versus periphery) and their position in the organizational hierarchy, fails to explain why actors at the center of fields (be they in a high status organization and/or a high status social group) might initiate divergent organizational change.

In this paper I argue that in order to explain why actors both at the center and the periphery of fields may initiate divergent organizational change, it is necessary to account for the fact that organizational changes may diverge from different dimensions of the dominant institutional logic thereby corresponding to different types of divergent organizational change. Below I examine the relationship between individual actors’ positional characteristics (both in the organizational field and in their organization) and their likelihood to initiate two types of divergent organizational changes, namely, changes that diverge from the institutionalized model of organizations’ role division and changes that diverge from the institutionalized model of social groups’ role division. I analyze how different positional characteristics may influence actors’ willingness and/or ability to initiate the two different types of divergent organizational change.

Actors’ position within the organizational field is likely to influence their willingness to initiate divergent organizational change. Organizational fields are political arenas (Brint and Karabel, 1991). Because the institutionalized models of organizations’ and social groups’ role division imply differential access to and control over key resources and decision processes (Shils, 1975; Hargrave and Van de Ven, 2006), they are a source of power for the members of those organizations and social groups who benefit from “positive privileges” and not for those who suffer from “negative privileges”
In other words, the status of the organizations and social groups in which individual actors are embedded is determined by the institutionalized model of organizations’ and social groups’ role division. Depending on the status of the organization and social group to which they belong, individual actors’ willingness to diverge from the institutionalized model of organizations’ or social groups’ role division may thus vary.

In the meantime, actors’ position in the hierarchy of their organization is likely to influence their ability to initiate divergent organizational change (Tushman and Romanelli, 1985). Because willingness and ability to initiate change are not independent dimensions (Vroom, 1964), as previous research has illustrated (e.g., Palmer and Barber, 2001), it is necessary to consider the joint effect that individual actors’ position in the organizational field and in the organization might have on their likelihood to initiate either of the two types of divergent organizational change.

**Position in the Organizational Field**

**Organization status.** Research has shown low status organizations to be more likely to introduce new practices that diverge from the existing institutions and high status organizations to be more likely to mobilize resources to maintain the status quo (e.g., Leblebici et al., 1991; Kraatz and Zajac, 1996; Haveman and Rao, 1997, D’Aunno et al., 2000). In most of these studies, divergent organizational changes introduced in low status organizations diverged from the institutionalized model of organizations’ role division. Although organizations were the unit of analysis in the latter stream of research, it is apparent that individual members of low status organizations initiated these changes.

Within a given organizational field, actors who belong to low status organizations are in a challenger position (Fligstein, 1997; Hensmans, 2003) relative to actors who belong to high status organizations. Because low status organizations, being less privileged by the institutionalized model of organizations’ role division, have less to lose from social deviance, members of these organizations are more likely to be willing to transform the existing model of organizations’ role division. The “pattern of value commitments” (Greenwood and Hinings, 1996: 1036) in low status organizations, that is, the extent to which members of low status organizations are committed to the prevailing institutional arrangements, is also likely to facilitate the development and implementation of changes.
that diverge from the institutionalized model of organizations’ role division insofar as other organizational members are likely to be less committed than actors who belong to high status organizations to the institutionalized model of organizations’ role division.

**H1a:** Within a given organizational field, actors who belong to low status organizations are more likely than other actors to initiate changes that diverge from the institutionalized model of organizations’ role division.

**Social group status.** Different fields host different types of social groups with varying levels of social status. For example, in the healthcare sector, in which professional groups are the most salient social groups, physicians are accorded higher status than other groups of healthcare professionals (e.g., Starr, 1982). Actors who belong to high status social groups benefit from the prevailing model of social groups’ role division, which reinforces their dominance over actors who belong to low status social groups. For example, in multi-professionalized organizational fields, different professions have different statuses. Members of high status professional groups are likely to defend their traditional privileges and autonomy, whereas members of low status professional groups less favored by the institutionalized model of professional groups’ role division, are more likely to be willing to fight the status quo (Abbott, 1988; Starr, 1982). Being in a challenger position (Fligstein, 1997; Hensmans, 2003), members of low status social groups might have more incentive than members of high status social groups to modify the institutionalized model of social groups’ role division.

**H1b:** Within a given organizational field, actors who belong to low status social groups are more likely than other actors to initiate changes that diverge from the institutionalized model of social groups’ role division.

**Position in the Organization**

Because actors low in the organizational hierarchy lack legitimacy and access to the resources needed to initiate divergent organizational change, it falls to those higher up to initiate such change (Tushman and Romanelli, 1985). Top managers have been shown to play a key role in organizational change (e.g., Hambrick and Mason, 1984; Finkelstein and Hambrick, 1996). Executives, for example, have been instrumental during the 1970s and 1980s in liberal arts colleges’ adoption of professional programs that diverged from taken-for-granted practices (Kraatz and Moore, 2002).
Actors who occupy higher hierarchical positions can leverage the authority associated with those positions to impose divergent organizational changes that break with the norms for the field. They are also more likely to have access to key resources needed to support the initiation of any of the two types of divergent organizational change.

**H2a:** Actors higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of organizations’ role division.

**H2b:** Actors higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of social groups’ role division.

**Joint Effect of Position in the Organizational Field and in the Organization**

Thus far I have discussed the possible independent contributions of position in the organizational field and position in the organizational hierarchy to the initiation of divergent organizational change. The arguments advanced regarding the impact of position in the organizational field (H1a and H1b) revolve mainly around actors’ willingness to initiate divergent organizational change, while the arguments advanced regarding the impact of position in the organizational hierarchy (H2a and H2b) revolve mainly around actors’ ability to initiate divergent organizational change.

But willingness and ability to act are not, as noted earlier, independent (Vroom, 1964). Actors who have the ability to act are more likely to positively assess the probability for success, and, hence, to decide to take action. The relationship between willingness and ability to act suggests that actors’ position in the organizational hierarchy will moderate the relationship between their position in the organizational field and their likelihood to initiate the different types of divergent organizational change. Actors who belong to low status organizations or social groups, although likely to be willing to initiate changes that diverge respectively from the institutionalized model of organizations’ role division or from the institutionalized model of social groups’ role division, might lack access to the necessary resources to initiate such changes (Greenwood and Hinings, 1996). As they get higher in the hierarchy of their organizations, however, and become more able to initiate divergent organizational changes, they become, owing to the interaction between willingness and ability, even more willing to do so.
**H3a:** Actors who belong to low status organizations and are higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of organizations’ role division.

**H3b:** Actors who belong to low status social groups and are higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of social groups’ role division.

**THE UNITED KINGDOM'S NATIONAL HEALTH SERVICE**

In 2004, the NHS, the public, state-funded healthcare system established by the United Kingdom in 1948, had a budget of approximately £42 billion and employed more than a million people. All UK residents have access to NHS services, which are free at the point of delivery. The NHS can be regarded as an organizational field (DiMaggio and Powell, 1983) because NHS organizations and professionals, patients and governing bodies are involved in the common purpose of commissioning and providing health care services in the UK and interact with each other frequently and fatefuly to do so (Scott, 1994). Although the NHS has undergone changes over the past 60 years, the key actors and dominant institutionalized template for organizing have remained virtually the same.

**Key Actors in the Organizational Field**

The government has always played a central role in the management of the NHS (Le Grand, 1999, 2002) including mandating strategic change initiatives. But managers at the regional and organizational levels, guided by local needs and circumstances, are responsible for implementing such change. Hence, rather than provide a specific blueprint for change, NHS policies tend to offer a broad outline, allowing for local innovation during implementation (Harrison and Wood, 1999; Peckham and Exworthy, 2003).

The seven professional groups to which those who deliver services belong—physicians, including consultants who work in hospitals and general practitioners (GPs) who work in general
practices, nurses, allied health professionals\(^1\), pharmacists, health assistants, managers, and support staff such as porters and cleaners—are the most salient social groups in the NHS. Healthcare professionals, whether physicians, nurses, or allied health professionals, can fill purely clinical positions, but might also have either both clinical and managerial responsibilities or only managerial responsibilities. Those who fall into the two latter categories are said to be clinical managers.

In 2003 and 2004, the organizational field of the NHS encompassed more than 600 organizations that fell into three broad categories: administrative organizations representing 7% of the NHS organizations; primary care service providers representing 49% of the NHS organizations; and secondary care service providers representing 44% of the NHS organizations (NHS Hospital and Community Health Service non-medical workforce census, 2004). Administrative organizations are responsible for running the NHS at the regional and/or national level. All NHS professionals who provide primary care services, that is, services provided to patients when they first have a health problem, are managed by Primary Care Trusts (PCTs), local health organizations that serve large populations of 250,000 or more. General practices were required to join PCTs when the latter were created in 1998. PCTs provide primary care services and commission secondary care services from hospitals. NHS hospitals provide secondary care services, that is, acute and specialist services required to treat conditions that normally cannot be dealt with by primary care providers. Hospitals are managed by NHS Trusts that closely monitor the quality of health care and the efficiency of budgets. Figure 3 identifies the key organizational and professional actors in the organizational field of the NHS.

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**Insert Figure 3 about here**

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**The Dominant Institutional Logic of Medical Professionalism**

As observed above, in multi-professional organizational fields like the NHS, institutional logics specify desired ends as well as the appropriate model of organizations’ and professional’s role

\(^1\) Allied health professionals include art therapists, chiropodists and podiatrists, dietitians, drama therapists, music therapists, occupational therapists, orthoptists, paramedics, prosthetists and orthotists, physiotherapists, diagnostic radiographers, speech and language therapists, and therapeutic radiographers.
division to reach these ends. Following the same approach as Thornton (2002, 2004) (also see Thornton and Ocasio, 1999), I identified the ideal-type (Weber, 1904) of the dominant institutional logic in the NHS, which, consistent with other healthcare systems throughout the western world (e.g., Kitchener, 2002; Scott et al., 2000; Reay and Hinings, 2005), is the logic of medical professionalism. I determined this prevailing institutional logic through a comprehensive literature review and forty-six semi-structured interviews conducted with different categories of NHS professionals. These two sources yielded remarkably consistent descriptions of the dominant institutional logic. To cross-validate my analysis of the organizational field of the NHS, I conducted three additional interviews with academics who specialize in the NHS.

The institutional logic of medical professionalism has dominated the NHS since its inception, despite attempts by various Conservative and Labour governments to infuse new logics (Giaimo, 2002). As do most other logics in the healthcare sector, the logic of medical professionalism has as its desired end the reduction of morbidity and mortality. To that end, it prescribes a specific role division among both professionals and organizations. The model of professionals’ role division is predicated on physicians’ dominance over all other categories of healthcare professionals. Physicians have been the key decision makers controlling not only delivery of services but also, in collaboration with successive governments, the organization of the NHS (for a review, see Harrison, Hunter, Marnoch and Pollitt, 1992: 30-33). They are powerful both collectively at the national level and individually at the local level (Harrison et al., 1992). Their power stems from both the social legitimacy of their mission and their exclusive ability to apply expert knowledge to particular cases (Freidson, 1986; Abbott, 1988: 99-100). Physicians command deference from the general public as well as from most other groups of healthcare professionals. Nurses, for example, are expected to act as physicians’ assistants, and allied health professionals, termed medical auxiliaries when the NHS was created, act on physicians’ instructions (Jones, 1991). Managers not only refrain from contradicting physicians but often act in the capacity of “diplomats” to smooth internal conflicts in organizations and facilitate the physicians’ work (Harrison, 1988; Giaimo, 2002).
The logic of medical professionalism also specifies a model of organizations’ role division that places hospitals at the heart of the healthcare system. Hospitals often enjoy a monopoly position as providers of secondary care services in their health communities (Le Grand, 1999), providing most of the healthcare services and receiving most of the resources. Primary care organizations serve as gatekeepers to the secondary care sector, but primary and secondary care organizations tend to operate in isolation (Peckham and Exworthy, 2003). The emphasis in patient care on treating acute episodes of disease in the hospital setting rather than providing follow up and preventive care in the home or community setting that is under the responsibility of primary care organizations corresponds to an acute episodic health system. Table 1 presents the ideal-type of the logic of medical professionalism.

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Insert Table 1 about here
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Setting the Stage for Change

Different governments have challenged the dominant institutional logic of medical professionalism by attempting to infuse the NHS with new logics. The set of reforms implemented by the Conservative government of Margaret Thatcher, beginning in the mid-1980s with the Griffiths’ report (Griffiths, 1983) and continuing with the implementation of quasi-market reforms in the early 1990s, aimed to make healthcare services manager-driven rather than profession-led and to shift the balance of power from the secondary to the primary care sector (Klein, 1998). Similarly, the Labour government of Tony Blair tried to infuse the NHS with a new logic that promoted collaboration across both professions (Peckham and Exworthy, 2003) and sectors (Hunter, 2000; Le Grand, 2002; Peckham and Exworthy, 2003). The public authorities’ objective was to operate a shift from an acute episodic healthcare system to a system that would provide continuing care by integrating services and increasing cooperation among categories of professionals.

Despite these change attempts, however, a distinct dominance order that finds physicians (Harrison, 1988; Harrison et al., 1992; Crilly, 2000; Ferlie, Fitzgerald, Wood and Hawkins, 2005) and hospitals (Peckham and Exworthy, 2003) operating at the apex continues to prevail, suggesting that the NHS remains a relatively institutionalized organizational field. But the attempts begun in mid-1980s to challenge the dominant institutional logic have set the stage for change by introducing
heterogeneity in the NHS (Sewell, 1992; Whittington, 1992; Clemens and Cook, 1999; D’Aunno, Succi and Alexander, 2000; Seo and Creed, 2002; Dorado, 2005; Lounsbury, 2007).

The practices proposed as alternatives to the logic of medical professionalism, although they have not been institutionalized, have introduced some variance across existing practices in the field, thereby sowing the seeds of change. Yet the vast majority of actors in the NHS continue to take for granted the model of medical professionalism. Very likely, given that they are embedded in the same organizational field, factors other than organizational field characteristics such as social position are responsible for enabling some actors to initiate divergent organizational change. This study examines how individual actors’ position both within the organizational field of the NHS and within their organization influences their likelihood to initiate two different types of divergent organizational changes, namely changes that diverge from the institutionalized model of organizations’ role division and changes that diverge from the institutionalized model of professionals’ role division in the NHS.

METHOD

Participants

Participants were 93 clinical managers (i.e., actors with both clinical and managerial responsibilities) from the NHS who had attended a strategic leadership executive education program between January 2003 and May 2004. Participation in the executive education program was entirely voluntary. As part of the program, which was focused on leading change, participants were required to design and implement a change project within their organization. Participants were completely free to choose the type of change project that they wanted to implement, and no reference was made to “divergent” (or “radical”) organizational change in the program presentation. Hence, although the program undoubtedly attracted participants with an interest in change, participants were neither selected nor did they self-select into the program on the basis of their interest in engaging in divergent organizational change per se.

Participation in the present study was voluntary, but all 95 of the program attendees agreed to participate. The final sample of 93 observations, corresponding to 93 change projects, reflects the omission of two participants for whom data were incomplete. Participants ranged in age from 34 to 56.
years, with an average age of 43. Seventy one (i.e., 76%) were women; 22 (i.e., 24%) were men. All had clinical backgrounds (24% were physicians, 28% were allied health professionals, and 48% were nurses\(^2\)) as well as managerial responsibilities, the level of responsibility varying from mid- to top-level management. The participants also represented a variety of NHS organizations (44% worked within PCTs, 45% worked in hospitals or other secondary care organizations, and 11% worked in NHS administrative units).

**Data Collection**

Data collection focused on the characteristics of the participant-change agents and characteristics of their change projects. Data on the former were obtained from their curriculum vitae. I collected data on the latter at two different points in the design and implementation of the change projects. I had access to both a comprehensive description of each participant’s intended change project submitted prior to attending the executive education program, and to their project descriptions refined after three months of implementation. Project implementation started when the participants returned to their organizations immediately following the executive education program.

**Dependent Variables**

The primary dependent variable in this study is the degree to which participants’ change projects diverged from the NHS’s institutional logic of medical professionalism on two dimensions: the institutionalized division of organizational roles, in which hospitals have traditionally dominated, and the institutionalized division of professional roles, in which physicians have traditionally dominated. Following Cliff et al. (2006), I developed a questionnaire intended to create a rank-ordered categorical measure of the change projects’ degree of divergence on each of these two dimensions thereby constructing two dependent variables. Four items in the questionnaire (scale 1) captured the degree to which change projects diverged from the institutionalized model of

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\(^2\) In 2003 and 2004, women represented approximately 74% of the NHS workforce. If we consider only the population of healthcare professionals instead of the entire NHS workforce, the breakdown between men and women was the same. During the same period, physicians represented approximately 21 percent, nurses 54 percent and allied health professionals 25 percent of the population of healthcare professionals (NHS Staff 1995-2005, 2005). Hence, the sample used in this study was, by and large, representative of the NHS.
professionals’ role division ((1) To what extent does the project aim to increase nurses'/allied health professionals'/managers’ decision making power in the clinical domain?, (2) To what extent does the project aim to increase nurses'/allied health professionals'/managers’ decision making power in the administrative domain?, (3) To what extent does the project aim to decrease doctors’ decision making power in the clinical domain?, and (4) To what extent does the project aim to decrease doctors’ decision making power in the administrative domain?).

Six additional items in the questionnaire (scale 2) assessed the degree to which change projects diverged from the institutionalized model of organizations’ role division ((1) To what extent does the project aim to increase the influence of the primary care sector in the clinical domain?, (2) To what extent does the project aim to increase the influence of the primary care sector in the administrative domain?, (3) To what extent does the project aim to decrease the influence of the secondary care sector in the clinical domain?, (4) To what extent does the project aim to decrease the influence of the secondary care sector in the administrative domain?, (5) To what extent does the project aim to improve cooperation across organizations (especially across primary, secondary and social care organizations)?, (6) To what extent does the project aim to promote continuous care through integration of services?). Each of the ten items in the questionnaire was assessed using a three-point rank ordered scale that ranged from 1 (no extent) to 2 (some extent) to 3 (great extent).

I developed instructions (see Appendix 1) for coding the change projects using this 10-item questionnaire. I and two independent coders blind to the study’s hypotheses, coded the change project descriptions participants wrote after three months of project implementation. These descriptions averaged three pages in length and followed the same template: presentation of the project goals, resources required to implement the project, people involved, key success factors, and measurement of the outcomes. Inter-rater reliability, as assessed by the kappa correlation coefficient, was 0.90, suggesting a high degree of agreement among the three raters (Landis and Koch, 1977; Fleiss, 1981). To resolve coding discrepancies, we noted passages in the change project descriptions deemed relevant to the codes and discussed them until we reached consensus (Larsson, 1993).

I ran a confirmatory factor analysis on the results of the coding to assess the validity of scales 1 and 2. For scale 1, which measured degree of divergence of the change projects from the
institutionalized model of professionals’ role division, the confirmatory factor analysis had a GFI of .98, suggesting that a single factor represented this scale very well. This scale also exhibited an acceptable reliability value (Cronbach alpha of .79). For scale 2, which measured degree of divergence of the change projects from the institutionalized model of organizations’ role division, the GFI was .80, representing a lower fit compared to scale 1. Further investigation (results not presented here) revealed this to be due mainly to the variables corresponding to the last two items in scale 2 (i.e., To what extent does the project aim to improve cooperation across organizations? and To what extent does the project aim to promote continuous care through integration of services?) having a strong, but relatively weaker, relationship with the factor than the other four variables. However, Cronbach's alpha for the 6-item scale was very high (.91), increasing my confidence in using all six variables for scale 2. The low level of correlation (.106) between scales 1 and 2 suggests that they should be treated as two distinct dependent variables. All change projects were assigned a score on each of the two scales ranging from 1 (no extent) to 3 (great extent) and corresponding to the average of the items included in each scale.

A project aimed at transferring stroke rehabilitation services, like language retraining, from a hospital-based unit to a PCT (i.e., from the secondary to the primary care sector) is an example of a project that diverges from the institutionalized model of organizations’ role division to a great extent. Prior to the change, people experiencing strokes were stabilized and rehabilitated in the hospital, thus incurring long stays and tying up resources more appropriate for the acute treatment phase. The service transfer involved both physical relocation of patients to a unit operated by the PCT and transfer of responsibility for the rehabilitative services to PCT staff. The transfer of both resources and responsibility for service delivery from the secondary to the primary care sector thereby greatly diverged from the institutionalized model of organizations’ role division.

A project aimed at developing a day-hospital for the frail elderly that would involve both primary and secondary care service providers is an example of a project that diverges from the institutionalized model of organizations’ role division to some extent. The day-hospital served people too ill to be cared for at home but not sick enough to justify full admission to the hospital. Patients who checked into the hospital-operated day-unit for a few hours received services from both primary
and secondary care professionals. Although primary care service providers were engaged in the provision of services formerly provided only by secondary care service providers, which involved increased collaboration between primary and secondary care service providers, the project diverged from the institutionalized model of organizations’ role division only to some extent because the new service was still operated by the hospital.

A project aimed at transferring a ward that specialized in the treatment of the elderly from a PCT to an hospital is an example of a project that does not diverge from the institutionalized model of organizations’ role division. Prior to the change, both the PCT and hospital provided services for the elderly, the bulk of patients receiving care in the hospital setting. Transferring responsibility for all elderly care services to the hospital extended the institutionalized delivery model, thereby reinforcing the hospital’s dominance over the PCT.

Projects aimed at developing nurse-led preadmission clinics or nurse-led discharge, which transferred both clinical tasks and decision making authority from physicians to nurses, are examples of change projects that diverge from the institutionalized model of professionals’ role division to a great extent. In these projects nurses’ expanded scope of practice involved more responsibility, accountability and risk for their clinical decisions. In contrast, the physicians ceded control over some aspects of clinical decision-making, thus freeing them to focus on more complex patients and tasks.

A project aimed at delegating ultrasound examinations from physicians to nurses, without expanding nurses’ authority to participate in subsequent decisions regarding patients’ treatment, is an example of a project that diverges from the institutionalized model of professionals’ role division to some extent. Although this project aimed at enabling nurses to perform medical examinations that they usually did not perform, it diverged from the institutionalized model of professionals’ role division only to some extent, because nurses gained no decision-making power in either the clinical or administrative domain.

Finally, a project aimed at hiring an administrative assistant to implement and manage a computerized appointment booking system in a general practice is an example of a project that does not diverge from the institutionalized model of professionals’ role division. The addition of this
assistant to the workforce did not change the balance of power between professionals within the general practice.

**Independent Variables**

**Organization status.** Of the three types of organizations that compose the NHS, PCTs were considered to be lower status organizations than hospitals and administrative units (Peckham and Exworthy, 2003). Their role of commissioners of secondary care services in the NHS notwithstanding, PCTs were newer organizations and they still depended on both hospitals and administrative organizations. Healthcare professionals working in the primary care sector were still very often perceived to be gatekeepers, as if their only function were to regulate access to secondary care services. Even if they were the new budget holders, PCTs also remained dependent on administrative organizations for budget allocation. Although both hospitals and administrative units were higher status organizations than PCTs, there was no clear status hierarchy between the hospitals and administrative organizations that collaboratively ran the NHS (Peckham and Exworthy, 2003). Accordingly, I measured organizations’ status with a dummy variable coded 1 for low status organizations (i.e., PCTs) and 0 for high status organizations (i.e., hospitals and administrative organizations).

**Social group status.** Two social group statuses were represented: physicians, who are of higher status, and other healthcare professionals (i.e., nurses and allied health professionals), who were of lower status. As noted earlier, professional groups are the most salient social groups in the NHS. Ferlie et al. (2005) observed strong boundaries between the different professional groups, which have been educated and socialized in different ways. In the NHS, as in most healthcare systems, physicians benefit from a higher status position relative to other healthcare professionals (Harrison et al., 1992). Accordingly, professional groups’ status was measured with a dummy variable coded 1 for low status professionals (i.e., nurses and allied health professionals) and 0 for high status professionals (i.e., physicians).

**Hierarchical position.** I measured actors’ hierarchical position by means of a rank-ordered categorical variable. Positions ranged from middle to top-level managers, ranked from low to high as follows: 1=deputy head/assistant director, 2=head of service; 3=non executive director; 4=executive
director with a seat on the organization’s board. As a government-run set of organizations, the NHS has standardized definitions and pay scales for all positions, insuring that participants’ roles, responsibilities and hierarchical positions were uniform across organizational sites.

Control Variables

Because clinical managers in my sample might have initiated divergent organizational changes for reasons other than their social position, in particular, as a consequence of the extent and diversity of their managerial experience, I controlled for the impact of three career specific variables, namely, tenure in management positions, tenure in the current formal position, and level of inter-organizational mobility.

Tenure in management positions. Tenure in management positions was measured straightforwardly as the number of years spent in management positions. Management experience is likely to make an actor more comfortable initiating change, especially divergent organizational change that breaks with practices widely accepted and used not only within a given organization, but throughout a field. Actors with longer tenure in management positions might be more confident of their ability to implement divergent organizational changes and thereby more likely to do so.

Tenure in current position. Tenure in their current position was measured, again straightforwardly, as the number of years spent in the current position. Actors who would convince other organizational members to abandon practices widely accepted and used not only in their organization but throughout the organizational field must have legitimacy in the eyes of those other organizational members. They also need in-depth knowledge of their organization in order to overcome the obstacles likely to be encountered during the implementation of divergent organizational change. Actors with longer tenure in their current position usually command greater legitimacy in the eyes of both subordinates and superiors, and tend to be highly knowledgeable about the specificities of their organization (Huber, Sutcliffe, Miller and Glick, 1993). Longer tenure in their current position is thus likely to be positively related to actors’ ability to, and therefore the likelihood that they will, initiate divergent organizational change.

Inter-organizational mobility. Research suggests that degree of inter-organizational mobility might be an important predictor of who initiates divergent organizational change (Kraatz and Moore,
Actors’ with higher levels of inter-organizational mobility, having been exposed to greater numbers of different organizational contexts, are less likely to take for granted the functioning of their current organizations and more likely to be aware of existing opportunities for action in their organizational field. They are more likely, for instance, to be aware of the existence of heterogeneous institutional arrangements across their organizational field. To the extent that such awareness is likely to trigger their reflective capacity (Emirbayer and Mische, 1998; Seo and Creed, 2002; Sewell, 1992) and thereby enable them to take some critical distance with the existing institutional arrangements, they will be more likely to initiate divergent organizational change. I measured inter-organizational mobility as the number of different NHS organizations in which they worked during the course of their career.

**Data Analysis**

My dependent variables being categorical and rank-ordered, I used ordered logit estimations in all models. But because a non-trivial number of my observations (24 of 93) were clustered in the same organizations\(^3\), and hence might not be independent within groups, baseline ordered logit estimates might be biased. I therefore adjusted these estimations by clustering data with repeated observations of organizations in order to obtain robust variance estimates that adjust for within-cluster correlation (Williams, 2000). I report heteroskedasticity-adjusted (i.e., robust) standard errors for all models.

**RESULTS**

I report below results associated with the two dependent variables, that is, the degree of divergence from the institutionalized model of organizations’ role division and the degree of divergence from the institutionalized model of social groups’ role division. Table 2 reports means, standard deviations, and correlations. There are no critically collinear variables, that is, greater than .8 in absolute value (Kennedy, 2003) in my data set.

\[^3\] Sixty-nine organizations are represented once in our sample, 9 organizations twice, and 2 organization three times.
Diverging from the Institutionalized Model of Organizations’ Role Division

Table 3 reports results from three ordered logit regressions predicting actors’ likelihood to initiate a change that diverges from the institutionalized model of organizations’ role division. In column 1 are results from a model with only the control variables (tenure in management positions, tenure in current position, and interorganizational mobility). Column 2 shows results from a model with control variables and the main effect variables that correspond to the status of the organization to which actors belong (low status organization) and their position in the hierarchy of this organization (hierarchical position). In column 3 are results from a model with control variables and all the above cited main effect variables plus the interaction term (organization status x hierarchical position). The contribution of one or more variables was assessed with the likelihood ratio test, which compares the goodness of fit of a pair of nested models distinguished by one or a set of variables (Bishop, Fienberg and Holland, 1975).

The results supported H1a, which states that actors who belong to low status organizations within a given organizational field are more likely than other actors to initiate changes that diverge from the institutionalized model of organizations’ role division (see column 2). H2a, which states that actors higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of organizations’ role division, was not supported. Although the relationship between actors’ hierarchical position and the likelihood that they will initiate changes that diverge from the institutionalized model of organizations’ role division was significant, it was in the opposite direction to the one hypothesized (see column 2). H3a, which states that actors who belong to low status organizations and are higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of organizations’ role division, was not supported (see column 3).

As expected, there was a positive and significant relationship between inter-organizational mobility and the likelihood that actors will initiate divergent organizational change that diverges from the institutionalized model of organizations’ role division (see columns 1, 2 and 3). Neither tenure in management positions nor tenure in current position was significantly related to the likelihood that
actors will initiate organizational change diverging from the institutionalized model of organizations’ role division (see columns 1, 2 and 3).

Diverging from the Institutionalized Model of Social Groups’ Role Division

The columns in table 4 correspond to the same models presented in table 3, save that the dependent variable is the degree of divergence of change projects from the institutionalized model of social groups’ role division and the first independent variable corresponds to the status of the social group to which actors belong (low status social group). H1b, which states that actors who belong to low status social groups within a given organizational field are more likely than other actors to initiate changes that diverge from the institutionalized model of social groups’ role division, was supported (see column 2). The results also supported H2b, which states that actors higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of social groups’ role division (see column 2).

Although the interaction effect of the status of the social group and hierarchical position of the actors on the likelihood that the latter will break with social groups’ role division was statistically significant (see column 3), the sign of the coefficient indicated that the effect was counter to the one hypothesized in H3b, which states that actors who belong to low status social groups and are higher in the hierarchy of their organization are more likely than other actors to initiate changes that diverge from the institutionalized model of social groups’ role division. In fact, there was a negative relationship between the likelihood that actors will break with social groups’ role division and the interaction term between the status of the social group to which actors belong and their hierarchical position.

Tenure in management positions had the expected positive and significant impact on the likelihood that actors will initiate changes that break with the institutionalized model of social groups’ role division (see columns 1, 2 and 3). Tenure in the current position being only borderline insignificant at the 10% level (see columns 1, 2 and 3), we can speculate that managers with longer tenure in their positions were more likely to initiate changes that diverged from the institutionalized

23
model of social groups’ role division. Finally, there was no statistically significant relationship between inter-organizational mobility and the likelihood that actors will initiate changes diverging from the institutionalized model of professionals’ role division.

Robustness checks

In supplemental regression models (not reported here), I included as additional control variables gender, age, educational background, and organizational budget. These variables (whether added separately or together) were not significant in any model and did not affect the sign or significance of any variables of interest. Finally, I examined both the relationship between the status of the organization to which actors belonged and their likelihood to initiate changes that diverged from the institutionalized model of social groups’ role division and the relationship between the status of the social group to which actors belonged and their likelihood to initiate changes that diverged from the institutionalized model of organizations’ role division. None of these relationships was significant, which strengthens the finding that different positional characteristics influence the likelihood that actors will initiate one or the other of the two types of divergent organizational change.

DISCUSSION

This study demonstrated that there are different types of divergent organizational change and that their social position influences the type of divergent organizational change individual actors are likely to undertake. As expected, actors disadvantaged by certain institutional arrangements, that is, actors who were at their periphery (Shils, 1975) of those arrangements, were more likely to initiate change that diverged from those arrangements. The results also showed that actors’ position in the organizational field was not the only factor that influenced their likelihood to initiate the different types of divergent organizational change, but that their position in the hierarchy of their organization also influenced their likelihood to initiate the different types of divergent change.
Social Position and Divergent Organizational Change

As expected, actors who belonged to low status organizations were more likely to initiate change that broke with the institutionalized model of organizations’ role division and actors who belonged to low status social groups were more likely to initiate change that broke with the institutionalized model of social groups’ role division. These results are consistent with results of studies conducted at the organizational level of analysis that showed that organizations disadvantaged by existing institutional arrangements are more likely to initiate divergent organizational change (e.g., Leblebici et al., 1991; Kraatz and Zajac, 1996; D’Aunno et al., 2000). More important, these results clearly show there to be at least two different categories of institutional arrangements: those that have to do with organizations’ role division, and those that have to do with social groups’ role division. Actors might be advantaged by one and disadvantaged by another category of institutional arrangements. As expected, actors might thus, depending on their position in the organizational field, initiate one type of divergent organizational change but not the other.

It is further clear that their position in the hierarchy of their organization also influences the likelihood that actors will initiate divergent organizational change. The results show the influence of actors’ hierarchical position to differ depending on the dimension on which actors break with the dominant institutional logic in the organizational field. As expected, the higher they were in the hierarchy of their organization, the more likely participants were to initiate change that diverged from the institutionalized model of social groups’ role division, but, contrary to what I hypothesized, the less likely they were to initiate change that diverged from the institutionalized model of organizations’ role division.

This radically different relationship between actors’ hierarchical position and likelihood to initiate the two types of divergent organizational change might reflect the fact that one type, namely, change in social groups’ role division, relates mainly to change that is internal to an organization, whereas the other type, namely, change in organizations’ role division, relates to change that is also external to an organization. As expected, because they have the legitimacy and access to resources that other organizational members might lack (Tushman and Romanelli, 1985), actors higher in the hierarchy of their organization are more able, and consequently more likely, to initiate divergent
organizational change within their organization, including change that diverges from the institutionalized model of social groups’ role division. But actors higher in the hierarchy of their organization might also be more likely to conform to inter-organizational rules of interaction in a field and therefore be less likely to initiate divergent organizational change that diverges from the institutionalized model of organizations’ role division.

Actors’ position in the hierarchy of their organization also, again as expected, moderated the relationship between the status of the social group to which they belonged and their likelihood to initiate change that diverged from the institutionalized model of social groups’ role division. Findings related to the interaction term between the social group to which actors belonged and their position in the hierarchy of their organization, however, suggest that, contrary to what I hypothesized, actors who had made it to the top of the hierarchy of their organization and who belonged to low status social groups were relatively less likely to initiate changes that diverged from the institutionalized model of social groups’ role division. These results are consistent with studies of women and ethnic minorities in the workplace, which show that members of these groups become relatively less likely to assist in-group members when they themselves make it to the top of the hierarchy of their organization. Women who have made it to the top of the organizational hierarchy sometimes display the so-called “queen bee” syndrome (Kanter, 1977a, 1977b; Cohen, Broshak and Haveman, 1998) whereby they perceive the inclusion of other women to be a threat to their special status. In the same vein, Smith (2005), studying the conditions that enable black, urban, poor job seekers to mobilize their network of relations for job-finding assistance, observed that job contacts within this community often express great reluctance to assist their job-seeking ties. The findings of the present study are similar to those reported above in that they suggest that actors who belong to low status social groups but are currently high in the organizational hierarchy are more reluctant to promote other actors who belong to low status social groups.

There are several possible explanations for such behavior. It might be that having made it to “the top,” managers belonging to low status social groups adopt a highly individualistic approach: that having achieved their personal objective, they feel it is no longer necessary to fight. They might also perceive others who still belong to low status social groups to be a potential threat, an explanation
equivalent to the “queen bee” syndrome explanation related above. Another possibility is that as they rise higher in the organizational hierarchy, actors might identify more with their organization and less with their social group. Finally, it might be that actors seeking to be regarded as legitimate members of the group of top managers attempt to forget, and have others forget, their initial low status social group membership. This type of behavior is a way for them to demonstrate loyalty to the group of top managers and distance themselves from their former group members (Dittes and Kelley, 1956).

Contributions

This study makes two contributions to the literature on change in organizations. First, it broadens that literature by accounting for the influence on change initiatives of the wider institutional context. While some studies about change in organizations (e.g., Armenakis, Harris and Mossholder, 1993; Cunningham, Woodward, Shannon, MacIntosh, Lendrum, Rosenbloom and Brown, 2002) account for the influence of the organizational context as well as individual actors’ characteristics on their likelihood to implement change, most of these studies ignore the constraining role of institutional pressures stemming from the wider organizational field, as well as the influence that organizational change initiatives may have on this wider context. Second, and more important, the findings suggest that there are likely multiple dimensions on which a change project might break with the dominant institutional logic within organizational fields. Studies conducted thus far about divergent organizational change do not distinguish among dimensions on which such change diverges from the dominant institutional logic (e.g., Greenwood and Hinings, 1996; D’Aunno et al., 2000; Amis, Slack and Hinings, 2004; Battilana, 2006). The results presented here show there to be at least two different types of divergent organizational change characterized by different predictors with respect to actors’ positional characteristics.

This study also contributes to the literature on institutional change. First, it demonstrates that there are different categories of institutional arrangements. Further, the results show that the widely held belief that divergent organizational change emerges at the periphery of fields might be misleading. Actors at the periphery of a category of institutional arrangements might be more likely to diverge from these arrangements but not to diverge from another category of institutional arrangements, suggesting that the center versus periphery imagery (Shils, 1975) should be used
carefully, as actors might be at the periphery of certain institutional arrangements and at the center of others. The findings also suggest that actors’ position at the center versus the periphery of different categories of institutional arrangements is not the only positional characteristic that influences the likelihood that they will initiate divergent organizational change but that their position in the hierarchy of their organization has an important influence as well.

Second, the present research complements the work of researchers who have already identified field-level and organizational-level conditions that enable divergent organizational change (Dacin, Goldstein and Scott, 2002; Strang and Sine, 2002) by empirically testing the influence of individual actors’ social position on the likelihood that they will initiate such change. In doing so it helps to resolve the paradox of embedded human agency (Holm, 1995; Seo and Creed, 2002), which alludes to the tension between human agency and institutional determinism. Resolving this paradox is crucial, as it is a prerequisite for establishing the foundation for a theory of action within the framework of institutional theory. Many (e.g., DiMaggio and Powell, 1991; Zucker, 1991; Hirsch and Lounsbury, 1997) have called for the development of such a theory of action. This paper contributes to the micro-foundation needed to support the development of such a theory by empirically showing that individual actors’ social position might be an enabling condition for diverging from different categories of institutional arrangements despite institutional pressures towards stasis.

Third, the focus on individual actors’ social position contributes to the development of institutional theory by linking the individual level of analysis back to the organization and organizational field levels. Institutional change processes are complex processes in which different types of forces and agents are involved (Jepperson, 1991). Individual change agents’ actions, which have so far received scant attention (Reay, Golden-Biddle and Germann, 2006), are one type of force that might affect the institutional order. This study contributes to the continuing awareness of the importance of human agents and paves the way for multi-level research that takes into account the individual, organizational, and organizational field levels of analysis suggested as a promising avenue of research within the framework of institutional theory (Friedland and Alford, 1991; Ocasio, 2002; Palmer and Biggart, 2002; Strang and Sine, 2002; Reay et al., 2006), and, more broadly, in the field of organizational studies (e.g., Rousseau, 1985).
Limitations and Directions for Future Research

This study has a number of limitations that suggest directions for future research. First and foremost, the analysis must be considered exploratory given the small, non-probability sample of managers in the NHS. I cannot fully discount the possibility of sampling bias, as the study group consisted of self-selected individuals who applied, and were then all selected, for advanced leadership training. Although they were neither selected nor self-selected into the program for their interest in engaging in divergent organizational change per se, the participants had some interest in change, which might be correlated with a stronger inclination to initiate divergent organizational change. The majority of the participants, however, ended up initiating changes that were not divergent on either of the two dimensions.

Because the analysis was limited to a non-probability sample of change projects initiated by clinical managers in the NHS, one also cannot be assured that it is representative of any particular population of organizational leaders. The setting, the NHS, is a large, public sector organization that was undergoing changes during the study period. Although this makes the NHS an ideal setting for this study, it also raises questions about the generalizability of the results to other contexts (e.g., the private sector or more stable industries). To address this concern will require comparisons across contexts and probabilistic samples to better account for the potential interactive effects of actors’ social position and contextual factors on actors’ likelihood to initiate different types of divergent organizational change.

Depending on the context, it might also make sense to distinguish between not just two social statuses, i.e., low and high, but between three, i.e., low, middle and high (Phillips and Zuckerman, 2001). In the context of the NHS, there is a clear dichotomy between non-doctors, who are the lower status professionals and doctors, who are the higher status professionals (Harrison, 1988; Harrison et al., 1992; Crilly, 2000; Ferlie, Fitzgerald, Wood and Hawkins, 2005) as well as between PCTs, which are the lower status organizations and other organizations (hospitals and administrative organizations), which are the higher status organizations (Peckham and Exworthy, 2001). It would be interesting to see, in contexts in which one can distinguish between low, middle, and high status social actors, how findings related to the influence of social position on the likelihood of actors to initiate...
different types of divergent organizational change might vary.

The impact of other positional characteristics such as actors’ position in informal organizational networks and in multiple organizational fields might also be a fruitful area of exploration. For example, their position in intra-organizational networks might enable actors who belong to low status social groups to undermine resistance to divergent organizational change on the part of actors who belong to high status social groups. Some studies (e.g., Sewell, 1992; Schneiberg, 2002; Boxembaum and Battilana, 2005) have already highlighted the enabling role of embeddedness in multiple fields in fostering divergent organizational change. But a number of questions remain to be answered regarding the impact of actors’ multiple embeddedness. In particular, is the likelihood of individuals to initiate different types of divergent organizational change dependent on the degree of similarity of the different categories of institutional arrangements that characterize the organizational fields in which they are embedded?

Future research should explore as well other individual factors that might enable different types of divergent organizational change, individual psychological factors, for example. Leaders might have unobserved attributes that predispose them to initiating different types of divergent organizational change. This line of inquiry, although promising, is highly demanding because it requires researchers to control for the impact of other identified enabling conditions including field-level and organizational-level conditions. One way to avoid this trap is to examine the role of psychological factors in relation to actors’ social position, which accounts for the interaction between the individual, organizational and organizational field levels of analysis (Rousseau, 1978, Emirbayer, 1997).

Finally, this study paves the way for more research on divergent organizational change. It would be helpful, for example, to know more about the strategies managers use to implement the different types of divergent organizational changes and to examine the corresponding outcomes. What are the factors for success when implementing divergent organizational change? Answers to this question are likely to vary depending on the context in which change occurs and on the type of divergent organizational change that is implemented. While this study represents a first step towards accounting for the different types of divergent organizational change, it would be interesting to inquire into other types. Changes might diverge from the appropriate means specified by the dominant
institutional logic, i.e., the institutionalized model of organizations and/or social groups’ role division, but also from the desired ends specified by this logic. Breaking with the ends that characterize a dominant institutional logic might actually be more challenging than breaking only with the means because ends reflect the core system of values and references in a field (Pache, 2007). There is a need for comparative studies across types of divergent organizational change, including changes that diverge from the dominant institutional logic on multiple dimensions.

CONCLUSION

This study demonstrates that there are different types of divergent organizational change that tend to be undertaken by actors with different profiles in terms of social position. Although the findings lend partial support to the widely held belief that organizational change that diverges from the existing institutions in a field is more likely to emerge at the periphery of the field, they also suggest limits to this belief. Depending on the institutional arrangements that are considered, individual actors might be at the center or at the periphery of these institutional arrangements, and consequently likely to initiate one type of divergent organizational change but not another. The results further suggest that the likelihood that actors will initiate different types of divergent organizational change is influenced by their position not only at the center versus the periphery of the different institutional arrangements, but also in the hierarchy of their organization.

To identify the locus of divergent organizational change, it is thus necessary to take into account individual actors’ position both in the organizational field and in their organization and to distinguish between the different types of divergent organizational change. By distinguishing between two types of divergent organizational change, this study has paved the way for research that will account for differences across types of divergent organizational changes.
REFERENCES


Management Journal, 45(1) 120-143.


Figure 1: Characterization of logics

MEANS

Organizations’ role division
• Organizations’ roles
• Rules of interaction among organizations

Social groups’ role division
• Social groups’ roles
• Rules of interaction among social groups

Figure 2: Individual actor’s social position
Figure 3: Key organizational and professional actors of the NHS
Table 1: Ideal-type of the logic of medical professionalism

<table>
<thead>
<tr>
<th>Medical Professionalism Logic</th>
<th>END</th>
<th>MEANS</th>
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<tbody>
<tr>
<td>Professionals' role division</td>
<td>Reduce morbidity and mortality</td>
<td></td>
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<tr>
<td>Professionals’ role</td>
<td>Physicians as key decision makers in the clinical and administrative domains</td>
<td></td>
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<td></td>
<td>Nurses as physicians' assistants</td>
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<td></td>
<td>Allied health professionals as medical auxiliaries</td>
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<td></td>
<td>Managers (administrators) as ‘diplomats' facilitating the work of physicians</td>
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<tr>
<td>Rules of interaction among professionals</td>
<td>Physicians hold authority over all other NHS professionals in the clinical and in the administrative domains</td>
<td></td>
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<tr>
<td>Organizations' role division</td>
<td>Hospitals as both commissioners and providers of secondary care services</td>
<td></td>
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<tr>
<td>Organizations’ role</td>
<td>Administrative organizations responsible for planning and budget allocation</td>
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<td></td>
<td>General practices as gatekeepers to the secondary care sector</td>
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<tr>
<td>Rules of interaction among organizations</td>
<td>Hospitals hold authority over most other NHS organizations</td>
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Table 2: Summary statistics and bivariate correlations

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<tbody>
<tr>
<td>[1] Degree of divergence from the institutionalized model of organizations’ role division</td>
<td>1.387</td>
<td>0.520</td>
<td>1.000</td>
<td>2.833</td>
<td>1.000</td>
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<td>[2] Degree of divergence from the institutionalized model of social groups’ role division</td>
<td>1.449</td>
<td>0.509</td>
<td>1.000</td>
<td>2.500</td>
<td>0.106</td>
<td>1.000</td>
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<td>[3] Tenure in management positions</td>
<td>11.624</td>
<td>4.917</td>
<td>2.000</td>
<td>26.000</td>
<td>-0.009</td>
<td>0.237</td>
<td>1.000</td>
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<td>[4] Duration of tenure in current position</td>
<td>2.677</td>
<td>2.102</td>
<td>0.000</td>
<td>11.000</td>
<td>-0.142</td>
<td>0.101</td>
<td>0.032</td>
<td>1.000</td>
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<td>[5] Interorganizational mobility</td>
<td>4.796</td>
<td>2.577</td>
<td>1.000</td>
<td>14.000</td>
<td>0.152</td>
<td>0.046</td>
<td>-0.055</td>
<td>-0.137</td>
<td>1.000</td>
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<td>[6] Low status organization</td>
<td>0.441</td>
<td>0.499</td>
<td>0.000</td>
<td>1.000</td>
<td>0.313</td>
<td>0.025</td>
<td>-0.171</td>
<td>-0.143</td>
<td>-0.014</td>
<td>1.000</td>
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<td>[7] Low status social group</td>
<td>0.763</td>
<td>0.427</td>
<td>0.000</td>
<td>1.000</td>
<td>0.009</td>
<td>0.169</td>
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<td>-0.104</td>
<td>-0.117</td>
<td>1.000</td>
<td></td>
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<tr>
<td>[8] Hierarchical position</td>
<td>3.022</td>
<td>1.000</td>
<td>1.000</td>
<td>4.000</td>
<td>-0.020</td>
<td>0.125</td>
<td>-0.215</td>
<td>-0.064</td>
<td>0.331</td>
<td>0.046</td>
<td>-0.344</td>
<td>1.000</td>
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N=93
Table 3: Ordered logit coefficients predicting likelihood of actors to initiate a change that diverges from the institutionalized model of organizations’ role division

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
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<tbody>
<tr>
<td>Tenure in management positions</td>
<td>0.007</td>
<td>0.020</td>
<td>0.038</td>
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<tr>
<td></td>
<td>(0.037)</td>
<td>(0.041)</td>
<td>(0.043)</td>
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<tr>
<td>Tenure in current position</td>
<td>-0.070</td>
<td>-0.046</td>
<td>-0.050</td>
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<tr>
<td></td>
<td>(0.072)</td>
<td>(0.074)</td>
<td>(0.073)</td>
</tr>
<tr>
<td>Inter-organizational mobility</td>
<td>0.134 **</td>
<td>0.168 ***</td>
<td>0.169 ***</td>
</tr>
<tr>
<td></td>
<td>(0.065)</td>
<td>(0.064)</td>
<td>(0.063)</td>
</tr>
<tr>
<td>Low status organization</td>
<td>1.155 ***</td>
<td>0.751</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.443)</td>
<td>(1.433)</td>
<td></td>
</tr>
<tr>
<td>Hierarchical position</td>
<td>-0.259 *</td>
<td>-0.301 **</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.190)</td>
<td>(0.180)</td>
<td></td>
</tr>
<tr>
<td>Hierarchical position x Low status organization</td>
<td></td>
<td>0.134</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0.454)</td>
<td></td>
</tr>
</tbody>
</table>

Log pseudolikelihood       | -170.80 | -166.02 | -165.97 |
Wald chi-squared            | 6.42 *  | 17.32 ***| 18.11 ***|
Δ LR-test                   | 9.57 ***| 9.67 **  |

N=93; Robust standard errors in parentheses
* significant at 10%; ** significant at 5%; *** significant at 1%
Statistical significance based on one-tailed tests for all independent variables and interaction terms
Δ LR-test based on comparison with model (1)
Table 4: Ordered logit coefficients predicting likelihood of actors to initiate a change that diverges from the institutionalized model of social groups’ role division

<table>
<thead>
<tr>
<th></th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenure in management positions</td>
<td>0.083 ***</td>
<td>0.079 **</td>
<td>0.071 *</td>
</tr>
<tr>
<td></td>
<td>(0.032)</td>
<td>(0.039)</td>
<td>(0.040)</td>
</tr>
<tr>
<td>Tenure in current position</td>
<td>0.064</td>
<td>0.092</td>
<td>0.118</td>
</tr>
<tr>
<td></td>
<td>(0.072)</td>
<td>(0.075)</td>
<td>(0.084)</td>
</tr>
<tr>
<td>Inter-organizational mobility</td>
<td>0.043</td>
<td>-0.026</td>
<td>-0.005</td>
</tr>
<tr>
<td></td>
<td>(0.063)</td>
<td>(0.077)</td>
<td>(0.081)</td>
</tr>
<tr>
<td>Low status social group</td>
<td>0.739 *</td>
<td>7.738 **</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.557)</td>
<td>(4.654)</td>
<td></td>
</tr>
<tr>
<td>Hierarchical position</td>
<td>0.530 **</td>
<td>2.291 **</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(0.234)</td>
<td>(1.171)</td>
<td></td>
</tr>
<tr>
<td>Hierarchical position x</td>
<td></td>
<td></td>
<td>-1.871 *</td>
</tr>
<tr>
<td>Low status social group</td>
<td></td>
<td></td>
<td>(1.227)</td>
</tr>
</tbody>
</table>

Log pseudolikelihood          -145.93   -143.01   -141.56
Wald chi-squared               10.08 **  12.73 **  19.21 ***
Δ LR-test                      5.84 *    8.74 **

N=93; Robust standard errors in parentheses
* significant at 10%; ** significant at 5%; *** significant at 1%
Statistical significance based on one-tailed tests for all independent variables and interaction terms
Δ LR-test based on comparison with model (1)
APPENDIX 1
CODING INSTRUCTIONS FOR THE RATERS

All the project descriptions that you will read display the same structure. They fall into 6 parts:
(1) Brief description of the change project
(2) Goals and objectives of the change project
(3) Required resources to implement the change project
(4) Measurement of the outcomes of the change project
(5) Key factors for success in implementing the change project
(6) People involved in the change project

The objective of this coding is to assess the extent to which the different change projects diverge from
the dominant model of organization and care provision used in the NHS, i.e., the model of medical
professionalism (see the doc that you read about the NHS). For each category of items, I provide a
framework and precise coding instructions.
I do not ask you to think of the potential consequences of the projects that you are going to code. Your
coding should be based only on the information that is available in the different change project
descriptions.

Professionals’ role division
Professionals’ role division specifies what each category of professionals should do, i.e., their scope
of practice and the rules of interaction among these professionals.
In any healthcare organization, one can distinguish two domains: the clinical and the administrative
domains. The clinical domain focuses on patients’ treatment and the corresponding delivery of care
for individuals or groups of patients (e.g., services for Mrs Jones who has just delivered a baby on the
maternity ward). The administrative domain has to do with the management of organizational and
clinical resources (e.g., beds rotation, machines purchase, staffing, physical plant). For this reason, it
is necessary to distinguish between the roles that each category of professionals has in the clinical
domain, on the one hand, and in the administrative domain, on the other hand.
According to the dominant model, i.e., the model of medical professionalism, doctors play a key role
in decision making both in the clinical and in the administrative domains. Allied health professionals
and nurses carry out the medical plan of care as prescribed by doctors. As for general managers, their
role is to facilitate doctors’ activity and to act as diplomats to reach a consensus any time there is
some disagreement among organizational members.

1. To what extent does the project aim to increase nurses’/AHPs’ decision making power in the
   clinical domain?
   If the project has nothing to do with the role that nurses/AHPs play in decision making in the clinical
domain or if it aims to either maintain the status quo regarding their decision making power in the
clinical domain or decrease their decision making power in the clinical domain, then the answer
should be NO EXTENT.
   If the project aims to enable nurses/AHPs to perform medical procedures or examinations that they
usually do not perform without giving them the power to participate more in decisions regarding
patients’ treatment, then the answer should be SOME EXTENT.
   E.g.: nurses are enabled to make ultrasounds but they do not participate in their interpretation.
   If the project aims to enable nurses/AHPs to participate more in decisions regarding patients’
treatment, then the answer should be GREAT EXTENT.

2. To what extent does the project aim to increase nurses’/AHPs'/managers’ decision making
   power in the administrative domain?
   If the project has nothing to do with the role that nurses/AHPs/managers play in decision making in
the administrative domain or if it aims to either maintain the status quo regarding their decision
making power in the administrative domain or decrease their decision making power in the
administrative domain, then the answer should be NO EXTENT.
   If the project aims to enable nurses/AHPs/managers to participate more in administrative decisions
about the management of their ward/service, then the answer should be SOME EXTENT.
   If the project aims to enable nurses/AHPs/managers to participate more in administrative decisions
about the management of their organization as a whole, then the answer should be GREAT EXTENT.
3. To what extent does the project aim to decrease doctors’ decision making power in the clinical domain?
If the project has nothing to do with the role that doctors play in decision making in the clinical domain or if it aims to either maintain the status quo regarding their decision making power in the clinical domain or increase their decision making power in the clinical domain, then the answer should be NO EXTENT.
If the project aims to force doctors to make a decision collegially with other health professionals regarding some aspect of patients’ treatment, then the answer should be SOME EXTENT.
If the project aims to transfer the decision making power from doctors to other health professionals regarding some aspects of the patients’ treatment, then the answer should be GREAT EXTENT.

4. To what extent does the project aim to decrease doctors’ decision making power in the administrative domain?
If the project has nothing to do with the role that doctors play in decision making in the administrative domain or if it aims to either maintain the status quo regarding their decision making power in the administrative domain or increase their decision making power in the administrative domain, then the answer should be NO EXTENT.
If the project aims to decrease the role or influence of doctors in administrative decisions about the management of their service, then the answer should be SOME EXTENT.
If the project aims to decrease the role or influence of doctors in administrative decisions about the management of their organization as a whole, then the answer should be GREAT EXTENT.

Organizations’ role division
Organizations’ role division specifies what each category of organization should do and the rules of interaction among these organizations. In the NHS, one can distinguish two main categories of organizations: primary care organizations and secondary care organizations. As already explained, there are two different decision making domains in the healthcare sector: the clinical domain that has to do with patients’ treatment and the administrative domain that has to do with the management of organizational and clinical resources. For this reason, it is necessary to distinguish between the role that each category of organizations has in the clinical domain on the one hand, and in the administrative domain, on the other hand.
According to the dominant model, i.e., the model of medical professionalism that focuses on treating diseases, secondary care organizations have more influence than primary care organizations both in the clinical and in the administrative domains. Secondary care organizations provide most of the healthcare services and get most of the resources. In addition, each type of organization delivers its services in a quite isolated way. In the dominant model of medical professionalism, a person’s care is focused on treating acute episodes of disease in the hospital setting without providing follow up and preventive services in the home or community setting. As a result, this model of care is characterized as episodic and fragmented. Opposed to this model is a model of continuous care through integration of services. This model relies on integrated care pathways, which reduce fragmentation by setting out the interventions to be carried out by different services and/or organizations for the treatment of specific diseases.

5. To what extent does the project aim to increase the influence of the primary care sector in the clinical domain?
If the project has nothing to do with the influence of the primary care sector in the clinical domain or if it aims to either maintain the status quo regarding its influence in the clinical domain or decrease its influence in the clinical domain, then the answer should be NO EXTENT.
If the project aims to involve jointly the primary and the secondary care sectors in the provision of healthcare services that are usually provided only by the secondary care sector, then the answer should be SOME EXTENT.
Similarly, if the project aims to involve jointly the primary and the secondary care sectors in the provision of new healthcare services, then the answer should be SOME EXTENT.
If the project aims to either transfer responsibility for the provision of a healthcare service from the secondary care sector to the primary care sector or to create new healthcare services within the primary care sector, then the answer should be GREAT EXTENT.
6. **To what extent does the project aim to increase the influence of the primary care sector in the administrative domain?**

If the project has nothing to do with the influence of the primary care sector in the administrative domain or if it aims to either maintain the status quo regarding its influence in the administrative domain or decrease its influence in the administrative domain, then the answer should be NO EXTENT.

If the project aims to jointly involve the primary and the secondary care sectors in administrative tasks that are usually performed only by the secondary care sector, then the answer should be SOME EXTENT.

Similarly, if the project aims to involve jointly the primary and the secondary care sectors in new administrative tasks, then the answer should be SOME EXTENT.

If the project aims to either transfer responsibility for some administrative tasks from the secondary care sector to the primary care sector or to give new administrative responsibilities to the primary care sector, then the answer should be GREAT EXTENT.

7. **To what extent does the project aim to decrease the influence of the secondary care sector in the clinical domain?**

If the project has nothing to do with the influence of the secondary care sector in the clinical domain or if it aims to either maintain the status quo regarding its influence in the clinical domain or increase its influence in the clinical domain, then the answer should be NO EXTENT.

If the project aims to involve primary care organizations in the provision of health services that are usually provided only by secondary care organizations, then the answer should be SOME EXTENT.

If the project aims to transfer the provision of healthcare services from secondary care organizations to primary care organizations, then the answer should be GREAT EXTENT.

8. **To what extent does the project aim to decrease the influence of the secondary care sector in the administrative domain?**

If the project has nothing to do with the influence of the secondary care sector in the administrative domain or if it aims to either maintain the status quo regarding its influence in the administrative domain or increase its influence in the administrative domain, then the answer should be NO EXTENT.

If the project aims to involve the primary care sector in administrative tasks that are usually performed only by the secondary care sector, then the answer should be SOME EXTENT.

If the project aims to transfer responsibility for administrative tasks from the secondary care sector to the primary care sector, then the answer should be GREAT EXTENT.

9. **To what extent does the project aim to improve cooperation across organizations (especially across primary, secondary and social care organizations)?**

If the project has nothing to do with cooperation across organizations or if it aims to maintain the status quo regarding such cooperation or to prevent it, then the answer should be NO EXTENT.

If the project, while not explicitly aiming to improve cooperation across organizations, involves different organizations, then the answer should be SOME EXTENT.

If the project aims to develop cooperation across organizations on an ongoing basis, then the answer should be GREAT EXTENT.

10. **To what extent does the project aim to promote continuous care through integration of services?**

If the project has nothing to do with the promotion of continuous care through integration of services, or if it aims to either maintain the status quo regarding the provision of care or prevent the promotion of continuous care, then the answer should be NO EXTENT.

If the project aims to develop integrated care pathways in a given organization, then the answer should be SOME EXTENT.

If the project aims to develop integrated care pathways across organizations, then the answer should be GREAT EXTENT.