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MAINTAINING THE VALUES OF A PROFESSION: INSTITUTIONAL WORK AND MORAL EMOTIONS IN THE EMERGENCY DEPARTMENT

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Specialization within professions creates challenges for maintaining the macro-level values of the profession in the everyday work of specialists at the micro level inside organizations. By conducting a qualitative study of emergency-department physicians and their interactions with other hospital specialists, we show how specialists maintain professional values through two distinct processes of institutional work in which moral emotions—that is, emotions linked to the interests of others—play a key role. The first process is activated when a perceived episodic problem, which arises from value conflicts in interactions between different specialists, elicits transitory moral emotions that motivate institutional maintenance work through individual action. The second process is activated when a perceived systemic problem, which arises from conflict between professional values writ large and organizational practices, elicits moral emotions that are enduring and shared across specialists. These emotions mobilize collective action in institutional maintenance work that changes the organizational practice. By focusing on values as a source of conflict and a motive for professional action inside organizations, our model contributes a nuanced understanding to the everyday work of professionals and specialists and draws attention to emotion elicitors and emotional scope as affective mechanisms in processes of institutional work.

Patients stream into the hospital emergency department. Dr. Banjo, a specialist in emergency medicine, is on duty. An elderly man with a broken hip requires admission, so Dr. Banjo phones a specialist in general medicine and a specialist in orthopedics. Each resists, proposing the other specialty department would be better suited to admitting the patient. A nurse reports that the woman bleeding in early pregnancy is anxious. Concerned, Dr. Banjo pages a gynecologist for the third time. He checks on the patient with abdominal pain who is still waiting for a surgeon. Noting the delays and resistance, a junior doctor asks, "Don't other specialists care about patients?" Dr. Banjo shrugs. "I'd like to think that other specialists value patient care as much as I do, whatever their area of expertise and training. We're all doctors so we have a common professional value of acting for the patient's best interests." Dr. Banjo reflects for a moment. "But we work in a big public hospital with a lot of specialty departments and budget constraints, so putting our professional value into practice isn't always easy. That's our challenge as specialists." (Fieldnotes from observations of a hospital emergency department)

Professions have been transformed through specialization in recent decades. Whereas professions

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were traditionally unitary communities of experts (Abbott, 1988), these communities have increasingly become fragmented into heterogeneous groups of specialists (Brock, Powell, & Hinings, 1999). Specialization has important implications for the values of a profession, defined as "conceptions of the preferred or the desirable, together with the construction of standards to which existing structures or behaviors can be compared and assessed" (Scott, 2008a: 54). Historically, professions have pursued social trusteeship values of prioritizing the interests of others above their own (Abbott, 1988; Brint, 1994; Parsons, 1939), with the value of acting in the best interests of the patient or client going to the very heart of professions such as medicine and law (Leicht & Fennell, 2001).

As our opening example illuminates, specialization creates two challenges for keeping the values of a profession alive in the everyday work of specialists. The first challenge arises because specialist identities become customized during training and socialization (Pratt, Rockmann, & Kaufmann, 2006), and specialists then bring these customized identities into their day-to-day work in organizations that are often structured into separate specialty departments (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Martin, Currie, & Finn, 2009). As a result, different specialists who share the same value at the macro level of the profession may interpret the profession's value differently in their everyday work at the micro level, inside organizations. In essence, the profession's value becomes "refracted" for different specialists as the value travels from macro to micro levels (Czarniawska & Joerges, 1996). Values refraction creates the potential for conflict in the day-to-day interface between specialists inside organizations, as per Dr. Banjo's experience in the opening example.

The second challenge is created by the potential for practices inside organizations, which are designed to meet organizational requirements such as resource efficiency, to inadvertently undermine the value of a profession (Kraatz, Ventresca, & Deng, 2010). This can lead to conflict between professional values and organizational practices. In Dr. Banjo's hospital, budgetary pressures can shape organizational practices in ways that seem inconsistent with the medical profession's overarching value of the primacy of patient welfare.

Together, these two challenges create a core puzzle for maintaining the values of a profession. If values can conflict because of how they become refracted when professions are specialized, and if organizational practices can conflict with professional values writ large, the values of a profession at the macro level may not be easily or routinely achieved by specialists at the organizational level. How, then, do specialist actors maintain the values of their profession in everyday work inside organizations?

This is an important question because society benefits when professions are able to evolve without sacrificing their traditional values of acting in the interests of others rather than their own (Abbott, 1988; Parsons, 1939). Given that "professional values are defended and maintained or lost" in interactions in organizational contexts (Noordegraaf, 2011: 1356), unpacking the puzzle of how specialization and professional values play out inside organizations matters for both theory and practice. Yet the puzzle has received little scholarly attention, despite calls for greater explanation of "how the professions may retain normative value" (Muzio, Brock, & Suddaby, 2013: 703–704) and the "everyday realities of front-line work" of professionals in this retention (McCann, Granter, Hyde, & Hassard, 2013: 753).

We investigate this core puzzle by conceptualizing professions as institutions comprised of regulative, normative, and cultural-cognitive pillars that provide stability and meaning to social life (Scott, 2008a). Values are a key component of the normative pillar of professions as institutions (Leicht & Fennell, 2008) and help to maintain the institution through members of the profession acting out its values as they perform professional duties at the front line of organizations (Muzio et al., 2013; Scott, 2008b). Thus, maintaining the values of a profession, which exist at the macro level, requires purposive effort by reflective professionals inside organizations at the micro level. This effort can be conceptualized as institutional work. In general terms, the institutional work of maintaining a profession entails "supporting, repairing or recreating the social mechanisms that ensure compliance" with the regulative, normative, or cultural-cognitive pillars of the profession (Lawrence & Suddaby, 2006: 230). Our interest lies in institutional work directed at the normative pillar. In particular, we focus on how specialist actors, as members of a profession, engage in institutional work to maintain their common professional value when they interact both with each other and with organizational practices in their everyday work inside organizations.

We investigate our research question through a qualitative inductive study of a hospital in Australia and the everyday work of specialists in emergency medicine, who are required to interact with other specialists as they diagnose and treat acutely unwell patients presenting to the emergency department

(ED). By analyzing interview and observational data, we identify the triggers and mechanisms through which specialists engage in institutional work to maintain the normative value of the medical profession in the face of the dual challenges illustrated in our opening example and captured in our core puzzle: conflict arising from differences in how the medical profession's value of patient care is refracted for different types of specialists, and inconsistencies between the medical profession's values and the hospital's organizational practices and routines for delivering patient care.

Our data show that these challenges underpin two fundamentally different types of problems as triggers for institutional work. The first challenge seeds episodic problems, which arise at the boundaries between specialties during everyday work interactions and can be resolved through individual action. The second challenge underpins systemic problems, which arise at the boundary between the profession writ large and organizational practices, and are resolvable only through collective action. Our analysis reveals that in both cases, perceptions of a problem with achieving the profession's values elicit a distinctive category of emotions—described as moral emotions—in specialist actors. Moral emotions are defined as "emotions that are linked to the interests or welfare either of society as a whole or at least of persons other than the judge or agent" (Haidt, 2003: 853). As our opening example highlights, professionals care about the interests of patients and clients. We find that moral emotions elicited by episodic and systemic problems motivate specialists to take action to maintain the profession's values by engaging in individual and collective institutional work, respectively.

Our findings offer two substantive contributions. First, we contribute to the study of professions by advancing understanding of the relationships between specialization within professions, professional values, and everyday work inside organizations. By unpacking the core puzzle, we explicate the precise nature and dynamics of the episodic and systemic problems that specialists face in maintaining the macro-level values of their profession at the front line of organizations. This is an important contribution as our process model offers a more nuanced explanation of professional behavior than the power and self-interest motives that have dominated the professions literature (Evetts, 2006; Muzio et al., 2013).

Second, we contribute to the literature on institutional work by uncovering the cognitive and affective processes through which the normative pillar of institutions is maintained by action directed at values. By bringing attention to moral emotions as triggering mechanisms for individual action and mobilizing mechanisms for collection action, we illuminate how emotion elicitors and emotional scope shape institutional maintenance work processes. This is a significant contribution as the institutional work literature has only recently begun to grapple with questions of emotionality (Creed, Hudson, Okhuysen, & Smith-Crowe, 2014; Voronov & Vince, 2012; Voronov & Weber, 2015).

THEORETICAL BACKGROUND

Professions, Values, and Specialization

Values have historically been core to professions. Early work in sociology emphasized the moral force of professions (Parsons, 1939) and how their values placed "altruism at the center of society" (Muzio et al., 2013: 702). Studies in the 1950s and 1960s defined commitment to the value of providing service to others above self-interest as a key characteristic to professions (Etzioni, 1969; Goode, 1957). While attention to values diminished from the 1970s, when sociologists began exploring how professions were organized to gain power and privilege (Freidson, 1970, 1984), scholars have recently reiterated the contribution that professional values make to a fair, stable, and altruistic society (Evetts, 2006; Scott, 2008b). Professionals are not solely or always motivated by power, as our opening example highlighted, and they do care about acting in the interests of others.

Yet, also illuminated in our example is the impact of specialization on the values of professions. In recent decades, the knowledge base of professions has expanded and fueled specialization—in effect, creating sub-professions—through advanced training and certification (Brock et al., 1999). These specialists frequently work in large organizations that structurally compartmentalize their everyday work into separate activity units (Brock, 2006).

While scholars have not explicitly examined the impact of specialization on professional values, two streams of research have suggested that specialization may cause values conflict between different specialists within the same profession. The first stream draws attention to the identity effects of specialization. When professionals receive training and socialization into a specialist area of expertise, their generalist professional identity is customized to their specialty (Pratt et al., 2006). Specialist identities create intraprofessional differences in how professionals think and act,

as well as how they perceive organizational practices, innovations, and the boundaries of their jurisdictional authority (Chreim, Williams, & Hinings, 2007; Ferlie et al., 2005; Goodrick & Reay, 2010; Martin et al., 2009).

The second research stream has explored relationships between specialization and organizational structures. Many specialists are employed in large organizations structured as professional bureaucracies, which compartmentalize activities into areas of specialty expertise (Brock, 2006; Greenwood & Suddaby, 2006), creating intraprofessional boundaries and unidisciplinary communities of practice (Ferlie et al., 2005; Powell & Davies, 2012). This can seed conflict in interspecialty communication, coordination, and jurisdictional responsibility (Hewett, Watson, Gallois, Ward, & Leggett, 2009) as specialists perform interdependent routines within organizational practices (Spee, Jarzabowski, & Smets, 2016).

These two research streams have suggested that the values of a profession, which exist at the macro level, may become refracted as they are translated into action by different groups of specialists at the micro level inside organizations. That is, specialists with customized identities working in compartmentalized structures may interpret the values of the profession differently (Hewett et al., 2009). These refracted interpretations of values can cause conflict when different specialists who ostensibly share the "same" professional value interact at organizational interfaces. While prior research has tended to explain these types of conflicts between specialists as coordination problems (Bruns, 2013; Ferlie et al., 2005), or as contests over power or status (Kellogg, 2012; Martin et al., 2009), these explanations miss the important role that values can play in interactions between specialists belonging to the same profession. Returning to our opening example, coordination and power offer a superficial account of the conflict between different medical specialists and say little about the nuanced dynamics through which deeply held values of the medical profession shape different specialists' cognitions and emotions during those interactions.

Differences in refracted values causing conflict between specialists are not the only challenge that specialists face in maintaining the values of the profession in their everyday work. In large corporations and public bureaucracies that employ specialists, organizational practices—defined as bundles of routines and tools used to accomplish a task (Spee et al., 2016)—are designed to achieve organizational goals such as profitability and efficiency, and to meet corporate and state regulatory requirements (Adler, Kwon, & Hecksher, 2008). Specialists in these organizations can find that professional values are at risk from the way they must be implemented in technical and administrative practices designed to fulfill organizational requirements (Kraatz et al., 2010; Selznick, 1992).

In sum, specialists face two distinct types of challenges in enacting the macro-level values of the profession at the micro level inside organizations. First, different specialists who are seemingly committed to the "same" professional value may find that this value is differently refracted because of identity customization and organizational structures, which creates conflict in interspecialty interactions at organizational interfaces. Second, different specialists who share the "same" professional value may find that, due to organizational goals and requirements, this value is inadvertently undermined by organizational practices. In contemplating how specialists might respond to these challenges, we follow recent advances in the literature on professions and apply an institutionalist perspective (Muzio et al., 2013).

Institutional Work, Values, and Moral Emotions

The institutionalist perspective conceptualizes professions as institutions and a profession's values as part of the institution's normative pillar. The concept of institutional work brings attention to the effort that actors engage in to create, maintain, and disrupt institutions (Lawrence, Leca, & Zilber, 2013). The profession is maintained as an institution through "more or less conscious action of individual and collective actors" working at field, organization, and individual levels to support the profession's regulative, normative, and cultural-cognitive pillars (Lawrence & Suddaby, 2006: 229). Specialists are theorized to resolve the challenges of specialization using institutional work to maintain the values of the profession—the normative pillar of the institution—in their everyday work.

The institutional work literature has highlighted the types of work directed at maintaining professions and other institutions. Field-level professional bodies maintain professions through membership rules and education, and through theorization and mobilization when the profession is threatened (Dunn & Jones, 2010; Goodrick & Reay, 2011; Greenwood, Suddaby, & Hinings, 2002; Lawrence, 1999; Micelotta & Washington, 2013). At the same time, individuals engage in institutional work inside organizations because organizations represent the "institutional coalface" where the institution of the profession is kept

alive in the everyday social reality of specialists interacting with each other and with an organization's structure and practices (Barley, 2008). Individuals maintain the profession's knowledge base and status by theorizing, educating, and creating new routines (Currie, Lockett, Finn, Martin, & Waring, 2012); policing jurisdictions (Anteby, 2010); deploying rhetorical tactics and narrative acts (Daudigeos, 2013; Kellogg, 2012; Zilber, 2009); and reproducing the profession in client interactions (McCann et al., 2013). Studies in nonprofessional settings have reported that maintenance work includes performing social rituals (Dacin, Munir, & Tracey, 2010) and smoothing over and restoring practice breakdowns (Lok & de Rond, 2013).

Limited attention has been paid to whether and how institutional work can be used to maintain the normative pillar of an institution through supporting or reproducing its values. A few studies have pointed to a role for values in triggering work through an institution's impact on an actor's identity at the individual level (Creed, DeJordy, & Lok, 2010; Marti & Fernandez, 2013) and through an institution's values being placed at risk from their implementation in practices at the organization level (Kraatz et al., 2010; Wright & Zammuto, 2013). However, most empirical research, especially in professional settings, has been silent on values-directed institutional work (Marti & Fernandez, 2013) and, mirroring the trend in the sociology of professions, focused instead on institutional work motivated by power and self-interest in protecting expert control of organizational practices and jurisdictions (Currie et al., 2012; Kellogg, 2009). Such a narrow lens ignores "the broader set of motivations besides self-interest" that guide action in professional and other institutional settings (Muzio et al., 2013: 703). Thus, existing explanations of institutional work offer an incomplete—and overly negative (Evetts, 2006)—account of dynamics because action directed at maintaining the "deeply entrenched values" of an institution's normative pillar is likely to be very different to institutional work when values are not in play (Micelotta & Washington, 2013: 1159).

Two currently disconnected literature streams provide hints as to what these dynamics might involve. First, a new stream of theoretical literature has suggested that work directed at values may have an emotional component. Scholars have begun to theorize that institutional work is both a cognitive and an affective process, and that individuals invest effort to maintain an institution when they have high cognitive and emotional investment in the institutional order (Creed et al., 2014; Voronov & Vince, 2012). While the emotionality of institutional work is not yet well understood, emotions might be expected to be prominent in institutional work directed at maintaining normative values inside organizations because someone who is committed to the values of an institution "really cares" about holding organizations to those values and standards (Stinchcombe, 1997: 19). Dr. Banjo in our opening example is a case in point.

Second, social psychology provides a further hint as to the type of emotions that might play a role in institutional work directed at maintaining values. A stream of literature has argued that the link between moral values and behavior is influenced by moral emotions (Tangney, Stuewig, & Mashek, 2007). Moral emotions are associated with "the welfare or interests of society as a whole or of other persons" (Haidt, 2003: 853), and have two defining features. Moral emotions are triggered by eliciting events that do not directly harm or benefit the self (Haidt, 2003), including events that involve conformity to, or deviance from, moral codes regarding what is valued (Stets & Turner, 2007). In addition, moral emotions motivate tendencies to respond to the eliciting event through actions that "benefit others or else uphold or benefit the social order" (Haidt, 2003: 854). Given that professional values are concerned with the interests of clients or patients, moral emotions can be expected to shape "perceptions of the rightness or wrongness of particular actions" when evaluated against the profession's values (Kroll & Egan, 2004: 352). In our opening example, when Dr. Banjo's interactions with other specialists deviated from the medical profession's value of acting in the patient's best interests, he experienced moral emotions and was motivated to take action to uphold the value.

Institutional Work by Specialists to Maintain Professional Values

Revisiting our core puzzle, the literature applying an institutionalist perspective to professions has offered only coarse-grained insights into how specialists might resolve the two challenges of specialization that we identified: (1) values are refracted and can conflict when professions are specialized, and (2) organizational practices can conflict with professional values writ large. Because values represent the normative pillar of professions as institutions at the macro level, the literature has suggested that these conflicts will motivate specialists to engage in institutional work to maintain professional values in their everyday work. Moreover, because these values involve acting in the interests of others, the institutional work

of specialists is likely to be a cognitive and affective process in which moral emotions may be prominent.

However, significant gaps exist in the study of institutional work processes, such that extant research has shed little light on the core puzzle of professional values and specialization. The dynamics of how conflicts between refracted specialist values, and between values and organizational practices, trigger institutional work to maintain the macro-level value of the profession remain unclear, as do the mechanisms through which institutional work unfolds in specialists' everyday work at the micro level inside organizations. While moral emotions of specialists are speculated to play a role in these microprocesses, the precise nature and scope of that role is unknown. Thus, contemplating the core puzzle, we ask: How do specialist actors maintain the values of their profession in everyday work inside organizations?

RESEARCH SETTING

The medical profession in Australia offered a compelling professional context to investigate our research question. Doctors qualify for general registration as a medical practitioner after completing an approved degree program and an intern year including compulsory rotations in surgery, general medicine, and emergency medicine at an accredited training hospital. Doctors then undergo general residency training for at least another year to gain exposure to different specialties before choosing a specialist field of practice. Provisional and advanced specialist training, involving examinations and supervised training in hospitals, spans a further five- or six-year period. Training culminates in registration with a specialty college accredited by the Australian Medical Board, such as the Royal Australasian Colleges of Physicians and of Surgeons or the Australasian College of Emergency Medicine.

We focus our investigation on specialists in emergency medicine, a field of practice with broad expertise in diagnosing and treating acutely unwell "whole people' who present in unpredictable numbers to EDs. In their everyday work, emergency physicians interact frequently with other specialists who have specific expertise limited to a single body system (e.g., cardiology, gynecology), a distinctive area of medical knowledge (e.g., intensive care, psychiatry), or performance of procedures (e.g., surgery, neurosurgery, vascular surgery). The role of an emergency specialist is to assess, diagnose, and treat a patient's illness or injury before discharging them, or—if the patient is sufficiently unwell—referring them to another department for specialist treatment by enacting the organizational practice of an "emergency referral." A referral involves an emergency specialist phoning the appropriate department, presenting the patient's diagnosis and test results, and requesting an admission. An admitting specialist may elect to see the patient in the ED before agreeing. Hospitals support emergency referrals with a bundle of clinical and administrative routines for diagnostic investigations, clinical decision making, and interdepartmental communication that must be accomplished for an emergency patient to be admitted by a specialty department.

The organizational context for our study is public hospitals in Australia, which are funded by government through the tax system to provide health care free of charge to all Australian citizens (AIHW, 2012). Public hospitals are functionally structured into specialty departments, which are allocated a budget and a pool of staff, and bed and equipment resources to treat patients needing their distinctive expertise. Because public hospitals do not operate a fee-for-service model, patient demand exceeds available resources and specialist services are rationed according to the urgency of patient need. Patients with urgent conditions are admitted to hospital via a referral from the ED. Patients with non-urgent conditions are assigned to waiting lists for specialist treatment, either as hospital inpatients or through outpatient clinics.

The outcome is a division of specialist labor within the hospital such that (1) emergency specialists with expertise in diagnosing acute illnesses and injuries use the ED's resources to diagnose, treat, discharge or refer patients to appropriate specialties for urgent treatment; and (2) other specialists with distinctive expertise in specific body systems or technical procedures use their department's resources to care for the needs of both waitlisted patients and ED-referred patients. This division of labor creates potential for tension during emergency referrals, as specialists try to balance their responsibilities for the needs of competing patient groups within fixed capacity constraints: more bed resources allocated to waitlisted patients means fewer resources available for emergency patients, and vice versa. We inferred that the practice of emergency referrals in public hospitals in Australia offered a theoretically salient context for exploring how the medical profession's value of primacy of patient needs is maintained in the everyday work of specialists.

METHODS

This study emerged as part of an ongoing research project focusing on how emergency specialists balance

the demands of their profession and the public health care system. Data were collected at a large public hospital in an Australian city that delivers care across a comprehensive range of specialties and is an accredited training facility. The ED treats between 100 and 200 patients daily, with between 10 and 20% admitted to hospital.

Data Collection

We collected a mixture of observation, interview and archival data, as described in Table 1. Our primary data source was observation of emergency specialists on clinical shifts. Senior specialists in the ED have finished specialty training in emergency medicine and occupy the position of "consultant" in Australian hospital terminology. The second most senior doctors in the ED are "registrars," who are still completing specialty training. We use the equivalent term in U.S. hospitals of "resident" to refer to these doctors. Junior doctors are in their first and second years of prespecialty basic training. We identify qualified emergency specialists by the job title of emergency consultants and less senior emergency specialists as emergency residents to signal the position level in the hospital hierarchy and the area of medical specialty.

From mid-2009 to mid-2011, a researcher spent 501 hours observing in the ED. Observations occurred in four-hour blocks sampled for theoretical variability across clinical shifts in terms of supervising consultant, timing (morning, afternoon, evening), week day, and seasonality (flu and non-flu season). The majority of observations (83%) occurred during peak patient arrivals of weekday mornings and afternoons. We also included a sampling of evening, night, and weekend shifts (17%). A total of 35 emergency consultants and residents were observed (24 male, 11 female) over the two-year period. Handwritten fieldnotes were typed up after each shift. The researcher also observed 11 hours of training sessions led by emergency consultants. One of the authors observed for 50 hours to cross-check investigator perceptions, sometimes observing with the primary observer and sometimes observing alone.

The authors and a researcher conducted interviews with 22 emergency consultants (17 males, 5 females), representing almost the entire population of consultants regularly employed by the ED. The interviews were semi-structured, with questions designed to elicit the respondent's values as an emergency specialist and how they were maintained in everyday practice in a public hospital. Respondents were probed on whether, how, and when they took action in response to challenges faced in maintaining values. The interviews lasted between 60 and 90 minutes and were digitally recorded and transcribed. To verify and add further detail to the accounts of the emergency consultants, we interviewed nine residents who were undergoing specialty training in emergency medicine. Twenty-two nurses were also interviewed to improve our understanding of the clinical and administrative routines involved in caring for patients in the ED (Moore, 2009). Resident and nurse interviews typically lasted half an hour.

To gain insight into the perceptions and experiences of other specialties involved in emergency referrals, we collected data from sources outside the ED. We observed for 120 hours in two specialty departments that received emergency referrals from the ED, and a further eight hours were spent observing simulation exercises involving patient pathways and clinical routines between the ED and other specialty departments. We conducted interviews with six specialists in various fields of practice—including general medicine, surgery, psychiatry, gastroenterology, cardiology, and neurosurgery—and with seven residents who had undergone training in other specialty departments. We also formally interviewed four hospital managers, frequently attended meetings with managers and the hospital executive, and accessed documents pertaining to the hospital's structures and processes, governance of public health care and hospitals in Australia, and the medical profession and specialty colleges in Australia. Archival documents, many of which were publicly available, provided background information on the organizational and professional context of our study and helped verify and add detail to our observation and interview data.

Finally, after theoretical insights emerged from our data analysis, we returned to the field for a final round of data collection in late 2014 to refine and deepen our emergent understanding. Our focus was on ensuring we had a sufficiently balanced perspective of the distinctive expertise, responsibilities and priorities of the different specialties involved in emergency referrals as an organizational practice. A redesign of the physical space in the ED allowed us to observe and conduct informal debriefs with a range of doctors who were at various stages of training in different specialties. One author engaged in 80 hours of observation and notetaking. We also conducted formal interviews with 10 doctors who had completed training in multiple specialties or worked in roles connected with the development and implementation of interspecialty pathways as solutions to systemic problems.

TABLE 1
Description of Data

Dates	Source and type of data collected	Use in analysis
Emergency medicine		
June 2009–June 2011	Observation on the floor of the ED by a researcher shadowing emergency consultants and residents for 501 hours. Observation by an author for 50 hours for cross-checking.	Coded to generate episodes in which problems with values do and do not occur (84 and 854 episodes, respectively). Classification of source and type of problem (episodic and systemic), emotional responses of emergency specialists, and actions taken *[Analysis stage 1]*
Sept 2009–Oct 2009	Interviews with 22 nurses about clinical and administrative routines for care of patients who present to the ED.	Verifying and adding detail to episodic and systemic problems and solutions *[Analysis stage 3].*
June 2011	Observation of 11 hours of training sessions for junior doctors led by emergency consultants.	Enriching understanding of the distinctiveness of emergency medicine as a specialty *[Analysis stage 3].*
Sept 2011–Dec 2011	Interviews with 22 emergency consultants and with 9 residents completing specialist training in emergency medicine.	Coded to generate episodes in which problems with values occur (142 episodes). Classification of source and type of problem, emotional response of emergency specialists, and individual and collective actions taken *[Analysis stage 2].*
Other specialties		
Sept 2010–June 2011	120 hours' observation of emergency referrals in two specialty departments to gain understanding of how emergency referrals fit into everyday work of other specialties.	Identification of interspecialty differences in responsibilities and value interpretations as a cause of episodic and systemic problems *[Analysis stage 3].*
May 2011–June 2011	8 hours' observations of simulations of interspecialty pathways.	Deepening insight into how routines implemented collectively across specialties solve systemic problems *[Analysis stage 3].*
June 2009–Dec 2011	Interviews with 6 specialists in other fields, (including general medicine, cardiology, surgery, and psychiatry) and with 7 residents who had completed training in other specialties.	Comparative insight into how distinctive specialist expertise and department responsibilities shape value interpretations and perceptions of problems *[Analysis stage 3].*
Oct 2014–Feb 2015	80 hours' observation in "patient zones" in the ED to observe and conduct informal debriefs with a range of doctors who had experienced training in different specialties. Formal interviews with 10 doctors who had completed training in multiple specialties or worked in roles connected with development and implementation of interspecialty pathways as solutions to systemic problems.	Verifying and refining insights into how interplay between the medical profession's values, organizational responsibility, and interspecialty value interpretations trigger or do not trigger problems in emergency referrals. Deepening understanding of the distinction between episodic and systemic problems. *[Analysis stage 4].*
Hospital		
Jan 2009–Dec 2011	Multiple meetings with three hospital managers (10 meetings per manager, notes taken) and one meeting with two hospital financial administrators. Observation of one hospital executive meeting. Formal interviews with four hospital managers (digitally recorded and transcribed). Documents including annual reports, maps of clinical and administrative routines and patient pathways, research publications, media stories.	Identification of how hospital processes and structures for allocating resources and responsibilities to different specialty departments contribute to episodic and systemic problems. Deepening insight into how collective solutions to systemic problems are initiated, developed and implemented *[Analysis stage 3].*
Government and profession		
Jan 2009–Dec 2012	Reports into public hospital operations and performance, websites on government health policy frameworks and standards. Websites of Australian Medical Council and accredited specialty colleges.	Understanding of how problems with values occur within the broad context of public hospitals in Australia. Comparative insight into the distinctive expertise, training requirements, and field of practice of different specialties within the medical profession in Australia *[Analysis stage 3].*

Notes: The analysis stages reported in the "Use in Analysis" column indicate when the data were first coded. Consistent with prescribed procedures for inductive data analysis, coded data were returned to in subsequent stages to verify and deepen insights through constant comparison with new data entering the analysis process.

Data Analysis

Our analysis followed established procedures for inductive theory building from qualitative data (Corbin & Strauss, 2008). NVivo 9 software was used to assist with coding. As summarized in Table 1, our analysis proceeded in four stages.

Analysis stage 1. We began by focusing on the observational data collected in the ED from 2009 to 2011. We adopted Trefalt's (2013: 1807) "episode-as-a-unit-of-analysis approach." We extracted from the fieldnotes all of the observed interactions between the ED and other specialty departments involving the bundle of routines used to implement an emergency referral for a patient. This generated 938 data episodes, with each episode capturing all of the interactions observed for any one patient. We used these data episodes to examine how emergency specialists maintained their professional values when confronted with the first challenge of the core puzzle of specialization: professional values are refracted differently for different specialists and this may lead to values conflict at specialty interfaces. One author coded the 938 data episodes into two categories: episodes where there was no perceived problem with the achievement of professional values (i.e., refracted specialist values were aligned) and episodes where the emergency specialist perceived there to be a problem with achievement of professional values (i.e., refracted specialist values were not aligned). The category of "problematic" represented instances in which an emergency specialist responded to a situation in which their interpretation of how the medical profession's values should be enacted for a particular patient diverged from another specialist's interpretation, allowing us to examine individual maintenance work. To ensure the trustworthiness of our distinction between problematic and nonproblematic data, a second author recoded all of the problematic data episodes and a sample of nonproblematic data episodes. High interrater reliability was achieved, with agreement on all but seven episodes. Differences were resolved through discussion. The final classification was 854 data episodes where there was no evidence of a perceived problem with achievement of common professional values, and 84 data episodes where there was perceived to be a problem.

To better understand how specialist actors engaged in value maintenance work in response to problems with the professional value, we focused our attention on the dataset of episodes distinguished by what we labeled "episodic problems" (84 data episodes). We proceeded with our analysis by undertaking both open and axial coding. We coded each data episode according to the type of problem, emotional response, and maintenance work undertaken to solve the problem. We identified three types of episodic problems as perceived by the emergency specialist, namely problems in which the medical profession's value of prioritizing patient interests was undermined because (1) care was delayed, (2) patient safety was potentially at risk, and (3) responsibility for a patient was being contested.

We consulted the moral emotions literature for guidance on classifying emergency specialists' responses to these problems. Research has shown that moral emotions can be classified into four families (Ekman, 1992): self-critical, other-condemning, other-suffering, and other-praising. Self-critical emotions such as shame and guilt may be triggered when an individual personally violates a moral code (Tangney et al., 2007). Other-condemning emotions such as contempt, righteous anger, and disgust may be directed at the code violators when other people are perceived to have violated moral codes (Rozin, Lowery, Imada, & Haidt, 1999). Other-suffering emotions such as empathic concern and compassion may be elicited by another person's experience of a violation of a moral code (Hoffman, 2000). Finally, other-praising emotions such as pride and elation can be triggered when moral codes are upheld (Haidt, 2003). Applying these insights to our data, we identified that emergency specialists experienced two broad classes of moral emotions in response to episodic problems. Emotions such as anger and frustration were aroused at the injustice of other specialties behaving as if the needs of an emergency patient were of low priority. Emotions such as concern and compassion were aroused by a patient suffering when their needs were unmet. We classified these responses as other-condemning and other-suffering moral emotions, respectively.

Our coding distinguished three forms of maintenance work triggered by the moral emotional response to an episodic problem. We grouped together actions in which an emergency consultant advocated for the patient's interests by presenting a persuasive story or compelling justification to another specialty. We labeled this form of value maintenance work as advocacy. We grouped together actions in which an emergency consultant used the authority of their position in the organizational hierarchy, or appealed to a higher authority, to sanction approval for a course of action they deemed to be in the patient's interests. We labeled this work as sanctioning. Finally, we grouped together actions in which an emergency consultant acted as an intermediary

between other specialties to ensure emergency patients got what they needed. We labeled this form of maintenance work brokering.

Analysis stage 2. We used the same procedure to code the data from our interviews with emergency specialists. We extracted from the transcripts 142 segments of text in which an interviewee gave an example of how an emergency consultant responded individually to a perceived problem with professional values during an emergency referral. Examples included specific instances of problems with a particular patient and more general descriptions of common types of problems for exemplar patient cases. We coded text for type of problem, emotion, and action, following the same procedure as the fieldnote data. Examples of our coding of episodic data are presented in Tables 2, 3, and 4.

We report the frequencies of our coding categories pertaining to episodic problems, moral emotions, and value maintenance work for both the fieldnote and interview data in Table 5. We coded for the primary problem, primary emotional response, and primary form of maintenance work in each data episode. *Delayed care problems* elicited other-suffering emotions and triggered value maintenance work through advocacy in 21 data episodes and through sanctioning in 5 episodes. Delays elicited other-condemning emotions and triggered advocacy in 27 data episodes and sanctioning in 53 episodes. *Patient safety problems* elicited other-suffering emotions and triggered advocacy in 20 data episodes and sanctioning in 14 episodes. Patient safety elicited other-condemning emotions and triggered advocacy in 8 data episodes and sanctioning in 20 episodes. Finally, *contested responsibility problems* elicited other-suffering emotions and triggered brokering in 23 data episodes. Contested responsibility elicited other-condemning emotions and triggered brokering in 35 episodes.

Analysis stage 3. After completing our coding for how specialists maintain professional values when episodic problems arise, we turned our attention to deeper analysis of the second challenge of the core puzzle of specialization: professional values of specialists may be undermined by organizational practices. Revisiting the dataset of fieldnotes assembled in analysis stage 1, we examined the 854 data episodes where no problems with professional values were evident. We noticed that nonproblematic episodes typically involved patient needs that were unambiguous and could be accommodated via adherence to the existing bundle of routines in emergency referrals as an organizational practice. The fieldnotes for these data episodes often referred to pathways and routines developed collaboratively between emergency specialists and other specialists because "the system we had before didn't work." We tentatively speculated that a second category of problems with professional values—systemic problems—could act as a trigger for value maintenance work.

We reviewed our entire dataset of fieldnotes, interviews, and organizational documents to identify instances in which a systemic problem had arisen with how professional values were enacted in referrals for a group of patients and had been solved through maintenance work. In contrast to episodic problems, which arose at specialty boundaries and were solvable through individual action, systemic problems arose at the boundary between the profession writ large and organizational practices, and were resolved through collective action. We identified three cases of systemic problems involving professional values that had been solved by different specialists collaborating in collective maintenance work: trauma protocol for patients with internal bleeding, chest pain pathway, and night CT scanning.

The data pertaining to systemic problems could not be suitably analyzed using the episodes-as-unit-of-analysis approach we had adopted when coding episodic problems. The data resembled descriptive case study data and was more appropriately analyzed using cross-case comparison methods. For each of the three case studies (trauma protocol, chest pain pathway, night CT scanning), we assembled all of the data pertaining to that particular case and developed a case narrative of the systemic problem and how it was resolved through value maintenance work. By comparing patterns within and across the datasets for the three cases, we identified a qualitatively different institutional work process for systemic problems involving professional values compared to the process we had previously identified for episodic problems. A common pattern emerged across the three cases of a systemic problem eliciting a shared and enduring moral emotional response that mobilized collective value maintenance work and produced a change in the organizational practice. Table 6 presents illustrative data for the three case studies regarding the perceived problem, specialists' emotional response, and actions taken to mobilize collective action for value maintenance work.

We sought to verify and deepen our emergent understanding of episodic and systemic problems as microprocesses through which emergency specialists tried to maintain the values of the medical profession by returning to the data we had collected

TABLE 2
Delayed Care Problems, Moral Emotions, and Value Maintenance Work: Representative Data

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
The emergency consultant (C) is concerned about the patient with chest pain. "We've been trying to get on top of his pain and the minute we couldn't get on top of his pain, we called you," she tells the cardiology resident, who is examining the patient. When the chest x-ray shows a large amount of fluid, C hastens the cardiology resident over to view it. She appeals for the patient to be taken to the cath lab as soon as possible because the patient's pain has been really difficult to manage. The resident says he is still trying to make a case to put to this boss. "Quickly, go and give him a call," she pleads. After the resident departs, C explains her concern for the patient's pain and her approach of advocating for the patient with the resident, who wants to protect the cath lab's resources for the most deserving patients. "I'm trying to create this emergency for him to ring his boss." (Fieldnotes)	Patient is delayed in receiving timely treatment due to resource priorities of another specialty *(delayed care)*	Compassion for the patient's pain *(other-suffering emotion)*	Pleading for the patient's needs to be prioritized in justifying a case for admission *(advocacy)*	**Delayed care → other-suffering emotion → advocacy**
What I'm more concerned about is wasting time . . . As consultants we are in a fortunate position that we are, if you like we're the top of the clinical scale. . . . And we do still have some impact that the consultant has said, "The patient needs such and such" [so] it can happen. We have to be cautious with that, not just use it willy nilly. . . . But we do still have the authority that we can say, "I know what you've written down there. But this patient needs such and such and we're not going to argue about it at 10.00pm at night. The patient needs this test or doesn't need it until the morning. They need to come in. We can sort that out in the cold light of day" . . . My primary guide for decision	Patient admission is unnecessarily delayed by a specialty *(delayed care)*	Concern for the patient's comfort *(other-suffering emotion)*	Using authority as a consultant to ensure the patient gets what they need *(sanctioning)*	**Delayed care → other-suffering emotion → sanctioning**

TABLE 2
(Continued)

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
making is clinical experience and professional ethics. (Interview E10)				
The emergency consultant (C) believes a patient experiencing increased seizures needs an admission to general medicine. When a junior ED doctor tries to refer the patient and reports back that the medical resident is "too busy to deal with the patient," C feels frustrated and annoyed. He pages the medical resident and reads over the patient's chart for information to strengthen the justification for an admission. "I'm trying to reorganize my plan of attack," he explains because the only obvious abnormality is low sodium. "They won't jump at that," he discerns wryly. (Fieldnotes)	Patient is delayed by a specialist who sees the patient as work that can be postponed *(delayed care)*	Frustration at specialist for giving patient needs a low priority *(other-condemning)*	Presenting and justifying the patient's case for admission in compelling way *(advocacy)*	**Delayed care → other-condemning emotion → advocacy**
The emergency consultant (C) hangs up the phone. Annoyed, she complains, "I just had a fascinating conversation with gyne [gynecology]." She explains that the gyne resident seemed to "see only the 20 patients waiting in their own clinic and not the one really sick patient down in the ED." Over the next 45 minutes, C's irritation grows as she pages three times for the gyne resident to come and see the patient. When the gyne resident phones, C reproaches her. "This girl has actually got evolving sepsis and I think in terms of priorities she is more important than stable clinic patients." The gyne resident protests, "They won't let me leave the clinic." C contacts the gyne consultant who is the resident's boss. "I'm sorry to bother you but I've got a patient down here that I'm really worried about." She describes the patient's condition and explains her concerns. The gyne consultant provides advice on treatment and the gyne resident arrives to see the patient. (Fieldnotes)	Patient is unnecessarily delayed in being seen by a specialist *(delayed care)*	Irritation at specialist for not assigning patient's needs a sufficiently high priority *(other-condemning emotion)*	Report to a higher level of authority to ensure the specialist becomes involved in the patient's care *(sanctioning)*	**Delayed care → other-condemning emotion → sanctioning**

TABLE 3
Patient Safety Problems, Moral Emotions and Value Maintenance Work: Representative Data

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
You're always trying to see yourself as the advocate for the patient and trying to do what's best ... just being a bit more humanist about it. . . . [But] it's very easy for the doctor at the other end of the phone to be less compassionate because they haven't seen the patient. . . . My selling technique is to call a spade a spade . . . If it's a little old granny and you don't think there's a whole lot wrong with her but you are uncomfortable with the idea of her going home to her home circumstances and you feel this requires an admission, then that's what you sell it as. And it's not tugging at the heart strings because I'm not asking for a compassionate admission. I'm asking for a safety admission. (Interview E7)	Patient is not safe to discharge but specialist resists an admission because patient does not meet standard criteria *(patient safety)*	Compassion for the patient's suffering and personal circumstances *(other-suffering emotion)*	Presenting and justifying the patient's case for admission in a compelling way *(advocacy)*	**Patient safety → other-suffering emotion → advocacy**
My professional values are all based in and around the patient and the importance from my perspective of optimum care for that person . . . I went [to] bat for a young girl that came in with abdominal pain. I'd watched her over a period of twelve hours and it was atypical but I really believed that she had appendicitis. And a fairly junior surgical person came in to see her and said, "No, no, no. She's just got period pain" and tried to send her home. And I rang the fellow and said, "Look, one of us is right and one of us is wrong. I don't care who it is but this girl needs to be watched and we don't watch people here in the ED with abdominal pain that I believe have got a surgical abdomen. So she needs to come in under your bed count and be watched." And with	Patient is not safe to discharge but specialist has a lower risk assessment. ED cannot invest more resources (bed, staff) in observing the patient *(patient safety)*	Concern for patient's welfare *(other-suffering emotion)*	Intervening by using position as a consultant to withdraw authorization for discharge *(sanctioning)*	**Patient safety → other-suffering emotion → sanctioning**

TABLE 3
(Continued)

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
a bit of negotiation that's exactly what happened. . . . [I have authority as a consultant so] if it's the right thing for the patient, I will fight for that until we get some sort of resolution. (Interview E16)				
An example is when we're worried about an infection in the back. We don't see it on a CT scan but we may see other findings that could suggest it but we can't rule it in or rule it out because it's so hard to get the MRI. The conversation [with the radiologist] will sometimes go, "Are you absolutely certain that they've got an epidural abscess?" And you're like, "No. That's the reason why we're doing the MRI. But we can't rule it out. And the consequences of that if we missed it would be profound. You would have a patient who is paralyzed." So it's that tension between us trying to rule out horrendous diagnoses that have serious implications to the patient but using those investigations rationally so we're not wasting the resource. . . . It can be frustrating for both sides but [Consultant X] is very good at trying to bring us back to, "We've both got the same goal here. We're both trying to do the right thing for our patient." And we can usually agree that this is the right investigation. (Interview E8)	Specialist is denying patient a necessary investigation, which places patient at risk of harm *(patient safety)*	Frustration that specialist is allowing resource constraints to compromise a patient receiving a necessary investigation *(other-condemning emotion)*	Justifying the need for the investigation in a compelling way and making the case for a mutual focus on the patient's interests *(advocacy)*	**Patient safety → other-condemning emotion → advocacy**
The emergency consultant (C) approaches the medical resident who has refused to admit the patient with Crohn's disease until she has a CT scan. "It's unreasonable to subject a woman like that to medical radiation," C admonishes the resident, clearly	Patient at risk of harm because of specialist seeking an unnecessary investigation *(patient safety)*	Annoyed at specialist's lack of consideration for patient's welfare *(other-condemning)*	Using position as a consultant to reject the investigation *(sanctioning)*	**Patient safety → other-condemning emotion → sanctioning**

TABLE 3
(Continued)

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
annoyed. Given the patient's preexisting condition is well documented, C argues a scan is not warranted and he insists the patient be admitted to the gastro ward to begin appropriate treatment. (Fieldnotes)				

from sources other than emergency specialists. We compared iteratively within and between our data sources and our emergent categories to refine our tentative understandings of the cognitive and affective processes involved in value maintenance work in response to different types of problems.

Analysis stage 4. To gain a deeper understanding of how specialization triggers value maintenance work through moral emotions, we returned to the field site to collect additional data at the interfaces between the ED and other specialties. Many participants from our earlier rounds of data collection were still working at the hospital, although in the period since our departure from the fieldsite the hospital had made changes to the practice of emergency referrals in response to regulatory updates. Our new data suggested that the same microprocesses for episodic and systemic problems emergent from our analysis in stages 1 to 3 were still present. However, to avoid conflating data collected under different conditions, we kept the new data separate from our earlier data and analyzed the latter to refine our tentative understanding of the relationships between problems, moral emotions, and value maintenance work. We returned to our earlier data to confirm these relationships and more clearly discern the microprocesses in our emergent model of episodic and systemic problems.

Our analysis stages followed established procedures for inductive qualitative data analysis. We compared iteratively within and between our different sources of data and our emergent categories, challenged each other's perspectives to arrive at the most credible interpretation of our data (Corbin & Strauss, 2008), and assembled display tables to identify and verify patterns in the data (Miles & Huberman, 1994). We improved the dependability of our interpretations by collecting additional data to verify emergent theorizing, triangulating across multiple sources of data collected from multiple departments and levels in the hospital, and regularly debriefing with participants to ensure our interpretations made sense in the context of their lived experience (Denzin & Lincoln, 2000).[1]

[1] To protect the confidentiality of the study participants, we identify participants by the following codes: E = representatives of emergency medicine as a specialty, S = representatives of other specialties, N = nurses, and H = hospital managers. Dates are not included for fieldnote extracts to ensure that individual patients cannot be identified.

TABLE 4
Contested Responsibility Problems, Moral Emotions, and Value Maintenance Work: Representative Data

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
A patient is severely ill with a massive blood clot and a bleeding kidney. Sympathetic to the patient's pain but unable to administer too many painkillers in the ED because of the patient's poor kidney function, the emergency consultant (C) tries unsuccessfully to get either the intensive care unit or the renal unit to admit the patient. "ICU say they've got no beds and that's their answer. They've got no beds." He appears anxious. "I feel bad for the patient. I've got no buy-in at all." He continues, "The renal unit sort of accepted the patient then backed away. I've got no buy-in." After repeating how badly he feels for the patient, C speaks to the director of the ED and gains his support in brokering between the units to decide who should take over responsibility for the patient. (Fieldnotes)	Specialists are contesting who should take primary responsibility for patient's care *(contested responsibility)*	Compassion and empathetic concern for patient welfare *(other-suffering emotion)*	Brokering between specialists to facilitate the patient's care in the most appropriate specialty *(brokering)*	**Contested responsibility → other-suffering emotion → brokering**
A patient has anemia caused by rectal bleeding from suspected bowel damage. When the ED contacts general medicine and asks for the patient to be admitted, the resident refuses and suggests they contact gastro. The emergency consultant (C) is irritated. The patient's condition has been sufficiently worked up to determine that general medicine is "the right team with the right expertise to treat the patient's illness but they want us to try gastro on the miniscule chance that the patient might be sufficiently interesting to gastro for them to admit her—which we all know they would never do but we have to call." When contacted, gastro says the patient does not need an emergency colonoscopy or other procedure (i.e., any procedure can be safely delayed for a day) and therefore should go to general medicine. C observes sarcastically, "As predicted, gastro decided they didn't want to play the game." He looks annoyed and says,	Specialists are contesting who should take primary responsibility for patient's care *(contested responsibility)*	Irritation at the specialists for the injustice of using the patient in an interspecialty game *(other-condemning emotion)*	Brokering between specialists to resolve the issue of patient responsibility *(brokering)*	**Contested responsibility → other-condemning emotion → brokering**

TABLE 4
(Continued)

Data episode	Perceived problem	Moral emotion	Maintenance work	Process
"These ownership games irritate me—they're not fair to the patient." The general medicine resident is then paged three times without response. Aggrieved that the patient has now been waiting in the ED for over two and a half hours from the initial phone call requesting a referral to "the appropriate owner of the patient's condition," C sends a fourth page. When the general medicine resident phones, C advises that gastro wants general medicine to take the patient and the resident agrees. (Fieldnotes)				
I think it's a shame that there's almost this sort of consumer–retailer relationship between us [admitting departments and emergency] where you almost find that you're having to sort of almost advertise. You feel a bit like a door-to-door salesman sometimes . . .it's very frustrating . . . The classic one is abdominal pain in young females where you'll get the surgeons will say, "Yeah, we think it's gynecological." Or even worse, they'll say, "We completely agree that this lady needs to be in hospital but we think it's gynecological" and then gyne will come down and say, "We completely approve that this lady needs to be in hospital but we feel it's surgical." . . . They play ping pong with the patients and I hate it. . . . I phone both of them and I say, "You two come down here. Now. I'd like you to see this patient and between the two of you, you decide what the most appropriate place is." (Interview E22)	Specialists are contesting who should take primary responsibility for patient's care *(contested responsibility)*	Anger at the specialists for the injustice of treating the patient as a commodity in an interspecialty game *(other-condemning emotion)*	Brokering with the specialists to resolve the issue of patient responsibility between themselves *(brokering)*	**Contested responsibility → other-suffering emotion → brokering**

TABLE 5
Value Maintenance Work Involving Episodic Problems: Coding Frequencies for Fieldnote and Interview Data

Moral emotion / Episodic problem	Other-suffering emotions (83)	Other-condemning emotions (143)
Delayed care (106)	• Advocacy *Fieldnotes = 6* *Interviews = 15* • Sanctioning *Fieldnotes = 2* *Interviews = 3*	• Advocacy *Fieldnotes = 8* *Interviews = 19* • Sanctioning *Fieldnotes = 20* *Interviews = 33*
Patient safety (62)	• Advocacy *Fieldnotes = 4* *Interviews = 16* • Sanctioning *Fieldnotes = 7* *Interviews = 7*	• Advocacy *Fieldnotes = 0* *Interviews = 8* • Sanctioning *Fieldnotes = 7* *Interviews = 13*
Contested responsibility (58)	• Brokering *Fieldnotes = 14* *Interviews = 9*	• Brokering *Fieldnotes = 16* *Interviews = 19*

Notes: Total fieldnote extracts = 84; total interview extracts = 142.

FINDINGS

In response to our research question, a detailed account emerged from our data analysis of how specialists maintain the values of their profession in their everyday work inside organizations. All of the specialists were committed to the medical profession's value of prioritizing the patient's interests. A hospital manager explained "what these guys want is outcomes for patients" (H1). All doctors, regardless of their specialty area, used a language of primacy of patient's needs when describing the profession's values. Emergency specialists wanted to provide "optimum care for that person" (E16). Specialists in general medicine were "focused on the patient and helping them to feel better" (S6). Surgeons in various subspecialties used their operating skills to "benefit the patient" (S2, fieldnotes). Intensivists wanted to "help reverse illnesses in the sickest patients" (S1, fieldnotes). Psychiatrists sought to "help people work through difficult things in their lives" (S3).

However, specialization created challenges for specialists as they sought to live out the medical profession's common value in their daily work inside the hospital. One specialist, who had worked in the departments of emergency, surgery, and general medicine, reflected on what the creation of different expert identities located in separate specialty departments meant for the professional value of prioritizing patient interests:

> Subspecialization doesn't mean we don't all care about the patient. We all care. But in medicine, there are so many subspecialities that we take responsibility for patients at different points in their journey through the hospital. We work for the best interests of a patient when they're in our department and we're responsible for them. That's when we care the most about a patient—when we're responsible for their interests. We can't all be responsible for every single patient at every single moment in time. (S5)

This quote expresses much more than the pragmatics of how hospital work between specialists is coordinated. It speaks to the core puzzle of how specialization creates conflicts in translating the medical profession's common value—which exists at the macro level of the institution and which all specialists care about as the normative carrier of the profession—into everyday work at the micro level inside the hospital. Our data focus on emergency referrals as a hospital practice that crosses boundaries between specialist departments. A hospital manager described how at the micro level, potential exists for professional values to become misaligned between different specialists interacting in the care of an individual patient and to misalign with emergency referral practices applied to groups of patients:

> There's some loose alignments [among all specialists] at a high level—yes, it's always about the patient. But when the priorities come down to individual patients and to some groups of patients, then sometimes the alignment is not there. (H1)

TABLE 6
Value Maintenance Work Involving Systemic Problems: Representative Data

Case	Source of problem—systemic	Emotional response—shared, enduring	Mobilizing collective value maintenance work and organizational adaptation
Trauma protocol for trauma patients	Lots of issues beforehand getting into theater. Having been stopped at the door—Have you done the checklist? Oh my God, This person's dying! I haven't done the checklist! (Interview E15)	Sometimes I think it's good to be flustered . . . X got flustered and it brought things to a head to change things . . . How can we iron out the processes which are best for the patient? (Interview E3).	Having a bad event can focus people into creating a system that works. (Interview E4)
	Systems really just did not work . . . It actually is a simple problem in the end. Bleeding, blood pressure low, needs fixing. You just need to have a system that supports that decision making and removes the risk management that would go with most patient care, like checking them at the [theater] door. (Interview E21)	Various ones of us had experiences that drove us to want to do something. (Interview E19)	We had champions there [in surgery] who really pushed it along from that perspective as well. So once you have strong personalities in both emergency and theater effectively, which is the other geographical side of it, that was actually a fairly easy thing. . . . strong engagement from people in both places. (Interview E18)
	On a theoretical level it's all about organizing our thinking to the point of identifying patients who need to go to theater, what do they need most and how to make that happen without getting caught up in all of the bureaucratic nonsense that slows down everything else in hospital. (Interview E18)	The surgeon who initiated trauma explained his motivation as, "We've got people who have definitely had lifesaving outcomes. Someone with a stabbed heart, for instance, who's dying front of you, you know you've saved a life. All the effort is worth it just for that one person." (Hospital document)	No professional jealousies . . . [trauma was] clearly handled in a sensible way and talked through and it worked ... good robust discussions. (Interview H1)
	A surgeon said, "Liver injury is one of the common ways that you die through delay. . . . We needed to get [the patient] moving." (Quoted in hospital document)	I saw a patient die in the ED. Bled out and bled to death because there was no good system in place to manage that patient. That was crap. (Interview E2)	The doctor as the go-to guy, not just for clinical care but for the systems answers. (Interview H3)
			Surgery, anesthetics, theater, emergency . . . we have collaborated together to manage major trauma. And that's always satisfying now when our system of management works well. (Interview S13)
			Those trauma meetings bring those disciplines together and there's always a bit of robust discussion, as there should be to increase efficiency and patient care. (Interview S18)
Night CT scans	A young man who was punched at a nightclub is waiting for a CT scan of his facial fractures. The night staff in radiology suggest the ED should push for a night CT radiographer. The ED resident laughs. "I've been with the department for three years	The trauma alert alarm rings at 11.47pm. A drunk patient who was hit by a car is being brought in [by] paramedics. The ED consultant calls radiology because the patient will require a CT scan and the CT radiographer will be going home at midnight. Sharing the ED	The ED director and an emergency consultant have been lobbying unsuccessfully for 24-hour CT scanning. When they learn of the patient episode that occurred during the night, they ask the ED resident to report the incident. "This is pretty important," the ED

TABLE 6
(Continued)

Case	Source of problem—systemic	Emotional response—shared, enduring	Mobilizing collective value maintenance work and organizational adaptation
	and they've been pushing for it this entire time." (Fieldnotes)	consultant's concern for the patient's welfare, the radiographer agrees to stay late and complete the necessary scans. (Fieldnotes)	director urges. He shows the resident how to write up a "clinical incident claim" for the hospital committee that oversees these cases. "We need to escalate this so that administration finds out. Now's the time to escalate it. We've primed it." (Fieldnotes)
	There are issues about who gets the CT scan, and a lot of the hospital protocols are based around resource optimization, which is basically the same as resource restriction. (Interview E13)	Balancing resources also implies maintaining a certain standard of care. . . . Sometimes some people suffer . . . [and] it does get frustrating when we see that lack of equity. (Interview E12)	A clinical incident is any event or circumstance which has actually or could potentially lead to unintended or unnecessary mental or physical harm to a patient. By having a system that allows us to recognize, report, analyze and learn from incidents, we can ultimately minimize preventable harm. (Government document)
	Do things efficiently but my bottom line is that you can't compromise patient care for that efficiency. . . . Things like improving access to radiology [are important]. (Interview E16)	ED staff are angry this morning that a patient with a serious head injury nearly missed a window for time-critical neurosurgery because they waited almost two hours to get a CT scan during the night. Summing up the moral outrage of the group, an emergency consultant reproaches, "That's unacceptable! Close to two hours before he gets a scan." (Fieldnotes).	I've become more and more conscious even if you can't do something for the particular patient in front of you that you become an advocate for all of the patients and all of the potential patients. . . . If we think the department needs something, I will advocate for it and put up business cases [for more resources] and so on and keep going and I usually eventually get it. (Interview E1)
	We have a duty of care to that person because they could actually have a C-spine injury and then walk out of here [because they don't want to wait until morning for the CT] and be paralyzed for the rest of their life. (Interview N13)		
	The thing that takes the time is being reliant on medical imaging to determine do they need to come in under general surgeons or do they need to come in under the neurosurgeon or orthopedic surgeon (Interview S11)		
Chest pain pathway	It was always a battle with someone with chest pain that our inpatient colleagues would say, "It's pretty atypical. You could just send them home." (Interview E10)	It was something that wasn't being done as well as it could be and there was an opportunity for improvement. . . . [Our concern is to] get optimum care for the patient as rapidly as you possibly can. (Interview E16)	Cardiologist Y began work, together with colleagues from the departments of Internal Medicine and Emergency Medicine, on the redesign of the clinical services offered to patients presenting to hospital with acute chest pain. (Organization document)

TABLE 6
(Continued)

Case	Source of problem—systemic	Emotional response—shared, enduring	Mobilizing collective value maintenance work and organizational adaptation
	Five patients have presented today with chest pain. Three of them meet the criteria for the chest pain pathway. A sixth patient presents with chest pain most likely to be caused by anxiety. She does not fit the pathway and C performs tests to rule out a pulmonary embolism. She says the pathway was introduced to solve problems in ensuring patients with chest pain got the right treatment by the right specialty. (Fieldnotes)	Chest pain pathway . . . [We wanted to] reduce a lot of the angst that goes on . . . in getting patients the right care. (Interview E4)	Health is very interesting business because the actual brains trust—the rocket scientists if you like—are actually working on the floor. They're not in the backroom giving orders. . . . So they're the ones that have to come up with the solutions. (Interview H1)
	At the interfaces really, across different areas, different professions. . . . that's where a lot of the problems happen in hospitals—communications and systems. (Interview H2)	A cardiologist at the chest pain simulation said passionately, "We need systems that help very sick patients get the cardiac care they need as quickly as possible. We don't want them suffering because our systems don't work." Emergency specialists spoke up in agreement. (Fieldnotes)	X is an expert in cardiac research. If she says, "We should be doing this and this," I'm going to say, "Yeah, go for it." . . . I'm just going to support them." (Interview E9)
	Something needs to happen quickly for the patient's benefit . . . We need pathways or processes to surmount institutional and hierarchical barriers. (Interview E11)	What's motivating [cardiology is] . . . well-meaning and patient-oriented behaviors. (Interview H3)	Translating research findings into practice, the research project has already made rapid improvements in the assessment process for patients presenting with chest pain. (Organization document)
	An approach that integrates [evidence-based] advances is needed to deliver the best outcomes for chest pain patients. (Organization document)	We don't want patients sitting here for hours and hours and not being seen and sorted . . . that's not good care and comfort. (Interview N16)	The emergency consultant explains how problems with cardiology refusing to accept a patient can be averted by reference to the pathway: You can say, "That's the protocol. Your representative from your department agreed to it when it was developed." (Fieldnotes)

The manager's description of values misalignment mirrors the two challenges of specialization we identified as the core puzzle in the literature. Different specialists interacting during an emergency referral may have different interpretations of how the medical profession's values should be achieved for that particular patient, creating values misalignment—or conflict from differences in specialists' refracted values—during an individual patient episode at the micro level. In addition, specialists may perceive that one or more of the routines that make up emergency referrals as an organizational practice are not aligned with professional values for a group of patients, creating values misalignment between the profession writ large and organizational practices. Our data show that these value misalignments trigger specialist perceptions of two distinct types of problems—episodic and systemic—which initiate qualitatively different processes of institutional work.

Episodic Problems and Value Maintenance Work

Values could become misaligned when an emergency specialist's interpretation of how the medical profession's value should be enacted with respect to a particular patient bumped up against another

specialist's interpretation during an emergency referral. We distinguished three classes of episodic problems in which differences in specialists' refracted values caused misalignment between an emergency specialist's value interpretations and those of another specialist: delayed care, patient safety, and contested responsibility. Emergency specialists responded by engaging in institutional work directed at maintaining the profession's values not because they cared more about patients than other specialties did, but because they were responsible for the particular patient at that point in time. A doctor who had worked in multiple specialty departments explained, "the dichotomy isn't between caring and not caring but between caring and not being responsible" (fieldnotes).

Delayed care, moral emotions, and value maintenance work. The most common class of episodic problems arose from interspecialty differences in interpretations of timeliness. Timely care was vital to the everyday work and socialized identity of emergency specialists because of the time-sensitive nature of their specialty. Some patients presented with symptoms that were immediately, imminently, and potentially life-threatening, while others had symptoms that were only potentially serious and less urgent. Through their training and socialization, emergency specialists learned to associate professional values with time by "sifting and sorting" patients quickly, treating and discharging most of them, and "funneling" the sickest—a small proportion—into a specialty department.

Specialty admitting departments had different time priorities than did the ED because their specialist expertise and socialization was linked to the performance of particular procedures or the care of particular patient conditions. Admitting specialists were also responsible for non-emergency patients, whose needs were more predictable than the unplanned arrivals of emergency patients. Surgeons were sometimes not contactable for ED referrals because they were operating on patients who had been waitlisted for procedures. A trainee with the surgical specialties remarked that surgeons like to "just crack on [with] operating. It's really a bit of a pain when these emergency things come up" (S11). On-call surgeons either had to leave the theater or postpone seeing emergency patients until after completing the surgery list. Similarly, residents in general medicine stated that they were socialized to "do a lot of planning around outpatient clinics and ward rounds' because the "expectation" is these patients are a department priority over unplanned emergency patients (S8). A gastroenterologist said, "We didn't view the emergency patient as our core business" (S7).

The socialization of specialists in admitting departments to prioritize patients who were visibly their responsibility, and who they could easily see would benefit from their specialist expertise, impacted their timeliness in serving the needs of "unseen" patients arriving in the ED. As a hospital manager explained, "Doctors get completely fixated on the big P patient in front of them" which means specialists in admitting departments sometimes "struggle to move . . . to the unseen patient, the person who might need your care" (H3).

Differing specialty department interpretations of timeliness in attending to emergency patients created episodic problems whenever an emergency specialist perceived there was an unnecessary delay that was not in a patient's interests. For the emergency specialist, delayed care represented a twofold problem for the medical profession's value of prioritizing a patient's best interests. First, the patient being delayed was acutely unwell and an unnecessary wait for investigations and specialty treatment exacerbated their pain and discomfort. Second, newly arriving patients could not be assessed and diagnosed because the ED's bed, staff, and equipment resources were tied up with the delayed patient.

> [A specialist] not coming down means a patient can't leave [the ED to go to the ward] . . . which means that there's a guy uncomfortable waiting on an ambulance trolley. And I don't think the inpatient teams have any concept of that at all, partly because that's not how they practice medicine. One patient [and] sort that problem out—that's how most doctors practice medicine. I don't have responsibility for one patient. I have responsibility for not only the patients that are in the department, but also the patients who I haven't seen yet . . .potentially they are the ones who are really sick. (E7)

The encounter between an emergency specialist's interpretation of timely care and that of another specialist triggered action to maintain the values of the medical profession in the everyday work of the hospital. Our data show that a value maintenance process was initiated when the episodic problem of delayed care elicited moral emotions for an emergency specialist, as suggested in the above quote. Emergency specialists felt other-suffering moral emotions such as empathetic concern and compassion for the patient's comfort and welfare: "it's not right having someone waiting seven hours . . . I feel bad" (E2). Other-condemning emotions, such as

exasperation and anger, were elicited by the injustice of an emergency patient being treated as a low-priority unit of work: "it's demeaning" (E16).

As our illustrative examples in Table 2 show, the experience of moral emotions triggered an emergency specialist to focus their immediate attention on the problem and take practical action to bring the interspecialty enactment of the medical profession's values back into alignment for the particular patient. A common form of value maintenance work in response to problems of delayed care was *advocacy*. We defined advocacy as an expression of the medical profession's common value by representing the patient's needs and interests to another specialist and persuading them to become involved in the patient's care. Participants described it as "a collaborative approach [of] actually engaging somebody in the process" (E2) and using "polished language to really convince people" (E18). The fieldnotes below illustrate a process of value maintenance work in which the perception of delayed care elicits the other-suffering moral emotion of concern and triggers the emergency consultant to invest effort into maintaining the medical profession's values through advocacy.

> A patient who has been accepted for admission to general medicine is still waiting in the ED to go up to a ward. The patient's condition declines during the lengthy wait. Concerned that general medicine is acting too slowly in transferring the patient to a ward for specialist care and "having itchy fingers to want to help the patient," the emergency consultant contacts general medicine and persuades the resident to come down to the ED to conduct a follow-up assessment on the patient. He meets them at the patient's bedside and, after a long discussion, convinces them that the patient needs to be taken to the medical ward as soon as possible. (Fieldnotes)

Value maintenance work in response to problems of delayed care also occurred in the form of *sanctioning*. We defined sanctioning as the use of authority to approve a course of action consistent with the medical profession's values or to impose a penalty on behavior that contradicted the profession's values, such as through discipline. Emergency consultants could use their authority at the top of the clinical scale to sanction investigations and referrals, described as playing an "I-am-the-boss" card (E5). They also had the ability to report a patient's case to higher levels of administrative authority within the hospital for sanctioning of a solution. In the fieldnotes below, a process of value maintenance work can be seen to occur in which the perception of an episodic problem of delayed care elicits the other-condemning moral emotion of irritation at the dismissal of the needs of emergency patients. These emotions motivate the consultant to maintain the medical profession's values through sanctioning.

> A junior surgeon accepts patients for admission to the surgical ward but postpones writing up the notes because he has been called to theatre to observe "an interesting patient case." Aware patients will not be accepted by the surgical ward without notes, the ED resident is annoyed at the unnecessary delay and reports it to the emergency consultant. "Surely this is inappropriate behavior. He's going to theatre with an un-urgent case and he's left four of his patients waiting in the ED when they could be on the ward." Sharing the resident's irritation at the low priority being shown for the needs of emergency patients, the emergency consultant admonishes the junior surgeon for his lack of professionalism when he returns to the ED. (Fieldnotes)

Patient safety, moral emotions, and value maintenance work. The second class of episodic problem arose from differences between specialists in their interpretations of the safest line of care for a patient. Hospital managers explained that specialists "didn't want to put the patients at risk" (H4) and "are all innately driven by wanting to do things that are better for patients" in terms of reducing the risk of preventable harm and adverse events (H1). Nurses emphasized that "doctors want to do the right thing by the patients and make sure that they're safe" (N1). Our data show that different combinations of specialist expertise and information access refracted the medical profession's values differently, creating potential for divergence in specialist interpretations of the safest course of action for patients' best interests.

From the perspective of an emergency specialist, the decision to refer a patient for hospital admission was based on assessment of the clinical and situational risk of discharge. In making this "safe-or-unsafe-to-discharge" assessment, emergency specialists endeavored to reduce the risk of harm from adverse events including: discharging a patient from the ED before ruling out all potentially serious illnesses; discharging a patient to a home environment in which situational factors posed risk of harm; transferring a clinically unstable patient out of the ED to another department; and exposing a patient to potentially harmful side-effects from an unnecessary investigation such as a CT scan. Risk assessment by an emergency specialist was based on (1) their interpretation of codified information contained in necessary tests and investigations, and (2) tacit knowledge acquired through physical

examination, observation, and personal interaction with the patient and their family over their time in the ED.

> [It] is the whole vibe of a patient . . . I can describe the heart rate's up and so forth and probably put parameters around it but at the end of the day, it's that vibe that you have. It's very hard to tell that vibe over the phone. (E6)

As the above quote suggests, admitting specialists were dependent on the language used in a brief telephone conversation to express the emergency specialist's tacit knowledge. As a result, admitting specialists tended to focus more on the codified information contained in tests and investigations because it was easier to communicate interdepartmentally, less ambiguous, and more consistent with the knowledge base of their distinctive area of specialty expertise. A resident explained that general medicine is "more old-school than emergency and we like to run a lot of tests and use the results to carefully figure out what's wrong with a patient" (fieldnotes). Surgical specialists were also "reliant on medical imaging and pathology to determine actually do they need to come in" (S11), with a surgeon emphasizing, "It's very hard to be confident until you've seen them [the patient] yourself" (fieldnotes).

A potential outcome of these differences in information access and preferences was divergent risk assessments, such that specialists in other departments assessed the risk of patient harm as lower than the ED's evaluation. Our fieldnotes suggested that divergent risk assessment tended to occur when a patient presented with "symptoms at the borderline" between admission and nonadmission. Examples included elderly patients experiencing an array of vague symptoms but at risk of falling if discharged, and patients suffering high levels of abdominal pain suggesting a developing surgical condition with no confirmatory pathology. Divergent risk assessments induced admitting specialists to sometimes resist ED referrals because it was not clear from the information presented to them how the particular patient fitted within their department's criteria for admission. A resident who had trained in orthopedics indicated that sometimes "we think it's not an appropriate referral" because some bone fractures "need admitting [while others] are safe to go home and come back to our fracture clinics" (S20). Another resident who had completed training in medical and surgical specialties explained that if admitting specialists "don't have all of the information they want" during an emergency referral, it can seem like "there's nothing wrong with the patient and they're not the kind of thing that we should be dealing with" (S16).

Our data suggest that divergent risk assessments created episodic problems when an emergency specialist perceived another specialist had underestimated the potential for patient harm and the medical profession's value of acting in the best interests of the patient was therefore not being enacted in the referral. Examples of how these problems elicited moral emotions for emergency specialists and triggered value maintenance work are presented in Table 3. An emergency specialist felt other-suffering moral emotions, such as compassion and empathetic concern, when they confronted an episodic problem that they believed placed a patient at risk of harm. The risk of a potentially unsafe discharge was particularly emotive: "I would have more angst with trying to send someone home that I didn't think was quite ready" (E15). Compassion and concern triggered an emergency specialist to focus on practical actions to solve the problem through value maintenance work. This institutional work commonly took the form of advocacy of a compelling justification for the patient's need for safe care. If advocacy failed, an emergency specialist could engage in value maintenance work through sanctioning and invoke their authority to authorize admission.

We found that some episodic problems with patient safety elicited other-condemning moral emotions such as frustration and anger. Emergency specialists typically experienced other-condemning moral emotions when they felt that another department was not investing sufficient effort in risk assessment. In the fieldnotes below, an emergency specialist is exasperated that another department has underestimated the risk of harm because they have not adequately reviewed the codified information (an ultrasound) and have not sought to improve their tacit knowledge by personally examining the patient in the ED. Exasperation triggers a presented-oriented focus on value maintenance work in the form of sanctioning.

> An ED resident phones the gynecology resident about the ultrasound results for the patient who presented several hours ago with severe abdominal pain. "Looking at the scan to me, it looks like a cyst and it's bleeding." The gynecology resident disagrees and advises the patient be given analgesia and sent home if the pain settles. The ED resident hangs up the phone in dismay. "They've decided there's nothing there. They've decided not to review the patient." After

> speaking with the patient and learning the pain is worsening, the ED resident reports the situation to the emergency consultant. Given the potential for harm to the patient, he snaps in exasperation at gynecology's response, "She's got a bleeding ovarian cyst." Frustrated that the patient's condition is not being treated seriously enough, he pages the gynecology resident to insist they come down to the ED to examine the patient. (Fieldnotes)

Contested responsibility, moral emotions, and value maintenance work. The third class of episodic problem arose from differing interpretations of the appropriate specialty to take over responsibility for a patient. Whenever a patient presented with a condition that was multidisciplinary, managers explained that scope opened up for contests over "who should own the patient" (H2, H4, fieldnotes). Spinal injuries, for example, could be the responsibility of orthopedics or neurosurgery. Elderly patients with a bad heart, poor kidney function and a broken hip could go to general medicine, renal, or orthopedics.

Specialists in admitting departments enacted the medical profession's values with respect to multidisciplinary patients by seeking to ensure a patient's condition was "a good fit for our services" (S17, S18, H3, fieldnotes). An inappropriate patient consumed resources that might be better directed to helping other patients: "It wastes a bed day for our services" (gastroenterologist, fieldnotes). Some specialties—such as neurosurgery, cardiology, and intensive care—controlled "premium" resources in the form of technical expertise, high staff–patient ratios, and expensive equipment, and "you can't afford" to put inappropriate patients in these departments (S1, S2, S9, S15, H1). A resident noted that if a patient is admitted to the wrong specialty they will remain sick because specialists are "focused on their area of interest and if the patient doesn't have what they're looking for, it doesn't necessarily get picked up" (S16). A specialist in general medicine (S14) provided this example: "If the underlying cause of a female patient's anemia is pelvic bleeding then all I can do is give the patient a transfusion and refer her to gynecology," which could mean a three-day delay in treatment by the right specialty for the patient's condition (fieldnotes).

Our data suggest that when a patient's condition was multidisciplinary, specialists could contest responsibility. Specialists whose expertise lay narrowly in single-organ systems or specific technical procedures could argue that the patient's interests were better served under a specialist with broad expertise in whole-body systems (S5, S9). For example, "various things get missed" under vascular and plastics specialists compared to orthopedic specialists (S11). Specialists with narrow expertise often preferred to "consult" on their "part" of the patient's condition with the primary care role assumed by a specialty with broader expertise (S4, fieldnotes). However, this approach imposed the resource burden of admitting a patient and managing their ongoing care and treatment on the other specialty department, so specialists with broader expertise resisted being the "default" owner of multidisciplinary patients (S8, S14, fieldnotes). A participant who had trained in general medicine pointed out in reference to narrow surgical specialists: "You're not just a [surgeon] with a knife. You're a doctor as well" (S18). Hospital managers warned that subspecialists "reduced themselves to little more than technicians" if they failed to manage holistic care of patients (H3, also H1).

For an emergency specialist, contests over responsibility represented episodic problems for achievement of the profession's values. It was not in the best interests of a multidisciplinary patient to be installed in the ED without receiving ongoing care from an appropriate specialty. An emergency specialist noted that if two or more specialties consulted on a patient and contested who should take responsibility, the patient's length of hospital stay was doubled. At the extreme, patients could remain in the ED for 24 hours until responsibility was resolved, adding to patient discomfort and reducing ED capacity to care for new patients.

Problems of contested responsibility elicited moral emotions for an emergency specialist. Table 4 shows emergency specialists commonly felt other-condemning emotions at specialties that avoided taking appropriate responsibility for a patient's care. They felt frustration, irritation, and anger that the patient's best interests were compromised by a "game" in which departments sought to shift responsibility to others for patient conditions that they were resourced by the hospital to treat. In one example, four specialties—intensive care, neurosurgery, general surgery, and general medicine—agreed that a traffic accident victim with a cerebral contusion, pulmonary embolism, and multiple fractures needed hospital care "but not under us." The emergency consultant described his moral outrage: "I was ranting at people on the phone because it wasn't 'fair' to the patient" (E22).

In this example, the experience of anger, as an other-condemning moral emotion, triggered the emergency consultant to engage in value maintenance work in the form of brokering between the four departments to ensure the patient was admitted

under general medicine, the specialty able to best care for the patient's primary condition of a pulmonary embolism—"the thing that was going to kill them" (E22). Brokering entails the emergency specialist mediating interactions and information flow between different specialists to resolve the contest over responsibility in a way that ensures the patient receives care and treatment from the specialty best suited to their needs. Emergency specialists typically made an initial referral to one specialty and acquiesced to any request to contact a second specialty. If the second specialty resisted, the emergency specialist performed brokering. They actively mediated between departments to facilitate "appropriate ownership" of the patient, or they withdrew and encouraged departments to work together to define the appropriate owner of the patient's condition. On the rare occasions when these strategies failed, the emergency consultant escalated brokering to a higher level of authority. A hospital manager noted, "The best way to arbitrate is [to ask], well what's the best thing for the patient?" (H4).

While other-condemning emotions were the most common trigger for brokering directed at maintaining the medical profession's value of patient care, our data also show cases in which brokering was triggered by other-suffering emotions such as compassion and empathetic concern for the patient, as illustrated in Table 4.

Summary. Value interpretations of specialists involved in an emergency referral can be misaligned because the medical profession's value of prioritizing patient interests is refracted differently for specialists due to: (1) specialist expertise and socialization regarding timeliness and urgency of care, (2) information access and specialist knowledge preferences in making risk assessments, and (3) narrowness of specialist disciplinary expertise and defined specialty departmental responsibilities. Our data show that value misalignment can lead the emergency specialist to perceive episodic problems in which the professional value is undermined by delayed care, patient safety, and contested responsibility, respectively.

Value misalignment triggered a cognitive and affective process of institutional work on the part of the emergency specialist to solve the problem and maintain the medical profession's value. The process proceeded through the mechanism of moral emotions being elicited in the emergency specialist by the perceived episodic problem. Other-condemning moral emotions tended to be elicited when the emergency specialist focused on the other specialist's actions in not upholding the professional value of prioritizing patient interests along the dimension of timely care, safe care, or appropriate patient ownership. In contrast, other-suffering moral emotions tended to be elicited when the emergency specialist focused on the patient's experience of not having the professional value upheld. Our data suggest that the experience of moral emotions motivates the emergency specialist to expend effort to restore the professional value in the patient episode through value maintenance work, which takes the forms of advocacy, sanctioning, or brokering. When an episodic problem of delayed care or patient safety elicited other-condemning moral emotions, the emergency specialist was more likely to engage in maintenance work through sanctioning. In contrast, when other-suffering emotions were elicited, maintenance work through advocacy was more likely. Finally, when episodic problems involved contested responsibility, both other-condemning and other-suffering emotions triggered brokering as the form of value maintenance work.

Systemic Problems and Value Maintenance Work

Our analysis revealed the potential for a second, and qualitatively different, source of misalignment. Instead of arising from different specialist interpretations of values encountering each other and creating episodic problems, here the source of misalignment was systemic, and originated as the medical profession's value of primacy of patient interests encountered the bundle of administrative and clinical routines that constituted the organizational practice of emergency referrals. Systemic problems arose when an existing routine within the practice of referrals created an obstacle to specialists fulfilling the best interests of current and future patients. As shown in Table 6, our data contained three cases of systemic problems: (1) trauma protocol, (2) night CT scanning, and (3) chest pain pathway. Common across these cases was a process of value maintenance work in which evaluation of a systemic problem by groups of specialists elicited collective moral emotions and mobilized collective action to maintain the profession's value by changing the organizational practice.

Evaluation of a systemic problem. In each case, the perceived cause of the systemic problem was rooted in the bundle of routines that made up emergency referrals. Both trauma protocol and night CT scanning concerned obstacles to the profession's values created by administrative routines, while chest pain

pathway involved obstacles generated by clinical routines. An emergency specialist described the evaluation of systemic problems as follows:

> It's not demonizing the individual or even the behavior but just stepping back and going actually this is just our system not working as well as it could and we can make it better and obviously trying to do the right thing by the patient as the ultimate outcome. (E8)

In trauma protocol, normal administrative routines for patients going to the operating theater—related to patient identification and notification of theater, nursing staff, anesthetists, and surgeons—posed an obstacle to values. The hospital's intention was to encode the medical profession's value of primacy of patient interests in "checks and balances [that] are incredibly important in theater for safety reasons" (E17, E20). However, for a small subset of critically unwell patients who presented to the ED and required immediate referral to surgery, these routines subverted, rather than achieved, the profession's value by exposing them to risk of harm. A surgeon explained, "People die in EDs around the world because of a little delay [in getting to theater]" (S23). The magnitude of this risk was highlighted for emergency specialists and surgeons in a sentinel event, a term used in medicine to describe an event that results in patient death or injury and signals the possibility of system failure.

The sentinel event involved a young patient with internal bleeding who emergency specialist D determined needed immediate surgery. Circumventing normal administrative routines, D contacted surgeons and an anesthetist, who agreed to meet in theater. After rushing the patient to theater, surgery was delayed by theater nursing staff insisting on normal patient identification routines. When the patient began to go into cardiac arrest, D shouted for surgery to begin and pushed past nursing staff to offload the patient onto the operating table. The patient died during surgery. Some adjustments to theater practices were made, but when another patient nearly died during delays in getting to theater, both emergency specialists and surgeons perceived a systemic problem. Emergency specialists identified "a major problem" (E17); surgeons saw a "mountain" that slowed patients down (S22). Below, D describes how theater's routines became collectively recognized as a barrier to the profession's values:

> There's lots of protocols for patients who normally go to theatre and they're in place for a reason, but there's times when they need to be removed and this was certainly one of those times. I did create a bit of havoc up there. ... I felt fairly strongly that something had to happen and I wasn't all that interested in any kind of hospital process getting in the way. ... When the clock's ticking, they're actually putting the patient at risk. ... The patient was probably destined to die anyway [but] it's much easier to live with something like that outcome when you know the system has given their best shot for the patient. ... [Surgery] realized that there were some process issues that needed to be addressed [and] ... most of the [medical and nursing] staff appreciated why I was behaving that way.

In the night CT scanning case, the source of the obstacle was administrative routines for organizing CT scans of patients who presented to the ED after midnight. Because the hospital did not operate a 24-hour CT scanning service, night CT scans were delayed until the next morning. In extreme emergencies only, an on-call CT radiographer could be phoned to come to the hospital. This administrative routine was established to save staffing costs on specialist radiographers. For emergency specialists, the routine represented an obstacle to the profession's value of prioritizing patient interests because it delayed acutely sick patients in receiving a diagnostic investigation necessary for referral to an appropriate specialty.

In contrast to these two cases arising from administrative routines within emergency referrals, the chest pain pathway case involved clinical routines. A systemic problem in the clinical routines for patients presenting with chest pain was identified when specialists in emergency medicine, cardiology, and general medicine experienced repeated episodic problems of contested responsibility. Existing clinical routines for chest pain patients—8% of patients presenting to the ED—were unable to quickly, efficiently, and safely identify which patients should be (1) referred to cardiology for immediate treatment of acute coronary syndrome, (2) referred to general medicine for treatment of conditions such as pulmonary embolism, and (3) investigated by the ED and discharged because the patient was at low risk of a cardiac event. Thus, the existing referral routine was perceived by the different groups of specialists as an obstacle to achieving the medical profession's value of the patient's best interests: "the system we were working with at that moment just didn't make sense" (E16).

Eliciting collective moral emotion. Recognition of a systemic problem elicited collective moral emotions. In contrast to episodic problems where the moral emotions elicited were individually

experienced and transitory, moral emotions elicited by systemic problems were experienced within and across groups of specialists and were enduring.

Collective moral emotions of the highest intensity and duration were evident in the trauma protocol case because of the high magnitude of risk to patients. For emergency specialists as a group, "there was a lot of emotion" (E5) and "angst" that normal administrative routines were a barrier to "getting this patient who is clearly trying to die in front of you to theater" (E20). Specialists in surgery were equally concerned for patient welfare: "The only thing that matters is to stop the bleeding and stop the patient dying" (S22). An emergency specialist described how he and a senior surgeon met at a patient's bedside and shared their feelings of "this is terrible the way the situation is [and discussed] how can we fix it?" (E17). Thus, our data show that this systemic problem elicited collective moral emotions of concern for patient welfare (other-suffering emotions) among emergency specialists and surgeons as groups of specialists. These emotions were enduring and provided motivational energy for the professionals to work together to find a solution that would maintain the medical profession's values by protecting the interests of the "sickest and yet most saveable patients in the hospital" (E18).

Although the intensity of emotion was lower in the other two cases, the process of systemic problems eliciting collective moral emotion was similarly present. In the night CT scanning case, emergency specialists as a group felt other-suffering moral emotions of "concern" and other-condemning moral emotions of "frustration" that an administrative routine to "resource restrict" a diagnostic service (E13) was "compromising patient care for efficiency" (E16). Specialists in radiology shared these feelings and encouraged emergency specialists to "push for" change (fieldnotes). Attempts to lobby hospital management were unsuccessful. Collective moral emotions became heightened when an event involving a neurosurgical patient highlighted how disconnected the night CT scanning routine was from the medical profession's value. Heightened collective moral emotions provided extra motivational force for emergency specialists to "escalate" the problem to hospital management (fieldnotes).

Finally, in the chest pain pathway, lack of "consistency and predictability" (E18) in clinical routines for referring patients with chest pain elicited collective moral emotions for specialists in emergency medicine, cardiology, and general medicine. These specialists shared other-suffering and other-condemning moral emotions that existing clinical routines were not well aligned with the medical profession's value of providing "optimum care" for patients (E16). Cardiologists wanted to help patients by finding "faster, more reliable and safer ways of investigating" and identifying people with acute coronary syndrome (S24). Emergency specialists felt empathy for patients at low risk of a cardiac event who were "trapped in the ED for hours" (E16), and frustration that ineffective routines were reducing ED capacity to treat other patients. These collective moral emotions motivated representatives of the different specialty groups to "sink [their] heart[s] into" working together to solve the systemic problem by developing new evidence-based clinical routines (E16).

Mobilizing collective action in value maintenance work. In each of our cases, the experience of collective moral emotions mobilized different groups of specialists to engage in value maintenance work through collective action. This contrasted with value maintenance work through individual action to solve episodic problems. The mobilizing force of collective moral emotions was strongest in trauma protocol. The "life-and-death outcome for patients" (S13) meant that, compared to our other cases, the collective experience of emotions was the most intense, enduring, and viscerally connected to the medical profession's values.

In trauma protocol, emergency specialists and surgeons initiated, and mobilized around, a new administrative routine that worked for, rather than against, the interests of "a patient who is dying through blood loss" (S22) by getting them "moving" (S23). The ED committed to trauma and access to theater as priorities for reform. As they grappled with the question of "how does the ED integrate with theaters," the department of surgery committed to developing a dedicated trauma service. An emergency specialist emphasized that "their interest in the trauma service and our interests in improving the service coincided" (E19); another noted "the surgical drive was there from the beginning" (E20).

Two emergency specialists worked with a surgeon to champion an interspecialty solution to the systemic problem. The surgeon identified a model used in a Los Angeles hospital where a red-colored blanket was thrown over a patient with uncontrolled bleeding to indicate authorization for immediate transfer from the ED to theater (documents). Evidence of the model's effectiveness informed theorizing of a new protocol for referring patients requiring lifesaving surgery to theater. The champions mobilized support by engaging their colleagues in surgery, theater, ED, and anesthetics in developing criteria and

procedures for activating and coordinating specialist expertise, roles, and responsibilities. Mobilization was aided by collective moral emotions of concern linked to the medical profession's value that this was "the right outcome" for patients. A hospital manager stressed:

> They all bought into it [trauma protocol]. . . . There wasn't any ownership of it and so it wasn't somebody's pet project that they were trying to foist on anybody. Nobody owns it. It's owned by the patients who are in trouble and people [specialists] recognize that. (H1)

Mobilization of collective action was more political in the night CT scanning case. Motivated by collective moral emotions of concern for patients and frustration that resources continued to be inadequate for their needs, the ED director and another specialist encouraged ED staff involved with the neurosurgical patient to report the incident to a hospital committee that reviewed potential breakdowns in health service systems. The ED representative on the committee notified members that "we have a case for the next meeting and it's a good one" (fieldnotes). By focusing attention on the potential patient harm of the night CT scanning routine, emergency specialists successfully mobilized support within the hospital for an expanded administrative routine of 24-hour CT scanning.

Finally, in the chest pain pathway case, mobilization of collective action was founded on interspecialty research collaboration. A group of emergency and cardiology specialists collaborated to develop evidence-based risk indicators that could inform new clinical routines for chest pain patients. These specialists worked with other specialists in general medicine to specify pathways for patient investigation and interspecialty referral according to clinical risk indicators. An emergency specialist noted, "There's just such strong evidence clinically that these patients do better if we do X, Y, Z" (E16). Because commitment to better patient outcomes is core to the medical profession's values, researchers were able to mobilize strong support across specialists in the departments of emergency, cardiology, and general medicine to agree defined pathways for interspecialty referral.

Adaptation of organizational practice. In all three cases, value maintenance work through collective action encoded the values of the medical profession in new routines within the bundle of administrative and clinical routines that made up emergency referrals as an organizational practice. The trauma protocol brought emergency specialists, surgeons, and theater together to "work as a seamless service" (H1), reducing time to theater for trauma patients. The emergency specialists interviewed for our study all agreed that the new protocol "made it easier to maintain their values as a doctor." Similarly, the surgeon who championed the protocol said, "We've got people who definitely have had life-saving outcomes . . . all the effort is worth it" (S22). The improvements to night CT scanning encoded the profession's value in administrative routines for diagnostic investigations by prioritizing patient care over resource costs (E12). The chest pain pathway encoded values in new clinical routines for chest pain patients as "an agreed system that says these are important patients" (E10). The outcome of this process was maintenance of the profession's values by adapting emergency referrals as an organizational practice through changing the bundle of routines.

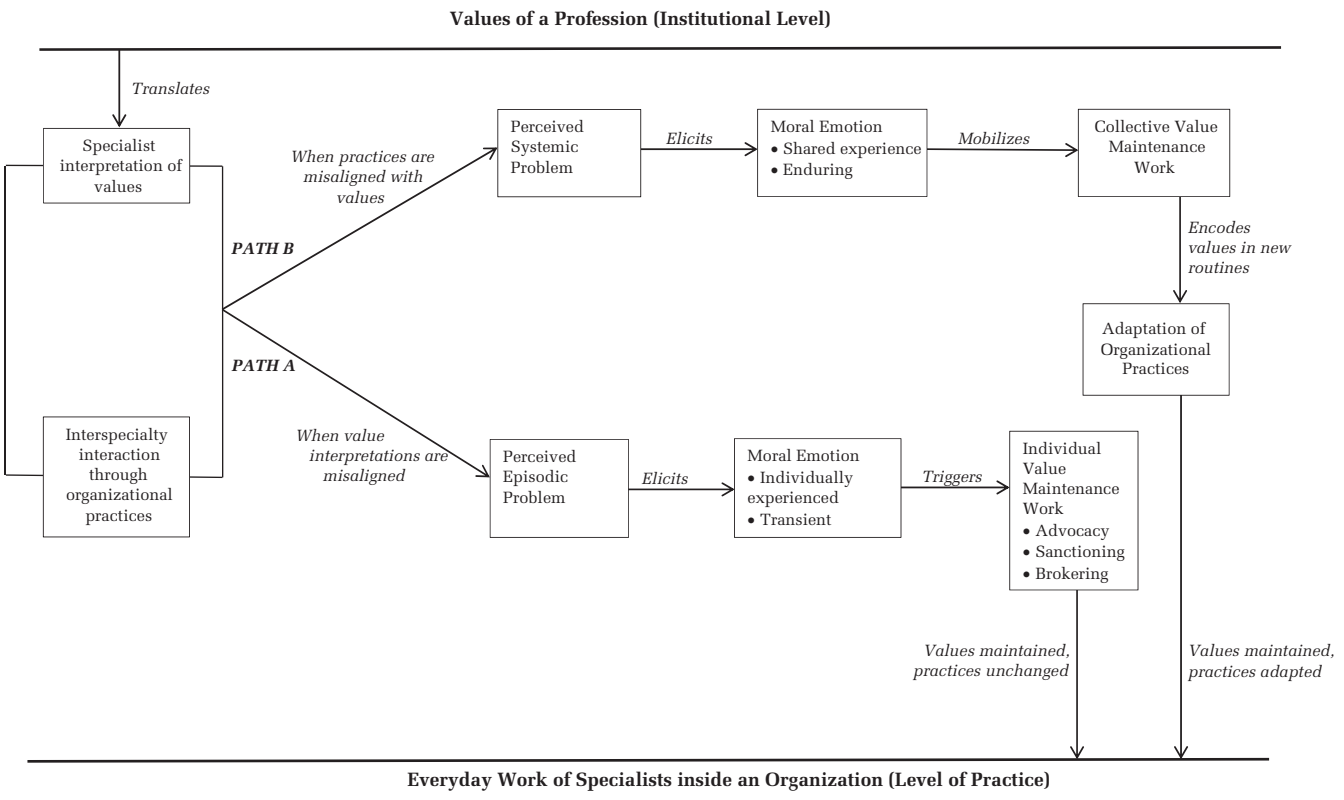
Process Model of Value Maintenance Work

Our process model in Figure 1 demonstrates the dynamics of how the values of a profession at the institutional level are translated, enacted, and maintained in the everyday work of specialists at the level of actual practice. The values of a profession are translated into everyday work inside organizations through interplay between specialist interpretations of the profession's values, which are refracted as they travel from the macro level to the organization level, and interspecialty interaction in organizational practices. If the outcome is misalignment between specialist value interpretations or misalignment between professional values and organizational practices, processes of institutional maintenance work are activated along two different paths, respectively.

As shown by Path A in Figure 1, a value maintenance work process is activated when the outcome of different specialist value interpretations encountering each other during interspecialty interaction associated with organizational practices is misalignment between value interpretations. Problems with another specialist's interpretation of the profession's values are *episodic* and *moral emotions,* which are individually experienced and transitory, and are a *trigger* for a specialist to engage in value maintenance work through *individual action*. This individual institutional work maintains the profession's values without changing the practice.

A qualitatively different value maintenance work process is activated along Path B (Figure 1) when encounters between specialist value interpretations and the bundle of routines associated with

FIGURE 1
Microprocesses of Value Maintenance Work by Specialists



organizational practices reveal misalignment between the profession's values and the practice itself. Problems are *systemic* and *collective moral emotions,* which are enduring and experienced by groups of specialists, who experience *motivational force to mobilize* maintenance work through *collective action*. Specialists collaborate in maintenance work that encodes values into new routines within the organizational practice. The profession's values are maintained in everyday work by changing the practice to be more consistent with values.

DISCUSSION

Contributions to the Study of Professions

We contribute to the study of professions by advancing understanding of the relationships between specialization, professional values, and everyday work in organizations. While it is well recognized that maintaining the values of professions is difficult given contemporary trends of specialization coupled with managerialist organizational structures and practices (Brint, 1994; Brock et al., 1999; Freidson, 1984; Muzio & Kirkpatrick, 2011), scholars have paid limited attention to unpacking the core puzzle and explicating the precise nature and dynamics of the problems created for value maintenance. Even less attention has been directed to exploring how specialists themselves are able to identify and react to these problems by taking actions to keep the values of the profession alive inside organizations (Evetts, 2006; Muzio et al., 2013). Our findings redress these limitations in two key ways.

First, we provide nuanced insight into the types of problems that specialists face in maintaining the values of their profession inside organizations. We contend that episodic problems with value maintenance arise because of how values refract as they travel from the macro level of the profession to the micro level of specialists working inside organizations. Extending the literatures on professional identity (Hewett et al., 2009; Pratt et al., 2006) and specialized organizational structures (Adler et al., 2008; Brock, 2006), we theorize that values refraction means that the same professional value has the potential to be interpreted differently when specialists, whose professional identities have been customized

through specialty training and socialization, interact in organizations that compartmentalize them in separate departments. Our study shows that values refraction causes episodic problems with value maintenance when the value interpretations of specialists interacting at organizational interfaces are misaligned. Our study also reveals that specialists can experience systemic problems with value maintenance. Building on Selznick (1992) and Kraatz et al. (2010), we find that systemic problems can arise from conflict between professional values writ large and the organizational practices that specialists perform to fulfill organizational requirements.

By extricating the nature and source of the problems that specialists face when trying to maintain professional values inside organizations, our study offers a way forward for a deeper and more balanced understanding of the sources of conflicts that happen in organizations. Extensive bodies of literature have sought to explain how organizational structures cause coordination problems (e.g., Bechky, 2003; Bruns, 2013; Ferlie et al., 2005), and have ascribed motives of power and self-interest to professionals (e.g., Brint, 1994; Currie et al., 2012; Daudigeos, 2013; Freidson, 1984; Kellogg, 2012). Thus, it is easy to dismiss the conflicts that arise in organizations between different specialists, and between specialists and organizational practices, as caused by structure or professional power plays. Our study brings to the surface an alternative explanation that is more respectful of specialists as actors with humanity who are deeply committed to the values of their profession.

Our findings illuminate that specialists care about their professional values and may experience problems in their maintenance due to episodic refracted-value conflicts and systemic value–practices conflicts. While we do not dispute that conflict can arise between specialists due to coordination problems and power plays, our data show that an important source of conflict also arises from how specialists cognitively interpret and affectively experience problems with professional value maintenance inside organizations. Because so much empirical attention has tended to focus on structural and power accounts of conflict to the exclusion of other motives (Muzio et al., 2013), the substantive role that professional values play as drivers of specialist behavior in organizations has been concealed to date.

Second, our findings redress the limitations of prior literature on professions and specialization by highlighting the active role played by specialists as the glue that binds professions, values, and specialization together at the micro level of everyday work. Our findings show that a profession's values are maintained inside organizations despite the challenges of specialization because specialists make connections between problems and professional values and take actions alone and together to resolve those problems in ways that maintain the profession's values. Rather than behaving like the self-interested experts portrayed in many prior studies (Brint, 1994), the specialists in our study were fundamentally people who were committed to a core professional value and reflective about its maintenance in their everyday work. This is not to say their motives were always or only pure or altruistic—the specialists we studied were, after all, people working in a resource-constrained organizational environment. Nevertheless, our careful data collection and analysis illuminated a set of interaction episodes and case studies in which specialists interpreted and responded to organization-level problems from a deeper place of professional values.

By drawing attention to the active role of specialists in resolving the problems that specialization creates for values, our study contributes new insight into the broader issues pertaining to how and by whom normative values of professions can be maintained, even as the nature and context of professional work shifts. Although some scholars have been skeptical that the normative values of professions have been maintained in the era of specialization (e.g., Brint, 1994; Freidson, 1984), others have argued that values are maintained because values lie at the heart of professional identity (Evetts, 2003, 2006; Scott, 2008b). However, these latter arguments tend to be ideologically grounded and offer little empirical explanation for how values are maintained in the face of specialization's distinctive challenges, conceptualized as our paper's core puzzle. While some research has suggested that value maintenance work is performed at the field level by professional associations creating and administering rules and standards for professional membership (Greenwood et al., 2002; Micelotta & Washington, 2013), a nascent research stream has pointed to the frontline work of actors as carriers of professions (McCann et al., 2013). Our study advances this debate by opening up the dynamic micro-level processes that underpin the "how" and "who" of professional value maintenance by shedding light on the individual and collective actions of specialists interacting within organizations.

Although our findings provide strong support for values-based explanations of the everyday work of specialists in our study, we acknowledge that we were not able to fully exclude an alternative

explanation that some of the emotions and actions we observed were rooted in professional power, status, and ego, rather than values. For example, it is possible that some of the anger felt over delayed care was an emergency specialist's response to having their work capacity controlled by another department. It is also possible that an emergency specialist's emotional response to divergent risk assessments was not elicited by professional concern over patient safety, but rather by ego at having another specialist challenge their expertise. Our data generally offered limited support for these alternative power- and ego-based explanations of professional action, and much stronger support for the value-based explanation we proposed in our model. We invite future research to explore the comparative conditions under which power, ego, and values provide motivation for the everyday work of specialists and other professionals inside organizations.

Contributions to the Study of Institutional Work

Our focus on professions, a key institution in society, provides the basis for contributions to the literature on institutional work. Extending research on maintenance work directed at the regulative and cultural-cognitive pillars of institutions (Dacin et al., 2010; Lok & de Rond, 2013; Micelotta & Washington, 2013), our study draws attention to work directed at maintaining an institution's normative pillar. We reveal how maintenance of institutions at the macro level occurs, in part, through microprocesses in which members of the institution—in our study, specialists within a profession—undertake actions that maintain the institution's normative foundations by reproducing its values in everyday work. Building on theorizing that has sought to integrate emotions into institutional analysis (Creed et al., 2014; Voronov & Vince, 2012; Voronov & Weber, 2015), we identify the role of a distinctive type of emotions—moral emotions—in triggering institutional work processes.

Our findings regarding the moral emotions involved in value maintenance work by specialists as members of a profession have theoretical implications for understanding the dynamics of institutional maintenance work by members of institutions more broadly. Our findings suggest that actors who are committed to institutions will undertake micro-level institutional work that maintains the institution's normative pillar when they feel moral emotions that the institution's values are not being upheld. Table 7, which complements our process model in Figure 1, elaborates the key affective mechanisms through which moral emotions drive processes of institutional maintenance work. The table shows two dimensions of moral emotions that are most salient to institutional maintenance work: the type of elicitor and the scope of the institutional member's experience of emotions.

The first dimension of moral emotions in Table 7 captures the *type of elicitor* when an institutional actor perceives that the values of the institution are not being upheld or are at risk. We use the broad label of a values violation to describe this general situation, which can include passive violations where the institution's values are perceived as not being enacted (episodic problems in our study) to more active violations where values are perceived as being undermined or subverted (the trauma protocol). Situations involving perceived violations have three types of emotion elicitors: (1) the victim, (2) the violator, or (3) the practice. When the elicitor is the *victim*, the institutional actor's moral emotions are elicited by the suffering of the victim of the values violation. When the elicitor is the *violator*, the actor's moral emotions are elicited by the person perceived to be violating the institution's values. Finally, when the elicitor is the *practice*, the actor's moral emotions are not elicited by people but instead by a practice perceived to violate the institution's values. An emergency specialist, for example, who perceived the medical profession's values as not being acted upon could feel compassion for the patient (victim), anger at another specialist (violator), or condemnation of an administrative practice applied to a patient group (practice).

The second dimension of moral emotions in Table 7 concerns the scope of the institutional actor's affective experience of the values violation. The *scope of emotional experience* has two forms: (1) individually experienced and transient, or (2) shared with other institutional members and enduring. When the emotional scope is *individually experienced and transient*, moral emotions are felt by a single institutional actor and last only while the values violation is directly experienced. In contrast, when the emotional scope is *shared and enduring*, moral emotions are felt by a group of institutional actors and these feelings remain long after the values violation has occurred. In our study, for example, a single emergency specialist could feel moral emotions for a brief period during a values violation with an emergency referral (as occurred with episodic problems), or the specialist could belong to a group of specialists who continue to feel moral emotions for an extended period after a values violation

TABLE 7
Relationships between Dimensions of Moral Emotions and Institutional Work Processes

Experience of moral emotions \ *Elicitor for moral emotions*	**Victim of institutional values violation**	**Violator of institutional values**	**Practice that violates institutional values**
Transient & individual	Individual institutional maintenance work solves episodic problem *[Cell A]*	Individual institutional maintenance work solves episodic problem *[Cell B]*	Inability to mobilize collective institutional maintenance work *[Cell C]*
Enduring & shared	Individual institutional maintenance work may progress to collective work over time *[Cell D]*	Individual institutional maintenance work may progress to collective work over time *[Cell E]*	Collective institutional maintenance work solves systemic problem *[Cell F]*

occurs during an emergency referral (as occurred with systemic problems).

Table 7, in conjunction with Figure 1, illustrates how the two dimensions of moral emotions trigger different processes of institutional work, which seeks to resolve the values violation and—consciously or unconsciously—maintain the normative pillar of the institution. When emotions are elicited by either the victim or violator and are individually experienced and transient (cell A and cell B in Table 7), the institutional actor is motivated to engage in institutional maintenance work through individual action. The actor resolves the episodic problem of the values violation and, in doing so, maintains the institution through its normative values. In contrast, when moral emotions are elicited by a practice that violates institutional values and are shared and enduring (cell F in Table 7), institutional actors use these emotions to mobilize other actors to engage in institutional maintenance work through collective action. This work is directed at resolving the systemic problem of the values violation through changing the practice to better embed the value in the routines that make up the practice, which has the outcome of maintaining the normative pillar of the institution through its values.

We speculate in Table 7 that other combinations of elicitor and emotional scope trigger processes of institutional work that are likely to be less effective in resolving the violations of an institution's values. When emotions are elicited by either the victim or violator and are shared and enduring (cell D and cell E), institutional work occurs through individual action because institutional actors do not recognize that the source of the values violation might be a systemic problem with the practice. Over time, repeated episodes of individual institutional work by multiple institutional actors, who share enduring feelings about the values violation, may shift the emotion elicitor from the victim or violator to the practice. If this occurs, shared and enduring moral emotions will help facilitate mobilization of a collective action response to solve the now recognized systemic problem.

Institutional work is also likely to be ineffective when the emotion elicitor of a practice is combined with emotional scope that is individually experienced and transient (cell C). Although the institutional actor recognizes that the values violation is a systemic problem with the practice, the actor is unable to mobilize the collective institutional work needed to solve the values violation because of the narrow emotional scope. Since the actor alone feels moral emotions in response to a perceived values violation, emotions cannot be leveraged to mobilize other institutional actors in collective action to change the practice.

We speculate that the mechanisms of moral emotions that we identified in Table 7 and Figure 1 are potentially generalizable to other types of institutional maintenance work. Future research should explore whether the microprocesses and affective mechanisms we uncovered for work directed at maintaining an institution's normative pillar can also explain work directed at the regulative pillar and the cultural-cognitive pillar. It is possible that for actors who are strongly committed to an institution, violations of institutional rules elicit moral emotional responses similar to values violations, triggering microprocesses of maintenance work directed at the regulative pillar that mimic those we found for the normative pillar. Violations of institutional beliefs and meanings could also potentially generate moral emotional responses similar to those

we uncovered for values violations, triggering microprocesses directed at maintaining the institution's cultural-cognitive pillar. Further investigation is needed to explore the extent to which our findings about moral emotions as a mechanism in institutional maintenance work directed at the normative pillar can also explain institutional work aimed at the regulative and cultural cognitive pillars of institutions.

We also speculate that our insights into moral emotions in value maintenance work might be generalizable to other types of "values work" at organizational and institutional levels (Gehman, Trevino, & Garud, 2013). Values work is an emerging area of research that has drawn attention to how values are performed in organizations (Gehman et al., 2013) and how values can be engaged strategically to change institutions (Suddaby & Greenwood, 2005; Vaccaro & Palazzo, 2015) and invoked politically to restore them following crisis (Gutierrez, Howard-Grenville, & Scully, 2010). Future research could explore the role of moral emotions in values work directed at creating, changing, and disrupting institutions and embedding values in organizational cultures through performance. Of particular interest is whether and how the emotion elicitors of victims, violators, and practice violations we uncovered in our study of value maintenance are mechanisms in other processes of values work.

Finally, we invite future research to explore the relationships between other dimensions of moral emotions and institutional work processes. While the relationships summarized in Table 7 were the strongest in our findings, our data also hint at a tentative relationship between the content of moral emotions and the form of institutional work triggered. We found that when an episodic problem elicited other-suffering moral emotions, institutional work was more likely to be triggered in the form of advocacy (41 instances) than sanctioning (19 instances). In contrast, other-condemning moral emotions were more likely to trigger sanctioning (73 instances) than advocacy (55 instances). When the episodic problem involved contested responsibility, institutional work took the form of brokering, irrespective of emotion content. Taken together, these findings open up a possible relationship between the content of moral emotions and the form of maintenance work, which requires further investigation. Another dimension of moral emotions that may influence institutional work is intensity of emotion. Future research could examine whether more intense moral emotions trigger more rapid institutional work processes. Researchers could also compare whether different threshold levels of emotional intensity are required to motivate institutional work through individual action and to mobilize work through collective action, respectively.

Contributions to the Study of Moral Emotions

We contribute to deeper understanding of moral emotions by bringing an institutional perspective to their study. Prior theory and studies by moral psychologists have generally cast moral emotions as being conditioned by society (Kroll & Egan, 2004; Tangney et al., 2007), such as anger at torture, but the role of societal-level institutions in shaping how individuals construe events as emotion elicitors is undertheorized. Our study extends this literature by drawing attention to how a specific type of institution in society—a profession—can drive moral emotions. Our findings about transitory and individual experience of moral emotions elicited by episodic problems, and enduring and shared experience of moral emotions elicited by systemic problems, enriches the psychology literature's understanding of the temporality of moral emotions (Agerstrom, Bjorkland, & Carlsson, 2012) and processes that trigger collective moral emotions (Branscombe & Doosje, 2004).

Limitations and Boundary Conditions

Our study was limited to a single case study of specialists within one profession in one organizational setting. Our data were generated in a profession with a long history of traditional values as social trustees and in a public sector organizational context. This suggests two boundary conditions on the generalizability of the relationships we uncovered between value-and-practice misalignment → problem perceptions → moral emotions → value maintenance work. First, these relationships are generalizable to settings in which actors are closely committed to the values of an institution. This includes not only professions, but also other institutions such as political, religious, and cultural organizations with entrenched ideological values, social movements such as the Occupy movement, and government agencies responsible for administering standards for values achievement. Commitment to values is a boundary condition because commitment is necessary to elicit moral emotions of sufficient strength to motivate action. Second, these relationships are generalizable to settings in which resources are constrained, as they were in our public hospital context. Resource

constraints are a boundary condition because they prevent values being implemented to the levels that committed actors might prefer, seeding the possibility for value interpretations to diverge and for values to misalign with practices. Future research could explore our model's relationships in settings that meet these boundary conditions.

In addition, our data collection focused in large part on the everyday work of a particular type of specialist actor. While we sought to reduce this limitation by collecting data from other specialists who interacted with emergency specialists, our model nevertheless reflects the perspective of a specialist engaged in everyday work that can be characterized as time-critical, unpredictable, and with high-stakes outcomes. We do not mean to suggest that because emergency specialists perform work of this nature their claim to maintaining the medical profession's values is superior to that of other specialties. No values monopoly is assumed for emergency specialists, nor is a values deficit implied for other specialists. We do, however, speculate that a relationship may exist between the characteristics of a specialist's everyday work and their cognitive perceptions of particular types of problems (delays, safety) and the intensity and type of moral emotions elicited in response as a trigger for value maintenance work. Future research is needed to explore this relationship in other professional work settings, including similar "extreme" settings, such as paramedics and SWAT teams, and settings where work is less time-pressured, more predictable, and with lower-stakes outcomes.

Finally, consistent with our interest in the everyday work of specialists inside organizations, we focused our data collection on the level of the organization and collected only limited background data on the professional associations, specialist colleges, and regulatory bodies that maintain professions at the field level. Thus, our findings are limited to the microprocesses of institutional work as the macro level of the profession is translated into individual and organizational action (top-down, institutional field → organization) and do not offer insight into the processes by which institutional work at the micro level feeds back into the profession (bottom-up, organization → institutional field). Future research could trace longitudinally whether and how value maintenance work that changes organizational practices in response to systemic problems impacts the institution of the profession over time.

Research is also needed to explore the outcomes of institutional work in terms of its positive and negative benefits to organizations, professions, and their clients. While the processes we uncovered led to positive outcomes, it is possible for value maintenance work processes to break down and for systemic problems with organizational practices to remain unrecognized by specialists and therefore unresolved, or—worse—for practices to be changed in ways that lead to negative outcomes that undermine the interests of a profession's clients or patients. Of particular interest is how negative outcomes may arise at the organization level because of an interplay between institutional work processes directed at the normative pillar of an institution and the regulative and cultural-cognitive pillars. It is possible that negative outcomes occur when mechanisms for maintenance of professional values are less powerful than mechanisms triggering specialist compliance with values-violating organizational practices. Mechanisms for the latter occur at both the organization level (e.g., a specialist might fear management reprisal for not meeting organizational goals associated with the practice) and the field level (e.g., government might impose performance targets with sanctions for noncompliance, leading hospital management to "track" to the target at the expense of patient care). The interplay between everyday value maintenance processes inside organizations and the normative, regulative, and cultural-cognitive pillars of institutions at the field level is both dynamic and complex, and requires further investigation.

Practical Implications and Conclusion

Our findings have practical implications for specialists and managers in organizations. Our study encourages specialists to be mindful that professional values can create sources of deep conflict at organizational interfaces and when performing organizational practices. Macro-level values may be refracted differently across specialists as they are translated to the micro level inside organizations because of identity customization and compartmentalized organizational structures. The outcome of this refraction can be misalignment between different specialists' value interpretations, leading to conflict during interactions at organizational interfaces. Values conflict also arises when specialists are expected to perform practices that inadvertently undermine the profession's values writ large.

A practical implication of our study is the need for specialists to be sensitive to, and reflective about, the emotions they feel during values conflict. Moral emotions trigger individual maintenance work that

resolves the episodic problem caused by refracted-values conflict and they help to mobilize collective action directed at solving the systemic problem underpinned by value–practice conflict. Our findings suggest that specialists should be sensitive to emotion elicitors. Correctly identifying the source as the organizational practice provides the capacity to mobilize collective action across specialty boundaries and to change organizations in ways that better uphold the profession's values. Managers can also provide opportunities for groups of specialists to reflect collectively on problems to distinguish those that elicit shared and enduring moral emotions. Helping specialists to focus on the practice, rather than the violated or violator, during values conflicts is key to solving systemic problems.

In conclusion, while prior research has tended to focus on power and structural explanations of professions and specialization, our study adopts a values perspective and opens up new insights into how specialists cope with the challenges that specialization creates for maintaining professional values in their everyday work. Our findings about the relationships between specialization and professional values, the microprocesses of institutional work directed at maintaining the normative pillar of institutions, and the dynamics of moral emotions in those microprocesses offer a way forward for a more nuanced understanding of both professional work and institutional work inside organizations.

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