Mobilizing the Logic of Managerialism in Professional Fields: The Case of Academic Health Centre Mergers*

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Abstract

This paper presents a qualitative inductive analysis of attempts to re-order the bases of legitimacy in fields of professional organizations. Concepts from institutional theory, political science and social movement theory are integrated to provide a model of the antecedents, processes and implications of this phenomenon. Findings from a study of US academic health centre mergers illustrate each element of the model. They show that as part of the political agenda to repress the prevailing institutional logic and structures of professionalism (Scott et al. 2000), executives are expected to adopt certain managerial innovations to maintain organizational legitimacy. Against this new basis of legitimacy, powerful agents have promoted merger so successfully that it has achieved mythical attributes of widespread and uncritical adoption (Meyer and Rowan 1977). The paper explains why the intended outcomes of this innovation emerge rarely when it is 'sedimented' (Cooper et al. 1996) uncritically upon enduring aspects of the logic and structures of professionalism.

Descriptors: institutional theory, academic health centres, professionals, change

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Introduction

Within organizational analysis, increasing attention is given to the ways in which 'fields' of inter-related professional organizations (DiMaggio and Powell 1983: 148) adapt to socio-economic and political shifts in their environments (Hannan and Carroll 1995: 2; Greenwood and Hinings 1996; Brock et al. 1999). Institutional scholars have shown that while fields of hospitals, universities, cultural organizations and social-care agencies display high levels of structural inertia, change may occur in response to alterations in the way that their 'cultural support', or legitimacy, is assessed (Meyer and Scott 1983: 201; Scott et al. 2000). Up to the early 1980s, in the US healthcare industry the 'institutional logic' of professional dominance (Friedland and Alford 1991: 248) prescribed that legitimacy was judged primarily against criteria of organizational prestige and the technical quality of the services provided (Ruef and Scott 1998: 883). The prioritization of these bases of legitimacy was reinforced within the prevailing 'professional bureaucracy' (Mintzberg 1979) model of

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organization that accommodated high levels of professional power and autonomy.

Since the early 1980s, voters in the United States, Canada, New Zealand and the United Kingdom have elected governments that promote an ideology of market-managerialism as the way to 'get more for less' from public services (Hood 1991). This political agenda is pursued through loosely linked 'new public management' doctrines (Ferlie et al. 1996) that include contracting welfare states, a reliance on market forces, and the introduction into professional fields, of managerial innovations such as merger (Osbourne and Gaebler 1992). Reformers intend that the implementation of these doctrines will establish managerial criteria for legitimacy assessment that will 'normatively fragment' the logic of professionalism and 'deinstitutionalize' its structural manifestations (Oliver 1992: 575). Early analyses in the United Kingdom and United States report that organizational responses involve the widespread and uncritical adoption of managerial innovations including 'hybrid' organizational forms (Ferlie et al. 1996), new modes of managerial control (Hoggett 1996), delayering, merger and downsizing (Clarke and Newman 1997; McKinley et al. 2000).

Meyer and Rowan (1977: 344) suggest that, in the absence of evidence to demonstrate the task-based efficacy of these innovations, the primary motivation for adoption is to provide an account of legitimacy against the new bases of assessment. As more field participants incorporate the managerial programmes, they achieve the myth-like attributes of widespread and uncritical adoption that compel further adoption. While the notion of conformance to myths provides a useful starting point from which to explain contemporary change in professional fields, the analytical scope that it offers is limited in three respects. First, it does not explain *why* some managerial innovations have become the myths to which the executives of professional organizations now conform, while others have not (Hasselbladh and Kalinikos 2000). Second, little is known about the *processes* by which myths become established (see Barley and Tolbert 1997; McKinley et al. 2000). Third, scholars have not explored the possibility that dysfunctional *outcomes* may arise when executives jump on 'bandwagons' to adopt certain myths uncritically (Staw and Epstein 2000).

This paper addresses these issues conceptually and empirically to extend the capacity of institutional theory to explain adaptive change in fields of professional organizations. The approach employed integrates existing institutionalist perspectives on change and presents an early response to Scott's (1999: 2) call to investigate what institutional theory can 'learn' from other areas of scholarship. The use of selected concepts from political science and social movement theory provides a means of framing purposive action within an enhanced model of (a) the antecedents, (b) the processes and, (c) implications of institutional change processes that involve the uncritical adoption of managerial innovations in professional fields.

The paper contains five main sections. The first describes the context of

the study, the qualitative inductive design, and the case methods (Yin 1999). The second section locates the concept of rationalized myth within institutional theories of change, explains the three limitations outlined earlier, and presents conceptual 'solutions' within an extended model of institutional process. In the third section, the example of 'merger mania' (Fuchs 1997) in the field of US academic health centres (AHCs) is used to illustrate the capacity of the model to explain the antecedents and processes of myth construction. Friedland and Alford's (1991) notion of competing 'institutional logics' helps to trace the *antecedents* of this phenomenon to the political agenda that seeks to repress the logic and structures of professionalism with a countervailing package of managerialism. Study findings explain how, against the new managerial bases of legitimacy, powerful agents have 'mobilized' (McAdam et al. 1996) the adoption of the merger process so successfully, that it now imbued with mythical qualities (Meyer and Rowan 1977). In the fourth section, evidence from prior research and a new case study of the merger involving the AMCs of Stanford University and University of California, San Francisco (UCSF) explains why the intended outcomes of this innovation rarely emerge when it is 'sedimented' (Cooper et al. 1996) uncritically upon the enduring logic and structures of professionalism. The final section provides an assessment of the implications of the model for organization theory and future research.

Research Context, Design and Methods

Research Context

The field of America's 125 AHCs contains 'the most complex organizations in human history' (Peter Drucker, cited in Goldsmith 1999: 150). Each unit comprises varying combinations of universities, affiliated teaching hospitals, medical schools, and other health professions' training schools (Rubin 1999). Approximately one half of the field is owned publicly (generally by state governments, e.g. UCSF), with the other half in private hands (e.g. Stanford and Harvard). Most AHCs continue to display the ideal-type characteristics of professional bureaucracy (Mintzberg 1979). This means that they maintain arrangements such as: decentralized decision-making; high levels of professional autonomy and power; and 'loose coupling' between professional jurisdictions and organizational sub-units (Weick 1976: 3).

In many cases, medical schools and their affiliated hospitals are owned separately, have multiple hierarchies, different (but overlapping) goals, and distinct sources of funding. The AHCs that are affiliated to universities are overseen by academic governing bodies (e.g. the 'Regents' of the University of California and the 'Trustees' of Stanford). Most component medical schools are based on collegial academic structures with a dean overseeing powerful department chairs who control large budgets. In some AHCs, the dean of the medical school will also serve as the provost or chancellor for

the health science schools at large. Still, the department of medicine is often the largest single unit in terms of student numbers, and clinical and research revenues. By contrast to the medical school and university, affiliate hospitals tend to have more hierarchical structures. At their apex sits a chief executive who oversees associate departmental directors and negotiates relationships with medical staff physicians.

AHCs are pluralistic domains in which participants (e.g. physicians, nurses, administrators and academics) attach differential value commitments to the three components of their distinctive 'academic mission'; caring for vulnerable populations, conducting biomedical research, and training healthcare professionals (Blumenthal and Meyer 1996; Rubin 1999). This tripartite mission differentiates AHCs from other healthcare providers and defines a field in which participants are (a) tightly coupled around the mission (in a normative sense), and (b) insulated (by government subsidy) from some of the market pressures in the wider US healthcare industry (Greenwood and Hinings 1996). While powerful professionals such as physicians expect to be involved in decision-making relating to aspects of the mission, they demand high degrees of autonomy and loose coupling between their distinct communities of practice (Barley 1986; Abbott 1988; Goldsmith 1999).

These features may once have helped AHCs in their pursuit of professional prestige and legitimacy through the production of public goods (e.g. professional training, care for the under/uninsured) that were subsidized from private revenues and governmental subsidies (e.g. through the Medicare and Medicaid programmes). Considerable revenue, but less legitimacy, accrued from the production of private goods and services (e.g. clinical services and intellectual property derived from research) that were sold to paying customers (Blumenthal and Meyer 1996). During the 1990s, however, governmental ideology and polices (e.g. reduced payments from public programmes) aimed to shift the bases of AHC legitimacy towards the production of private goods and the adoption of managerial innovations such as merger and downsizing (Commonwealth Fund Task Force on AHCs [Task Force] 2000). As AHCs continued to display the logic and structures of professionalism, they provide an excellent example from which to examine the implications of changing bases of legitimacy within a highly institutionalized field (Alexander and D'Aunno 1990).

Research Design and Methods

A qualitative inductive case study design was selected as appropriate for the primary goal of developing theoretical and empirical understandings of an unfolding institutional process within its real-life context (Yin 1994, 1999; Greenwood and Hinings 1996). The UCSF/Stanford merger case was sampled in a 'purposive' way (Miles and Huberman 1994) to provide a substantively and theoretically critical example from which to explore in-depth, the adoption of one managerial innovation (merger) in a highly institutionalized and professional field (AHCs). This section describes the

practices employed to produce 'trustworthy' study findings with reference to three of the four criteria appropriate for the assessment of case research: credibility, dependability, and confirmability (Lincoln and Guba 1985: 13). Transferability (the fourth criterion) is addressed in the concluding section of the paper where a 'replication logic' and strategy are proposed (Yin 1999; Ragin 1999).

Between the autumn of 1999 and the summer of 2000, this study sought to develop theory and conduct social research as two parts of the same process. The process began with, and returned to, literature reviews (e.g. health services research, political science, and institutional theory) from which components of a 'logic model' (Yin 1999) were assembled. The aim was to provide a flexible protocol that defined the research priorities and represented the investigator's agenda for inquiry. Throughout the study, the model was amended as new insights and evidence were discovered from the literature, internal documents, press reports, interviews, and tentative conceptualization. The aim of triangulating these multiple sources of evidence was to enhance the *credibility* of the model by (a) increasing the amount and quality of data, and (b) examining multiple perspectives (Miles and Huberman 1994; Yin 1999).

In a further technique to ensure the credibility of findings, professional contacts and reports of the merger were used to identify 11 key informants. The aim was to secure a breadth of information and insights from persons with relevant experience and expertise, whose perspectives might be complementary, conflicting, or even contradictory (Hurley 1999). The sample comprised four senior executives, three physicians, one nurse, two non-medical academics, and one labour representative. Data were collected from these individuals during informal sessions (i.e. over lunch and during telephone conversations), and confidential interviews (when requested by the informant). Each session generally lasted between one and two hours. In five cases, more than one session was held with each participant. While the issues discussed varied according to the knowledge of the respondent and the stage of the research process, most sessions concentrated on two key aspects of the logic model: (a) the people, events and ideas that were crucial within the merger process and, (b) how strategic options were identified and evaluated.

To reduce the influence of researcher bias and enhance the confirmability and credibility of the findings, this study used negative evidence testing and member checking. Negative evidence testing involved the search for disconfirming evidence and rival explanations from alternative and 'official' sources (Patton 1999, Yin 1999). This included content analyses of internal documents such as the minutes of the UC Regents' meetings as a means of revealing prevailing managerial assumptions, values and priorities. The process of member checking (Devers 1999) involved sending earlier drafts of this paper to key informants who were asked to provide additional data and confirm the findings. Five papers were returned with comments.

Data Analysis

Following Miles and Huberman (1994: 432), a combination of techniques was used to ensure the *dependability* of the narrative approach to sense-making that is reported in this paper (Langley 1999). The first involved noting patterns and themes from the literature and case study, in an attempt to make intuitive sense of the evidence and identify key themes. When a new theme was identified, tentative 'hypotheses' were constructed and included within the logic model. This triggered a new inductive cycle that produced inferences that were deemed 'valid' by the author to the extent that they appeared 'probable, reasonable or likely to be true' (Miles and Huberman 1994: 431). Second, conceptual groupings in the model were used to cluster emergent themes into comparative units of analysis. The boundaries of the chosen units were defined either by issues that emerged from the literature (e.g. the possibility of resistance), or by issues that emerged from the case (e.g. the role of consultants). The threat of these early categories becoming fixed frameworks was avoided by their re-definition as issues emerged and altered in complexion. Third, alongside the identified units of analysis, evidence was 'coded' (Strauss 1988: 20–1) using key words, phrases, and references to documents and interview notes.

To further enhance the *credibility* of the findings and model, the technique of sceptical peer review was used (Devers 1999). Earlier drafts of this paper were circulated to eight organizational scholars and five US healthcare experts. In a covering letter, each reviewer was asked to challenge the author with 'difficult' questions regarding the research design, interpretation of data, and credibility of the model. Six responses were received.

Rationalized Myths in Professional Fields: Three Theoretical Perspectives

Institutional theory provides an excellent basis for the study of change in professional fields, by providing a convincing definition of radical (as opposed to convergent) change, and by drawing attention to the contextual dynamics that precipitate organizational adaptation (Greenwood and Hinings 1996; Brock et al. 1999; McKinley et al. 2000). Analysts have shown that professional organizations such as AHCs are embedded within institutionalized fields that are constituted by rules and norms that represent shared expectations concerning how participants should operate (DiMaggio and Powell 1983). These institutions create powerful pressures for organizations to seek legitimacy and strive for social conformity through the adoption of legitimized 'templates' of structure and action (DiMaggio and Powell 1991: 27; Orru et al. 1991). While pressures for the task-based selection of strategy exist (Dacin 1997), the dominant mode of rationality is less concerned with technical notions of performance accomplishment (DiMaggio 1991), and more with providing accounts that make actions

appear to be 'legitimate' within the prevailing system of norms, values and templates (Suchman 1995; Greenwood and Hinings 1996). In the next section, a derivative concept from this institutional perspective is introduced as a basis for analyzing adaptive change within professional fields.

Rationalized Myths

Meyer and Rowan (1977: 344) argue that executives within highly institutionalized fields adopt innovations when (and because) they constitute 'manifestations of powerful institutional rules which function as highly rationalized myths that are binding'. As innovations achieve such social–factual or mythical status, non-adopting executives lack acceptable legitimate accounts of their activities and are vulnerable to claims that they are negligent, irrational, or unnecessary. This power of normative compulsion ensures that once legitimized, certain practices are adopted widely and uncritically not so much to execute tasks more efficiently but to gain legitimacy and cultural support (DiMaggio 1991; Tolbert and Zucker 1983). It is noted, however, that executives face a dilemma when the adoption of an innovation threatens their ability to conform to an existing arrangement. Thompson (1967) reports that a common tactic involves executives 'buffering' the pre-existing arrangement within a structure in which it is loosely coupled with the innovation. In a hypothetical example, a resource provider (e.g. an insurance plan) might demand that AHC executives implement a managerial innovation (myth) such as utilization review. The full adoption of that technique would threaten (what used to be seen as) the legitimate autonomy of the physician to determine care practice. Executives may choose to implement the review ceremonially and not allow it to challenge clinical autonomy. In this case, physician autonomy would be buffered from the review process within a loosely coupled structure.

Despite the promise that the concept of myth offers for the study of change in professional organizations, as with other institutional perspectives, little conceptual or empirical attention has been given to the processes by which myths are created, altered and eliminated (DiMaggio 1988; Hasselbladh and Kalinikos 2000; Kitchener 2001). The explanatory capacity that it offers is limited in the following three ways.

The Antecedents of Rationalized Myths

Political sociologists such as Brint and Karabel (1991: 355) argue that organizational analysts lack the theoretical tools with which to explain the antecedents of institutionalized myths and the ways in which they are established as social facts within 'arenas of power relations'. Previous accounts tend to employ notions such as fashion cycles (Abrahamson 1991; Staw and Epstein 2000) that ignore the fact that these are driven by the interests of certain designers. Powell (1991) and DiMaggio (1988: 16) acknowledge this oversight and argue that the 'critical agenda' for institutional analysis is to show how political choices made at one point in time create institu-

tions that work to generate at a later point, recognizable patterns of structure, action and public discourse.

From political science, Friedland and Alford (1991: 244) offer a frame of analysis that can be extended to address these issues and help explain the antecedents of attempts to reorder the bases of legitimacy in the field of AHCs. They argue that a primary means of providing accounts of legitimacy occurs through conformance to the prevailing 'institutional logic' which prescribes organizing principles and practice guidelines for field participants. While the possibility of intra-logic conflict is recognized, greater attention is given to argument that after long periods of relative stability, temporal resolutions in the struggle between competing logics involve the redistribution of power and influence among actors. This presents the winners with a renewed capacity to pursue their value commitments and interests through field and organizational transformation (Fligstein 1996; Greenwood and Hinings 1996).

In a development of prevailing unitary conceptions of legitimacy (e.g. Suchman 1995), Ruef and Scott (1998) propose that countervailing logics (e.g. professionalism and managerialism) vary in the relative emphases placed upon technical and managerial bases of organizational legitimacy. The ascendancy of a managerial logic and the repression of professionalism presents the opportunity for reformers and other winners to re-order the criteria by which organizational legitimacy is assessed. As DiMaggio (1988: 25) notes, new institutions only 'work' when the world has been 'constructed appropriately'. That line of argument led this study to investigate whether, how and by whom, the bases of AHC legitimacy have been re-ordered.

The Mobilization of Myths

Even though Zucker (1991: 104) noted that Meyer and Rowan's original conception of myths emphasized 'effects over process', empirical studies have concentrated on the application of DiMaggio and Powell's (1983) taxonomy of 'isomorphic' mechanisms: coercion, mimicry, and the normative influence of professions. This approach offers little help in explaining why some innovations (myths) are adopted while others are not (Greenwood and Hinings 1996). By contrast, within social movement theory, scholars such as McAdam et al. (1996: 2) concentrate on the proactive 'mobilizing' processes that agents use to legitimate their agendas for change. In a rare attempt to consider the role of such purposive action within institutional theory, Scott (1991: 174) draws attention to two processes. First, 'authorization' describes the processes by which executives manipulate institutional pressures to gain the attention and approval of external bodies. As Bigelow and Arndt's (2000) study of impression management during hospital restructuring shows, this may occur through trumpeted compliance to policy guidance and political rhetoric.

Second, 'acquisition' refers to the deliberate selection of structural models and practices by executives. During this process, a chimera of task-based

rationality is attempted when executives gather evaluative data assiduously, but fail to analyze them fully. Brunsson (1982) and Kitchener et al. (1999) illustrate the ways in which this 'decouples' decision-making from the 'rational' assessment of evidence and alternatives. This process often involves management consultants and business school professors, who are hired not to offer alternatives, but to confer legitimacy upon decisions to adopt certain innovations (Mintzberg 1979; DiMaggio and Powell 1991). In this study, the notions of authorization and inducement are used to help investigate the way that participants responded to, and fuelled, the mobilization of the merger myth in the AHC field.

Proconformance Bias

Recognition of the incomplete nature of managerial myths led Meyer and Rowan (1977: 353) to caution executives to develop a 'sagacious' understanding of the costs of conformance and adoption. While some versions of institutional theory contain implicit assumptions that organizations are less 'efficient' when they seek legitimacy rather than economic ends, Meyer and Rowan's warning has not led analysts to explore the possibility that institutional conformity may produce dysfunctional outcomes (Staw and Epstein 2000: 525). Instead, there is a general assumption and some empirical evidence that myth adoption derives positive outcomes, at least in terms of increased legitimacy (DiMaggio and Powell 1983; Singh et al. 1986; Deephouse 1996; Westphal et al. 1997). Abrahamson (1991: 587) notes that there is a similar assumption within the innovation literature. He warns that when such 'pro-innovation bias' is applied to prescriptions for organizational design, it fosters the repeated diffusion of technically inefficient innovations and the rejection of promising alternatives. Within institutional theory, a similar proconformance bias has maintained the presumption that myths diffuse when they benefit the organizations that adopt them, and they disappear when they do not. DiMaggio (1991: 289) predicts that attention to professional power 'will, I suspect, reveal substantially more interest-driven conflict and more problematic outcomes than much of the imagery of institutional theory has thus far suggested'.

Analyses of professional bureaucracies such as AHCs confirm that they present contexts in which such dynamics impede the successful implementation of rationalized managerial innovations (e.g. Freidson 1970; Kitchener 1999). In particular, three characteristics of this organizational form render such processes even more problematic than in organizations where the authority of executives is subject to less internal and external challenge. First, high levels of professional power maintain the anticipation that strategic *decision-making* will proceed as a collective process among 'negotiated orders' of plural interests and value commitments (Strauss et al. 1963, Greenwood and Hinings 1996). Second, strategic decision-making in professional bureaucracies is a supra-organizational process, particularly in those that produce public goods (DiMaggio and Powell 1983, 1991). This means that executives must mobilize support for innovations

such as mergers, not only within the organization, but also outside it within highly politicized environments. For the executives of state AHCs, this not only slows decision making but also reveals strategic plans to private competitors. Third, the tendency towards loosely coupled organizational structures generates structural inertia to the implementation of managerial programmes such as mergers that require integration amongst units (Hardy et al. 1984).

Cooper et al. (1996) provide a means of understanding why the adoption of managerial innovations may not produce the intended outcomes within fields of organizations in which these features are institutionalized. They draw on the example of Canadian law firms to explore the emergence of hybrid organizational forms that comprise 'sedimented' structures and logics. This geological metaphor is used to describe the unstable organizational forms that emerge when managerial innovations are imposed upon remnants of an institutional logic and structures of professionalism (i.e. autonomy and decentralized decision-making).

In summary, this section has identified three issues that limit the capacity of institutional theory to explain contemporary change in professional bureaucracies. Figure 1 represents these issues and the conceptual 'solutions' proposed in this paper.

Highly institutionalized population of professional bureacracies e.g. AHCs

Antecedent →	**Mobilization →**	**Establishment of Myths →**	**Organizational Outcomes**
The ascendancy of the logic of market-based managerialism over professional dominance (Friedland and Alford 1991; Scott et al. 2000). Emphasis placed on managerial as opposed to technical bases of legitimacy (Ruef and Scott 1998).	Proactive efforts of institutional change agents to establish certain managerial innovations as myths (McAdam et al. 1996).	Isomorphism plus managerial agency through authorization and acquisition (Scott 1991) — adoption of managerial myths e.g. merger and de-layering (Meyer and Rowan 1977; McKinley et al. 2000).	Fateful outcomes when myth (e.g. merger) is 'sedimented' (Cooper et al. 1996; Scott 1994) upon remnants of professional dominance e.g. loose-coupling, professional autonomy, and expectations of decentralized decision-making (Mintzberg 1979).

Figure 1.
A Model of Managerial Myths in Professional Fields

Working from the left-hand side of the model, the first element uses Friedland and Alford's (1991) concept of competing institutional logics to explain *why* assessment of the legitimacy of professional bureaucracies has shifted in emphasis from technical to managerial bases. The second part draws attention to the ways in which proactive institutional actors have 'mobilized' to establish certain managerial innovations (e.g. merger) as rationalized myths (McAdam et al. 1996). Third, Scott's (1991) extension of DiMaggio and Powell's (1983) isomorphic taxonomy points to the processes of agency by which executives conform to, and advance, such

myths. In terms of predicted outcomes, the model challenges the proconformance bias within institutional theory. It suggests that the intended outcomes of managerial innovations are unlikely to appear when they are sedimented upon the enduring features of professionalism (Cooper et al. 1996). The next section draws on the example of AHC mergers to illustrate the capacity of the model to explain the antecedents and processes of managerial myth construction in professional fields.

The Antecedents and Mobilization of the Merger Myth in the US Healthcare Industry

Establishing an Institutional Logic of Market-managerialism

Friedland and Alford's (1991) notion of institutional logics provides a convincing explanation of the antecedents of adaptive change among AHCs. In particular, it leads analysis back to the wider social and political transformations of the 1970s and early 1980s. During this period, governments in the United States, United Kingdom and elsewhere were successful in establishing an ideological hegemony that is based upon two main doctrines:

> '(1) The resurgent ideology of the market that proclaims that competition and efficiency are the major criteria that justify state expenditures, and (2) the ideologies of individualism, neo-conservatism, and self-help that justify reductions in or the elimination of state expenditures altogether.' (Estes and Alford 1990: 174)

The political mobilization of these doctrines aimed to repress the logic and structures of professionalism that had dominated fields of health care and other professional services in many western countries (Brock et al. 1999). The challenge was simultaneously symbolic and material. In terms of symbolism, as Friedland and Alford (1991: 260) note, it was not accidental 'that public choice theory flourished and that one of its American champions was crowned Nobel laureate at the same time that efforts were underway to disengage the state from major arenas of distribution and production'. The material challenge was mounted upon two main criticisms of the logic and apparatus of professional dominance. For public choice theorists, professionalism distorts the operation of markets, promotes rising costs, and encourages 'producer capture' of services. An associated management critique portrays the logic and structures of professionalism as inert 'impediments to the development of rationalized managerial control' (Ackroyd 1995: 6).

From within this ideological perspective, and against a background of escalating health costs, a revolt by insurance companies, rising consumer disquiet and political constructions of fiscal crisis (Starr 1982), the US political reformers of the 1980s mobilized two main solutions. First, health care was redefined from a 'social good' to an 'economic good' that required coordination through market disciplines (Shortell et al. 1985: 219–20). Second,

there were renewed calls for healthcare organizations to adopt 'business-like' structures and managerial practices (Fennel and Alexander 1987; Arndt and Bigelow 2000). The mobilization of these policies involved clear attempts to replace the prevailing professional logic and bases of legitimacy with a countervailing package of market-managerialism.

Enthoven (1980), Ellwood (1972) and other members of the Jackson Hole group helped to translate the ideology of market-managerialism into US health policy. In the early 1970s, they coined the term health maintenance organization (HMO), labelled its organizational characteristics and successfully lobbied the Nixon administration to endorse it as a means of encouraging savings (by managers) as opposed to spending (by professionals). Senior government officials such as Stockman (future director of the federal Office of Management and Budget) lent political legitimacy to the managerial agenda by declaring his hope that 'most hospitals will become parts of for-profit marketing operations or they will become for-profit on their own' (1981: 16; cited in Starr 1982).

Scott et al. (2000: 223) argue that, in 1981–1982, the logic of market-managerialism was further encoded and legitimized in US healthcare with the passing of two pieces of federal legislation that encouraged competition among providers (the *Omnibus Budget Reconciliation Act*, and the *Tax Equity and Fiscal Responsibility Act*). In 1982, California was among the first states to respond to this legislation when it allowed state and federal programmes — e.g. Medicaid and Medicare that were established under 1960s' logic of federal involvement in healthcare (Scott et al. 2000) — and commercial insurers to contract selectively with groups of physicians. In 1983, an even more decisive shift occurred when federal policy moved from retrospective reimbursement of hospital costs to prospective payments linked to diagnosis-related groups, or DRGs (Ruef and Scott 1998). The later restriction of capital flows and the introduction of capitated payment mechanisms induced further competition and added further legitimacy to the logic of market-managerialism.

As Starr (1982: 426) had warned, these initiatives 'hit' AHCs 'especially hard' for two reasons. First, because AHCs could no longer rely upon federal and state reimbursements to provide the (hidden and explicit) cross-subsidization of their public goods, many grew dependent upon equity markets for financial survival (Andreopoulos 1997). Second, AHCs were required increasingly to compete for patient revenues with providers that are less burdened with the financial responsibilities resulting from the academic mission (Reuter and Gaskin 1997). By the mid to late 1990s, most AHCs had ceased to be reasonably profitable partners for universities. Even the elite members of the field experienced substantial operating losses, downgrades in bond ratings, substantial layoffs, and/or wholesale changes in leadership (e.g. Duke University Medical Center and Partners HealthCare System [including Massachusetts General Hospital and Brigham and Women's Hospital]).

While strategic responses were not prescribed for AHC executives, political rhetoric, health policy and management consultancy firms promoted the

adoption of managerial symbols and practices that were pioneered in other industries and some early health plans (Starr 1982; Hafferty and Light 1995). AHC executives were provided with little evidence of efficacy but much encouragement to adopt managerial innovations, including merger, 'downsizing' physical plants and staffs, 'restructuring' through process re-engineering, and the 'disposal' of hospitals to nonprofit and for-profit corporations (Arndt and Bigelow 2000; Griner and Blumenthal 1998; Woodward et al. 1999; Task Force 2000). The next section explains the process by which merger was mobilized as a powerful myth within the health-care industry.

Mobilizing the Merger Myth

At least three powerful groups mobilized the adoption of mergers as a means by which healthcare executives may demonstrate legitimacy within the institutional logic of market-managerialism. First, the popular business press (e.g. the *Wall Street Journal*, *Fortune*, *Business Week* and *Forbes*) conveys tales of industrialists who merge organizations to achieve spectacular turnarounds. Despite research evidence that points to generic problems of implementation (e.g. Sirower 1997), these accounts contain seductive, yet opaque, suggestions that successful mergers are (a) possible across a variety of contexts, and (b) will derive outcomes such as reduced administrative costs and improved 'synergy' between sub-units. In a similar way, healthcare management journals have used anecdotal evidence to convince healthcare executives of the need to merge, in order to achieve these managerial imperatives. Bigelow and Arndt's (2000: 68) review of this 'gray literature' reports the continual and uncritical promotion of management innovations including merger. Each promises improvements in performance, but 'none ever demonstrates the ability to achieve its promises'.

Second, local business leaders on the governing boards of healthcare organizations and the increasing number of executives with management degrees, such as MBAs, are often informed by the standard economics and management texts which propose mergers as a rational strategic response to increasingly competitive market conditions (e.g. Williamson 1985). Third, an active management consultancy industry has added advice on mergers to the list of services that it offers to health executives. As Andreopoulos (1997) notes, healthcare executives generally rely on the same pool of consultancy firms that promote a limited set of techniques, including merger. In these ways, MBA professors, executive board members, the business press and management consultants have performed the role of 'Johnny Appleseeds' (DiMaggio and Powell 1983: 152) and spread the merger myth across the US healthcare industry.

The myth-like status of merger within US health care is confirmed within reports of widespread and uncritical adoption (Dranove and Shanley 1995; Luke et al. 1995; Brooks and Jones 1997; Burns et al. 2000) against economic outcomes that are 'moderate at best' (Snail and Robinson 1998: 27).

Sirower's (1997) analysis of 300 US hospital mergers concludes, for example, that few involve the consolidation of services, and that improved 'synergy' is rarely achieved (see also Bogue et al. 1995). Such evidence led Scott et al. (2000: 284) to conclude that hospital mergers are more oriented to influencing assessments of managerial legitimacy rather than to improving economic efficiency.

The Widespread and Uncritical Adoption of the Merger Myth in the Field of AHCs

The activity described in the previous section has now permeated the AHC field to the extent that the President of a New York AHC reports that mergers 'have become part of the daily agenda' (Eastwood 1999: 71). An early (and the most common) innovation has involved AHCs (or parts thereof) attempting to form integrated delivery systems (IDSs) through alliances with community-based providers, physician groups and hospitals (Iglehart 1995). In highly competitive metropolitan markets such as Boston, New York and Philadelphia, increasing combinations of AHCs have merged their teaching hospitals under parent organizations that have unified ownership of assets (Task Force 2000).

While few independent studies have explored this phenomenon, The Task Force (2000: 20) reports that amidst 'formidable' implementation problems, one AHC merger (involving the University of Pennsylvania) is in 'deep financial trouble', and two others (involving Pennsylvania State University and Dartmouth College) have been dissolved. The Center for the Health Professions (CHP 1999) provides another account of the Allegheny bankruptcy case, fresh evidence of a South Carolina case stalled by anti-trust legal action, and a description of how a Minnesota case was plagued by low clinical integration and inadequate information systems. Within each case, executives were unable to implement merger in the face of the barriers presented by enduring aspects of the institutional logic and structures of professionalism (e.g. loose coupling and professional power). Moreover, Burns et al. (2000: 34) conclude from the Allegheny merger that bankruptcy was partly the result of executives 'hopping on a managerial bandwagon' that lacked 'documentary efficacy or any research base'.

In sum, the evidence presented in this section confirms that merger has been mobilized to achieve a myth-like status across the US healthcare industry and, more recently, within the more insulated and highly institutionalized field of AHCs. Conformance has occurred in spite of a lack of evidence to suggest the efficacy of the innovation. While a fuller account of the UCSF/Stanford case and its implications for policy and management is presented elsewhere (Kitchener 2000), the next section challenges the pro-conformance bias in institutional theory by illustrating how enduring aspects of the institutional logic and structures of professionalism cause dysfunctional outcomes to emerge from uncritical attempts to implement managerial myths such as merger.

UCSF-Stanford: The Perils of Uncritical Myth Conformance

Background to the Case

During the mid-1990s, the AHCs of UCSF and Stanford continued to be recognized internationally for their research and academic programmes that were considered prestigious within the field by resource providers, including governmental and private research sponsors, and medical students (Blumenthal and Meyer 1996). In common with many other AHCs, however, the financial position of both clinical enterprises had weakened against a background of increasing competition, rising managed care penetration, and tightening federal payment schedules (Showstack 1997). Alongside these similarities, significant structural and cultural differences existed between the two organizations that are located 40 miles apart in the San Francisco bay area and which have a long history of competing with each other on the basis of prestige for staff, patients and research funding.

UCSF housed approximately 650 beds, employed 5,600 staff and sprawled like a 'coral reef' (Goldsmith 1999: 150) over millions of feet of poorly maintained estate. As part of the University of California, it employed many labour-union members and strategic decision-making involved considerable supra-organizational involvement by bodies such as the state legislature in Sacramento. At the private Stanford AHC, labour-union membership was much lower and strategic decision-making was subject to less external scrutiny than at UCSF. SHS provided approximately 720 beds, employed 7,000 staff and maintained a comparatively superior estate.

From the late 1980s, the leaders of the AHCs at Stanford and UCSF began to implement a series of managerial innovations (University of California 1997a; Van Etten 1999). In 1994, Stanford created a separate financial entity, SHS, to protect the university from a possible financial catastrophe at the teaching hospitals and clinics. At UCSF, while this process of 'spinning off' was considered and unsuccessful attempts were made to create an IDS, two alternative managerial innovations emerged. First, a division of tertiary care was established under a senior academic neurosurgeon who became interested in marketing specialized services when the volume of cases presenting to his practice fell sharply. The divisions' leaders identified 'product lines' or groupings of specialized services and tried to sell them through product managers in a stiff local market that included Stanford. Second, a new leadership constellation was established for the hospitals and the school of medicine. Showstack (1997: 105) argues that because this 'clinical services executive' was dominated by physicians, the downsizing of those specialties that endured reduced referrals (e.g. neurosurgery) was 'never seriously considered'.

'Irrational' Decision-making and the Influence of Consultants

During the summer of 1995, against this backcloth of early managerial innovations, senior executives of the two AHCs began secret discussions regarding the nature and extent of future links between the institutions. A

participant in the early talks recalled that two options were discussed: 'one was to build a union slowly through collaborations, the other to bring both sides together at once' (personal interview). Later that summer, a firm of management consultants was engaged to advise on possible options. Showstack (1997: 117) reports that the consultants' advice was 'if you're going to do something, you should do something'. Four years later, the influence of the consultants in promoting mimetic institutional pressures from other sectors was evident when a senior Stanford executive left unsubstantiated his claim that:

'Conventional wisdom in the business world is that you do it all the way. If we did it in a half-hearted way, we would never pull it off.' (Van Etten 1999: 146).

According to a UCSF participant in the negotiations, by the autumn of 1996, the notion of merger had developed a 'life of its own' and came to dominate the agenda of senior executives (personal interview). While considerable energy was devoted to considering the financial implications of the proposed innovation, it was agreed to 'delay' discussion of organizational implementation barriers such as downsizing clinical services, and the division of graduate medical education revenues. The Stanford CEO stated subsequently that the leaders of both organizations rejected the notion of forming an IDS as a means of implementing service lines (Van Etten 1999). He claims that this decision resulted from a rational process that involved consideration of their own poor records of alliances with primary providers and, a published account of an AHC that had experienced financial difficulties after joining an IDS. Beyond these rational explanations, a senior executive acknowledged later that 'a big part' of the merger decision was to provide an account of legitmacy to other field participants:

'It is well known that the success and survival of academic health centers depends on our ability to attract and retain key members of faculty. They bring in the research money, the patients, and the students. A big part of our decision to merge was to show that we were on an upward spiral ... This is the type of thing that Congress and the industralists on the boards of academic centres have been advising us to do. We were showing to the faculty and the patients and the insurance plans that we were on an upward spiral. We were creating an aura.' (personal interview).

In the winter of 1996, a second firm of management consultants was engaged to advise on the financial and legal implications of merger. Again, the consideration of organizational barriers to a possible merger was omitted from the consultants' terms of reference.

The Social Construction of a Prestige Cartel

Goldsmith (1999: 150) suggests that an unspoken premise of the merger was that cutting-edge research could be translated into competitive advantage in the market place for patients. The CEO later confirmed that an aim was to create a 'prestige cartel' that would enable the two centres to 'increase their market share of complex care' (Van Etten 1999: 145). As

late as 1999, however, he was still proclaiming the managerial rationality of the merger '[it] makes straightforward economic and operation sense: It reduces administrative overhead' (*ibid*: 146). In May 1996, the UCSF Chancellor gave a similarly vague promise of cost savings when he announced the merger as a *fait accompli* to UCSF staffs (Showstack 1997: 135). It is possible that the lack of consultation was intended to bypass the lengthy decision-making associated with professional bureaucracies. Unsurprisingly, however, the announcement provoked anxiety and suspicion amongst physicians and other staff groups. A representative of organized labour claimed, for example, that merger with the private Stanford was designed to 'break the unions at UCSF' (personal interview).

Supra Organizational Activity

As was the case at South Carolina (CHP 1999), community groups and politicians soon began to question issues of accountability when private and public AHCs merge. On 20 June 1996, the Lt. Governor of California and a UC Regent demanded that an independent 'third party review team' advise the UC Regents on the details of the merger proposal. This move reflected wider concerns amongst UCSF labour unions, the public, politicians and UC chiefs regarding (a) the legality of transferring $480 million in public assets to a private nonprofit entity (privatization), and (b) the insistence of Stanford officials that organizational meetings and records be kept secret (Martin et al. 1997). As with earlier considerations of the innovation, the third party review concentrated on the financial viability of the proposed merger (Hellman et al. 1996). In May, during the deliberations of the third party reviewers, the UC Regents were presented with the management consultants' assessment that:

> 'The combination of administrative and clinical cost reductions and increased clinical volume, when offset by merger costs, creates the potential for overall improvement in the bottom line of the consolidated enterprise of $256.6 million between 1997 and 2000. Such improved results would not be possible for either the UCSF or Stanford clinical enterprise to achieve on its own.' (University of California 1997a: 3, report of item 403x).

The final report of the third party review team reduced the consultants' profit projection by nearly half to $152 million. Despite this, the authors concluded that the proposed merger was 'a sound business decision for the University of California' (reported in *University of California* 1997a). Showstack (1997: 122) notes that each of these expert opinions contained no discussion of the relative merits of merger against other options, any analysis of previous healthcare mergers, limited examination of issues surrounding clinical integration and little consideration of possible barriers to implementation. In a candid reflection in 2000, a senior Stanford executive acknowledged that the supra-organizational nature of the decision-making process had encouraged the 'over-selling' of the merger to politicians, faculty and the unions. This, he felt, had created unrealistic expectations regarding the potential outcomes, and encouraged executives not to evalu-

ate the proposal as critically as they might otherwise have done (personal interview).

On 19 September 1997, following protracted and heated discussions regarding the reporting arrangements for the new entity, the UC Regents and Stanford Trustees voted to create UCSF/Stanford Healthcare. The merged entity comprised an $879 million private, nonprofit organization to operate four hospitals and their associated clinics (University of California 1997b). The merger process had dominated two years of participants' time and cost an estimated $78 million to initiate. These transaction costs of the merger comprised: the consultants' and lawyers' fees; incorporation of the UCSF pension scheme; obtaining joint hospital licences, purchasing a new administrative HQ, securing joint certification, and the purchase of new logos, stationery and signs.

Buffering, Loose-coupling and Ceremonial Conformance

As noted in the first section of the paper, Meyer and Rowan (1977) predict that buffering and loose coupling will accompany the incorporation of managerial myths such as merger. The UCSF/Stanford case provides three examples of these phenomena. First, while the merger combined the hospitals of the two organizations, the medical schools (and their powerful academics) were not included. It was also decided not to consolidate any clinical services on one site. As a result, the core teaching and clinical activities of each institution were 'buffered' from the rationalizing spectre of the merger (Thompson 1967). The CEO suggested that these strategic decisions reflected 'sensitivity' to the distance between the two sites, and the fear that consolidation on one site might allow a competitor to gain market share in the vacated region (Van Etten 1999). In an alternative analysis, Galdabini (1999: 5) reflected that this created a 'destabilizing' structure in which it proved too difficult to have faculty 'competing and cooperating at the same time' and reported a 'source central to the merger'.

The second example relates to the main attempt to integrate the operational activity of the two sets of professional communities of practice. As noted earlier, it was planned to develop services lines to link care provision across departmental boundaries. Each service line was to have an executive committee, a medical director, a dedicated administrator, and a devolved budget within three years. By 1999, 13 of the 16 service lines had been scrapped. An attorney involved with the merger suggested that loosely coupled organizational sub-units were maintained because 'the faculty staff were in total control, and they put a huge emphasis on academic independence' (cited in Galdabini 1999: 5).

In a third example of professional power, loose coupling and buffering working against the aim of implementing the merger, the new organization was run from neither the operational headquarters of UCSF, nor that of Stanford. As if neither party could face the ignominy of being managed from the opposing HQ, a halfway house was selected instead. A nurse reported that, to her colleagues, this decision typified the lack of consen-

sus that surrounded the merger (personal interview). It could also be interpreted as a means of buffering the operational core of each organization from the rationalizing spectre of a centralized administration that accommodated 350 employees in finance, marketing, computer systems and HR departments.

False Dawn

While some of the initial economic indicators from the merger were encouraging, the financial results for the first quarter of fiscal year 1998–99 demonstrated that the merged entity recorded a loss of $10.7 million against an anticipated profit of $10 million. It was projected that the organization would lose $170 million over the next two years. Management consultants were hired again, this time to identify cost savings and performance improvement opportunities. In March 1999, the consultants presented a recovery plan that identified $170 million in annual cost reductions (Hunter Group 1999: 43). $112 million was to be saved by 'downgrading' a hospital and 'reducing' 2,005 (20 percent) employees. Of the job losses, 800 were to be compulsory. In the face of mounting public criticism of the organization's financial state, the Stanford executives agreed reluctantly to a State audit.

The California State Auditor (1999) identified four areas of concern in the management control systems of the new $1.5 billion organization. First, the initial budget of $25 million to manage the tasks of integrating computer systems and tackling the Y2K issue had grown to $126 million. Second, the anticipated levels of integration (synergy) between the two sites had not been achieved. Third, the merged entity had been unable to market the prestige cartel to generate more referrals. Fourth, instead of reducing staff by approximately 120 FTEs, nearly 1,000 employees had been added to the payroll. Some 600 of those were in clinical areas, but only 313 of those positions were attributable to patient volume increases.

Cutting the Ties that Bind

Although the UC Regents confirmed their commitment to the merger on 14 July 1999, the UC and Stanford presidents ordered a review of the union on 5 August. In the next week, the two top executives of UCSF Stanford Health Care resigned, to be replaced by management consultants. On 28 October, the Stanford president wrote to his UC counterpart to state his desire to dissolve the merger — a proposal that was accepted on 9 November by the UC Board of Regents. While some senior executives expressed regret at this decision because they felt that the merged entity had begun to 'turn the corner', a senior member of the UCSF faculty association indicated the extent to which separate identities had been maintained, 'it gives us the opportunity to save our university'. By contrast, a senior executive reflected that it would have been better if one of the two organizations had been able to take over the other. This, he believed, would

have allowed the dominant partner to impose 'unpopular decisions, like they can do in the business world' (personal interview).
Announcing the formal ending of the merger did not prevent the associated costs from rising to $176 million. As a vice chancellor at UCSF commented, 'have you ever seen a divorce that was cheaper than the wedding?' During the final 7 months of its existence, UCSF Stanford Health Care accumulated losses of $127 million, including the costs of de-merger (Russell 2000). These additional costs of myth conformance comprised: the disposal of the joint HQ, devolution of administrative functions to the two AHCs, the fees of management consultants and lawyers, and the costs of new corporate logos, stationary and signs. In an ironic twist to the tale, it was announced that the merger would end formally on 1 April 2000.

Discussion, Implications and Conclusions

This study adopted a multi-disciplinary approach to provide a model that expands the capacity of institutional theory to explain adaptive change within fields of professional organizations. The first part of the model uses Friedland and Alford's (1991) argument from political science that the temporal resolution of conflicts between institutional logics empowers certain interest groups. This creates a 'capacity for action' for winners to alter the bases of legitimacy within field of organizations (Greenwood and Hinings 1996: 1036). This view framed an account of how political choices made at one point in time (e.g. the election of Reagan) created the power shifts that enabled reformers to attempt to normatively fragment and repress the institutional logic of professionalism in health care with a countervailing logic of market-managerialism. The example of the field of AHCs illustrates how, through manipulation of the wider political economy and the structures of the US health market, political reformers sought to alter the bases of AHC legitimacy (Zucker 1991).
Dobbin et al.'s (1993) study of affirmative action policies following federal policy changes demonstrates that the implications do not appear overnight and there is, more often, an initial period of uncertainty during which a variety of innovations are attempted. This study provides an explanation for this period within change processes. It shows that while AHC executives experimented with innovations such as forming IDSs and internal restructuring, other actors were mobilizing the myth-like status of merger as a dominant managerial innovation in the field. Insights from organizational theory and social movement theory were integrated in this paper to provide an account of how this occurred. It described how business school professors, AHC executive board members, the business press and management consultants used relatively little evidence to collectivize amongst AHC executives, a standard 'merger is effective' myth.
The UCSF/Stanford case and the others described in this paper present an account of how the mobilization of this myth has begun to shape managerial behaviour. As a senior executive at the focal case explained, in pursu-

ing an AHC merger the aim was to create an 'aura' of legitimacy within the new institutional logic. Reports of the less than critical adoption of this innovation by AHC executives in California and elsewhere provides two examples of ways in which the pursuit of managerial legitimacy 'decouples' decision-making processes from the 'rational' assessment of evidence and alternatives (Brunsson 1982; Kitchener et al. 1999). First, the new managerial bases of legitimacy encourage AHC executives to adopt practices such as secretive decision-making and strategic implementation through managerial fiat. The largely symbolic use of management consultants and third party reviews ensured that terms of reference did not include the critical appraisal of merger or alternative strategies. Second, in place of the traditional pattern of decentralized decision-making in AHCs (Mintzberg 1979), senior executives restricted participation in the strategic decision-making process. As Abrahamson (1991) warned, this limited the assessment of 'promising alternative' options such as the establishment of more loosely coupled cooperative relations. The diversion from the norm of inclusive decision-making also reduced the likelihood of developing a cadre of change champions amongst professional staffs (Pettigrew and Whipp 1991).

The final part of the model frames the main empirical contribution of this paper. In response to Staw and Epstein's (2000: 549) call for organizational researchers to express scepticism about unproven management techniques, this paper provides empirical evidence to challenge the proconformance bias that underpins much of institutional theory (e.g. DiMaggio and Powell 1983; Singh et al. 1986; Deephouse 1996; Wesphal et al. 1997). The cases presented show that the uncritical adoption of managerial innovations can prove to be more malignant than benign in their implications. The dysfunctional outcomes of uncritical conformance to the merger myth, reported here, are consistent with those in accounts of other hospital mergers and other early AHC mergers (e.g. Burns et al. 2000; CHP 1999; Task Force 2000). This is not, however, a story of institutional determinism, nor one that that portrays AHC executives as cultural dopes who conform to every passing managerial fad and fashion. This paper has shown that, before the establishment of the myth-like status of merger, executives did experiment with other innovations such as forming an IDS. Indeed, this paper gives more emphasis to the role of managerial agency than other institutional accounts of change. In common with some of the literature on strategic change in health-care organizations, it shows that managers do select innovations from recipes of legitimized options (e.g. Pettigrew and Whipp 1991; Ferlie et al. 1996). Beyond this confirmation, the narrative case presented in this paper provides an account of how and why, in one field, the menu has altered over time to emphasize options that display managerial as opposed to technical legitimacy.

This paper does not portray AHC executives as passive recipients in legitimating processes. Rather, it provides a rare empirical account that explains how they worked to manipulate (through conformance to a myth) the assessments that they received from internal and external stakeholders (Oliver

1991). In 'selling' the merger, AHC executives invoked institutional pressures to create an account of legitimacy in ways similar to those described in Arndt and Bigelow's (2000) study of hospital executives' use of 'impression management' during restructuring. First, AHC executives claimed that coercive external (market) pressures induced the need for the merger. Second, they suggested that the merger was essential for organizational survival and for the continued provision of legitimated public goods. Third, they attempted to attach legitimacy to the 'decision' by employing management consultants and creating the impression of thoughtful deliberation (DiMaggio and Powell 1983). Fourth, they created the appearance of mimetic mechanisms by claiming that the innovation (merger) was commonplace and successful in the business world (the source of legitimate managerial innovations).

In the light of evidence that corporate leaders who associate themselves with popular management techniques receive increased compensation and repute (Westphal and Zajac 1998; Staw and Epstein 2000), some may attribute the process and outcomes of myth conformance reported here, to senior executives' self interested behaviour and their attempts at self-aggrandizement. While this analysis leaves some scope for this interpretation, more emphasis is placed on the argument that the outcomes are inevitable consequences of political pressures to re-order the bases of organizational legitimacy to encourage the uncritical adoption of managerial innovations. The alternative (but not necessarily competing) view could form the basis of future research that considers whether an unintended outcome of this process is the creation of conditions that encourage executive self-aggrandizement through the promotion of managerial innovations such as the construction of prestige cartels. In the UCSF Stanford case, the more critical examination of the issues concerned with merger implementation would have brought to light the insights to be gained from research regarding the problems associated with (a) mergers in the business world (see Sirower 1997), and (b) other attempts to sediment the myths of market-managerialism upon the enduring structures of a countervailing professional logic. The apparent demise of the short-lived physician practice management (PPMM) industry provides but one warning of the pitfalls that await managerial innovations that threaten to rationalize the 'physician collegium' (Hurley 1999: 1120). As predicted by Cooper et al. (1996) such mixing of logics and structures produces 'unstable' organizational forms in which adopted myths (e.g. merger, PPM) become only loosely coupled to the structural remnants of professional dominance.

The Stanford/UCSF and other cases show clearly that, in the field of AHCs, enduring aspects of the logic and structures of professionalism (e.g. the tendency towards loose coupling and buffering) hinder attempts to integrate units effectively within mergers (Freidson 1970). They also demonstrate that AHCs and the professionals within them have grown accustomed to competition based on the ways in which they pursue their academic mission. In the area of research, for example, the drive for prestige has encouraged loose coupling and the creation of distinctive and strongly held

identities and work practices. While the pursuit of prestige is common across field participants, alternative methods come clearly into focus when executives attempt to integrate communities of practice with managerial innovations such as the introduction of service lines and merger. Such initiatives make sense within the rationalizing logic of market-managerialism. They jar against the enduring logic and structures of professional dominance in which local identity, interests and professional autonomy are valued. This paper also draws attention to the often over-looked power of the academic professionals that has led, for example, to the omission of medical schools from AHC mergers.

Future Research and Conclusions

Assessment of the extent to which the model presented in this paper is transferable beyond the focal case is a question essentially for future research. This will require a replication logic and strategy based upon inductive reasoning about why other cases might be replications and others might not (Yin 1999). Following Ragin (1999), one strategy would view the model in this paper as having established 'potential necessary conditions' for the failure of uncritical attempts to implement managerial innovations/myths in professional fields (e.g. professional power, previous insulation from management innovations and market forces, tight coupling around a normative mission, and a history of competition on the basis of prestige). The specific task of future research is to verify these conditions in studies of (a) other AHC mergers, (b) other managerial innovations in the field of AHCs, and (c) managerial innovations in similar fields.

If the model does not hold across these wider cases or if, at least, it falls short of being 'transferable', then researchers should study alternative outcomes in an in-depth manner to identify causally relevant commonalities in the disconfirming cases (Patton 1999). If, however, the extension of the model and findings hold in other cases, then the next step would be to address the sufficiency of the conditions identified as 'necessary' in this paper. This would proceed by studying managerial innovations in similar (highly institutionalized, tightly coupled, insulated, professional) fields to see if they involve similar processes and outcomes. If they do not, then in-depth study of the disconfirming cases would help to identify relevant sufficient conditions. These conditions could then be evaluated with variable-oriented methods in cases that display all of the necessary conditions.

The model will clearly be of relevance to future analyses of mergers between elite public and private AHCs in competitive health-care markets. The evidence reported from other AHC mergers and hospital mergers more generally implies that the model may also hold in those contexts. It also seems likely that the model can provide a basis from which to investigate the introduction of other managerial innovations into the field of AHCs e.g. re-engineering. In addition, it will be of value in helping to explore whether the purchase of state teaching hospitals by private organizations provides

the next step towards the accomplishment of a political goal: the normative fragmentation of the professional logic and the deinstitutionalization of its structural artefacts.

Extrapolation beyond the case of AHCs will require the careful consideration of contextual features. This study was concerned primarily with one dominant professional group (physicians associated with AHCs) and their resistance to one managerial innovation/myth (merger). As Denis et al. (1999) report, the 'disappointing outcomes' of the 'struggle' to implement Canadian teaching hospital mergers are generated by similar 'symptoms' of professional logic and structure, the model may also be relevant for teaching hospital mergers in other Western industrialized countries. The boundaries of transferability are indicated by studies of 'successful' change initiatives in other fields. Biggart's (1977) report of the implementation of a 'market' logic and structures into the US postal service shows, for example, how proponents of change in that context were able to repress a pre-existing 'service' logic and those who espoused it. This emphasizes that, in comparison to AHCs, some fields are less insulated from market pressures, some occupations have less power to resist, and some groups may support certain managerial innovation as a means of advancing their own interests and value commitments (e.g. certain groups of nurses and devolved budgets).

The model in this paper may, however, have wider applicability for the analysis of attempts to mobilize the logic and myths of market-managerialism in other insulated professional fields in which organizational legitimacy has been assessed on the basis of prestige rather than task-based efficiency. Studies of elite law firms, museums and art galleries emphasize this point (e.g. Cooper at al. 1996). The role of academic physicians in this paper also suggests that attempts to introduce managerial innovations uncritically into fields of higher education may provide a good test for the model. A recent report from the UK committee of university vice chancellors and principals prescribes that members 'cannot ignore' the need to consider 'mergers in a cut-throat world of global higher education' (Tysome 2000: 1). Indications of support from the future head of the English higher education funding body, and developments in Eastern Scotland, Birmingham and Wales, point to the mobilization of the merger myth in a new field.

Note

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