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Authors: Karan Sonpar · Jay Handelman · Ali Dastmalchian

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Abstract

This mixed-methods case study describes the experiences of a rural health organization in Canada that was a pioneer in undergoing institutionally driven radical change. This change was advocated by senior managers and physicians with the strong backing of the government. The senior managers and physicians made a strong case for the radical change and argued that a focus on efficiency and wellness would lead to improved service and quality of patient-care. However, this radical change initiative was resisted by nurses and support staff who perceived that these changes were being driven by market-based institutional logics and questioned their ethical appropriateness in a public system. They also expressed a lack of trust given the large-scale layoffs in a prior restructuring. These findings run counter to extant theory by highlighting the role of agency despite institutional pressures. Specifically, change implementers not only face the burden of justifying ethical

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Implementing New Institutional Logics in Pioneering Organizations: The Burden of Justifying Ethical Appropriateness and Trustworthiness

Karan Sonpar
Jay Handelman
Ali Dastmalchian

ABSTRACT. This mixed-methods case study describes the experiences of a rural health organization in Canada that was a pioneer in undergoing institutionally driven radical change. This change was advocated by senior managers and physicians with the strong backing of the government. The senior managers and physicians made a strong case for the radical change and argued that a focus on efficiency and wellness would lead to improved service and quality of patient-care. However, this radical change initiative was resisted by nurses and support staff who perceived that these changes were being driven by market-based institutional logics and questioned their ethical appropriateness in a public system. They also expressed a lack of trust given the large-scale layoffs in a prior restructuring. These findings run counter to extant theory by highlighting the role of agency despite institutional pressures. Specifically, change implementers not only face the burden of justifying ethical appropriateness of institutional logics, but also are required to engage in persuasive discourse that these institutional logics protect the interests of the members.

KEY WORDS: institutional logics, values, justify ethical appropriateness, change, trust

Introduction

Institutional theory (DiMaggio and Powell, 1983; Meyer and Rowan, 1977) proposes that radical or large-scale organizational changes are driven by institutional logics that serve as organizing principles as they encompass the values of institutions (Friedland and Alford, 1991; Rao et al., 2003; Scott et al., 2000; Thornton, 1999). For example, the 1964 Civil Rights Act was driven by logics of equality and granted under-represented groups better access to employment reshaped hiring practices in the US (Dobbin and Sutton, 1998). However, a problem with the theory is that it does not consider how institutions and their logics may have effects that are "pluralistic, and are challenged as well as hotly contested" (Dacin et al., 2002, p. 45). One could extend the above and develop the argument that political contests and conflicts based on ethical aspects of institutional logics do not occur since interests and values are institutionally determined. Yet, a handful of studies have shown that actors may contest institutional logics. For example, the 1964 Civil Rights Act did not get full support as some senior managers felt that the only ethical criterion for employment is merit (Edelman, 1992; Edelman et al., 2001). On a separate note, it appears plausible that contests on ethical appropriateness of institutional logics will be more explicit in pioneering organizations (or early-adopters) because institutional logics do not have a legitimate precedent. It is therefore somewhat ironic that there is a lack of attention to conflicts and contests in the current studies of institutionally driven change. It is for these reasons that experts have urged researchers to be attentive to "micro foundations" of change (DiMaggio and Powell, 1991, p. 16).

One specific conceptual area that has received very little attention is the implementation of emerging institutional logics in pioneering organizations. Arndt and Bigelow (2000) show that pioneering organizations may be faced with a differing set of circumstances considering that a legitimate practice or prototype does not occur thus far. Earlier studies on institutional logics (e.g., Thornton, 1999) have

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focused on their diffusion at the level of the field (i.e., at the macro level) and do not offer sufficient insights into what happens during adoption within pioneering organizations. This gap in the literature on radical change motivates our article where we studied an institutionally driven radical change initiative by a rural healthcare organization in Canada. This organization was aiming to implement a new model of integrated healthcare delivery.

We find that the change was strongly resisted despite it being championed by powerful organizational members – specifically the senior managers and physicians – who had strong backing from the government. They attempted to justify the new integrated model of healthcare delivery as being driven by the need to include wellness and efficiency in the agenda. However, some organizational mem bers – especially, the nurses and support staff – resisted the initiative as they perceived these changes being driven by market-based logics of efficiency. Thus it seemed to contradict the prior system driven by medicine-based logics that put patient interests above economics. As also, the resistance toward the new radical change initiative was aggravated by the mistrust of some organizational members who recalled a prior radical change initiative had led to large-scale layoffs. A closer analysis reveals that resistance had ethical underpinnings with regard to both institutional and organizational factors. Simply put, some organizational members questioned the ethical appropriateness of market-based logics, as also mistrusted the motive of the radical change initiative based on a negative past experience. In contrast, the organizational champions supported the change initiative because they believed that the new system was ethically appropriate as it would improve the wellness of people and lead to fiscal prudence.

The above findings lead us to theoretically focus on the underpinnings of institutional logics and trust as organizing principles in times of radical change, particularly in pioneering organizations. McEvily et al. (2003, p. 92) define an organizing principle as "the logic by which work is coordinated and information gathered, disseminated, and processed within and between organizations. An organizing principle represents a heuristic for how actors interpret and represent information and how they select appropriate behaviors and routines for coordinating actions." Although institutional theory proposes that institutional logics work as heuristics, which encompass the values of institutions (Friedland and Alford, 1991; Rao et al., 2003; Scott et al., 2000; Thornton, 1999), it is the heuristics of trust that engenders support at the individual level (McEvily et al., 2003). Moreover, the perceived ethicality of new institutional logics as also beliefs that change leaders will act ethically affects support for these changes.

It is also important to understand here that ethical issues remain implicit but inadequately developed in the two literatures. On the one hand, the literature on institutional logics focuses on how values or discourse on what constitutes appropriate behavior are embedded in institutional logics. In other words, priorities and definitions on what is legitimate (and consequentially, ethical) is determined at the institutional level. Note that the literature remains relatively silent with regard to burden of justifying ethical appropriateness considering that institutional prescriptions in the form or laws or norms should be sufficient in itself. On the other hand, the trust literature develops the argument that actors are willing to trust when their self-interests are met and/or when they believe that the latter can be believed to behave with integrity and fairness. In other words, acting ethically may not be sufficient if interests of actors are ignored.

The next section of this article presents the theory underlying institutional logics and trust within the context of radical organizational change. Of particular interest is the possible presence of trust as an organizing principle that resides alongside, and possibly in interaction with, institutional logics. This theoretical development is followed by an explanation of the research site and methodology. The findings are then presented, and a discussion section rounds out the article. The overall conclusion of the article is that conflicts – both institutional and organizational – may have an ethical component and affect the implementation of radical change initiatives.

Overview of the literature

New institutional theory directs our attention to coercive, mimetic, or normative forces that operate outside the boundaries of the organization, and at the level of the organizational field (DiMaggio and

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Powell, 1983, 1991; Meyer and Rowan, 1977). It explains how organizations attempt to align their structures based on current myths of the environment that permeate through institutional logics, which encompass the values of institutions (Friedland and Alford, 1991). Ethical underpinnings are somewhat implicit in institutional logics since they determine what is considered right and proper. Conflict, as per this paradigm occurs at the level of the organizational field (DiMaggio and Powell, 1991). This was unlike old institutionalism's emphasis on how coalitions and politics within organizations subverted attempts at change, mostly due to issues related to power and self-interest (Selznick, 1948, 1949, 1957).

Unlike institutional theory, which has sociological underpinnings, literature on trust focuses on how it is a psychological state that facilitates smooth transactions (e.g. Kramer, 1999; Mayer et al., 1995; McEvily et al., 2003). It draws our attention to how actors within organizations choose to support or resist organizational schemes. It explains how trust is determined by several factors to include past experiences, values held by an individual, and the perceived impact of an event on individual interests. It elucidates the role of individuals who are like intuitive auditors in the sense that they evaluate opportunities and try to maximize their gains and cut their losses in any transaction (Kramer, 1996; Tyler and Kramer, 1996). When new institutionalism's insights on the impact of institutional logics are understood in conjunction with the rational dimensions of trust, they might address the micro foundations of institutional theory related to causes and consequences of pluralistic effects. While institutional logics operates as an organizing principle in explaining how and why change occurs, the latter – trust – as an organizing principle, tempers the smoothness or success of implementation of such change.

Institutional logics as an organizing principle

New institutional theory has grown in stature as a powerful way to examine how institutions drive organizational change, and how institutions themselves change (Dacin et al., 2002; DiMaggio and Powell, 1991). Its burgeoning focus on organizational and institutional changes has shed light on another important phenomenon that has, until recently, received scant attention from researchers in the field – the microprocesses underlying institutional change (Johnson et al., 2000). Studies that have examined the interplay between individual behavior and institutional templates have largely examined how individual actors deal with and contribute to the macroprocesses of institutional change. For example, Johnson et al. (2000) described how individual organizational members deal with the process of change from a public to a privatized institutional environment. Conversely, Oliver (1997) identified functional, political, and social sources of micro level forces on institutional change. These studies highlight how individual social actors are influenced by and exert influence on ubiquitous institutional logics (Barley and Tolbert, 1997; Johnson et al., 2000). In doing so, a greater understanding is gained of how institutions drive organizational change and how they themselves are changed.

Institutions exercise effects or encompass myths that urge organizations to align their structures with pre-determined legitimate templates. Consistent with Friedland and Alford (1991), we believe that different institutions of the society may simultaneously exercise multiple and often contradictory influences upon organizations. Institutional expectations are espoused in the logics of institutions that work as organizing principles to drive change. These come to be shared by social actors (Friedland and Alford, 1991). Shared institutional logics provide social actors with the norms, values, and beliefs upon which understandings of how strategies and decisions are formulated (Thornton, 2002). The way these institutional logics shape individual behavior is by way of scripts. In this context, scripts are viewed as behavioral regularities in that "institutional rules are encoded in behavioral scripts that, in turn, are enacted in specific situations. The resulting behaviors revise or replicate the scripts that informed the action" (Johnson et al., 2000, p. 573 based on Barley and Tolbert, 1997).

Trust as an organizing principle

McEvily et al. (2003, p. 92) propose that "at a general level trust is the willingness to accept vulnerability based on positive expectations about another's intentions or behaviours." As trust arises

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out of vulnerability, there are dual underlying facets of self-interest and social orientation that influence individuals. On the one hand, trust allows individuals to maximize their own sense of security, representing the protection of self-interests (Hendry, 2002). However, in addition to purely selfish (and rational) imperatives, Kramer (1999) argues that trust is also influenced by the values and social orientation of an individual. When related to institutional logics, we argue that individuals make sense of institutional expectations and play an active role in supporting or rejecting the values embedded in these expectations.

These dual rational and relational elements of trust leads to the three critical components of trust: *ability*, *benevolence*, and *integrity* (Mayer et al., 1995). Ability, also referred to by McEvily et al. as competence, is based on the rational element of trust. If an organizational agent advocating change is deemed by potential followers to possess competence, business sense and judgement, then trust is more likely to ensue (Mayer et al., 1995). Benevolence is the extent to which the change agent is willing to do something apart from an egocentric profit motive. Feelings of kindness and concern for the welfare of another are central to this relational element of trust. A change agent whose intentions are regarded as benevolent is more likely to inspire trust. Finally, integrity is the degree to which the change agent's motives follow a set of principles at both a moral and personal level as opposed to self-interested driven motives. The change agent's integrity provides insight into his/her motives (McEvily et al., 2003). The agent for change who is regarded to have integrity, or motives that are not based solely on self-interest, is more likely to inspire trust. Mayer and Davis (1999) argue that perceived ability, benevolence, and integrity have independent influences on employee trust in management activities.

While institutional logics serve as drivers of change, it is trust that facilitates change, as trust implies risk-taking due to potential vulnerabilities it causes. Within organizations, there are powerful players who present the case for or against organizational change. This leads to an important micro-level phenomenon that might interact with the institutional logics that are driving the change – the trust an organizational member has in those organizational actors who are advocating the change. There is a growing recognition of the importance of trust in times of crisis, change, and conflict (Mishra, 1996; Tyler and Degoey, 1996; Webb, 1996). Trust has been acknowledged as a mobilizer of organizational resources in that it promotes teamwork and cooperative behavior that favors organizational goals (Jones and George, 1998; Kramer, 1999; McAllister, 1995). If changing or conflicting institutional logics might be considered the drivers of organizational change (Johnson et al., 2000), trust might be considered a facilitator of this change (McEvily et al., 2003). In the absence of trust in those actors presenting the case for change, organizational resources might not be mobilized in support of such change, and the process of change may be difficult despite the proposed shift in institutional logics.

The Interaction of institutional logics and trust

Just as Friedland and Alford (1991) regarded institutional logics as an organizing principle that guides behavior, McEvily et al. (2003) regard trust as an organizing principle as well. Trust as an organizing principle, heuristic, or frame of reference makes individual decision making easier in that it allows people to engage in given behaviors and routines, knowing that their trusted counterpart will not exploit one's vulnerability (McEvily et al., 2003). Trust, in turn, strengthens the identity and organizational commitment social actors feel (Lewicki and Bunker, 1996), leading to the willingness by social actors to contribute their resources and coordinate their efforts with others in the organization toward the achievement of organizational goals (McEvily et al., 2003). McEvily et al. note that trust operates in conjunction with other organizing principles. Given that institutional logics are also regarded as an important organizing principle, the interaction between institutional logics and trust is to be expected in times of organizational change. Just as institutional logics serve as an organizing principle by defining scripts of behavioral regularities based on definitions of legitimacy, trust is also an organizing principle that provides social actors the confidence to engage in behaviors that work toward organizational, as opposed to self-interested, goals. Where institutional logics serve as an organizing principle that drives or catalyzes organizational change, trust is an organizing principle that facilitates such change.

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In the absence of trust, social actors would be unwilling to mobilize their resources toward organizational goals.

Of specific importance during a change initiative is the role of organizational champions – generally senior managers or powerful players – who bring new institutional logics to the attention of organizations. Organizational champions are involved in the persistent and persuasive communication with others in the organization, that radical change is necessary (Floyd and Wooldridge, 1992). Consistent with the trust literature, one's trust in the organizational champion based on an assessment of his/her ability, benevolence, and integrity, will determine the willingness of organizational members to mobilize their efforts in favor of the change being advocated. After all, a proposal for radical organizational change potentially puts members in a framework of vulnerability, thereby making trust a key issue.

Empirical context

The site for this study is a regional healthcare organization in a rural Canadian community. The healthcare sector provides an appropriate venue for this study as it operates in an institutionalized environment implying that practices are well established and taken for granted with quality medical care being the dominant logic. However, recent years have seen market-based logics for efficiency and new public management principles replacing the quality medical care model. The particular changes facing the healthcare organization examined in this study include the restructuring of organizational positions and responsibilities, changes in the reward system for physicians, and implementation of enhanced information systems within the primary healthcare domain. As also, driving these changes is a transformation in institutional logic from healthcare organizations being regarded strictly as facilities that deliver quality care to patients (citizens) in need of health care (a non-market institutional logic), to organizations that must follow some form of society or market-based norm or logic? Denis et al. (1999), among others, have referred to the "wellness" model as an overarching logic that transforms the "disease"-centered logic to a more preventive model that contains societal and market driven logics. The kind of changes imposed on rural healthcare organizations can be considered radical in that any resulting change on the organization would mean a fundamental and rare shift in the organization's strategy and structure (Bartunek, 1984).

Under the traditional non-market-based institutional logic of "quality care," patients would visit physicians at the physician's office. Under the publicly funded healthcare system in Canada, the government paid a physician for each patient who physically visited his/her office. However, under the proposed new institutional logic of more integration (and possibly more efficiency), medical services will be offered for a selected services/diseases (e.g., baby wellness, asthma, diabetes) by "integrated teams". In this situation, the patient has access to a team of care providers with varying specialities. Rather than seeing individual patients, physicians are placed in more of a managerial role where they must coordinate and implement the resources. Rather than being paid on a per patient basis, physicians' remuneration would be based on a salary and incentive structure that rewards physicians for the estimated number of patients who need to be provided the services rather than purely by "fee for service" logic. This change in institutional logic impacts such fundamental organizational changes as reward systems and organizational structure and hierarchy whereby administrators have less of a role and physicians gain a more powerful role in managing the system.

Sample

A series of 41 interviews conducted by a team of healthcare researchers at a Canadian university were analyzed for this study. So as to maximize the variation in theoretical insights, the informants included individuals belonging to several professional groups to include representatives from the senior management, physicians, middle-level managers, nurse-managers, nurses, support staff and other allied staff from healthcare organizations in the region being affected by the institutionally driven change. An average interview lasted between 60 and 90 min. These interviews were conducted in the official premises of the healthcare organization.

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These interviews were taped and transcribed in verbatim to facilitate their subsequent analysis. The interviews followed a semi-structured format. The initial intent of the interviews was to understand how members within the organization understood this organizational change. The questions were not designed to measure the dynamics of trust or institutional logics. These two organizing principles emerged during our analysis of the transcribed interviews.

Analysis of data

We analyzed our data in two distinct steps. Consistent with the grounded theory studies (Glaser and Strauss, 1967; Straus and Corbin, 1990, 1998), the first step of data analysis was inductive in nature. Grounded theory uses techniques such as the flip-flop technique of analysis and the constant comparison to notice sameness and variation in the data. This implies constant comparison within and between cases to look for trends and differences in the emerging insights. Data is also collected to the point of theoretical saturation, defined as the stage whereby collection of additional data does not add to the existing insights. Emergent insights during analysis of transcripts guide subsequent investigation and review of the literature. The use of multiple interviewees and data coders serves as a type of "researcher triangulation" (Jick, 1979) and facilitated cross-validation of the emergent categories and insights.

The first step of data analysis revealed the political contests within the organization as a consequence of the change. Actors identified the change initiatives as driven by market-based logics. Earlier studies explain pressures for market logic to replace older logics of medical professionalism (Scott et al., 2000). However, another microdynamic emerged too. In the transcripts, several members made mention that it was ultimately a "trust issue for change." There was also a pattern in the responses in the sense that actors belonging to different professional groups seemed to differ in the normative values they espoused, and the trust they attached to the given change initiatives. Consistent with Miles and Huberman's (1994) suggestions that additional quantitative analyses are helpful to illuminate initial qualitative evidence, we content analyzed the transcripts with the aim of ascertaining (1) whether trust arises as an organizing principle in the interviews, and (2) the manner in which it shapes cognition of an individual.

So the second step of the analysis was more deliberate and was in line with the deductive approaches to qualitative data analysis such as content analysis (Krippendorff, 2004; Neundorf, 2002; Weber, 1990). The focus now shifted to generating a quantitative analysis of the data by measuring the presence of trust, and variance in trust across professional groups, as hypothesized by the framework of Mayer et al. (1995). These were further elaborated and substantiated with interpretive insights that emerged from the rich interview transcripts. The examination of the presence of trust as a key cognitive factor in times of radical organizational change was conducted using a partial reduction in loss approach advocated by Rust and Cooil (1994).

Partial reduction in loss approach

In this approach, independent coders were taught the conceptual trust framework of integrity, benevolence and integrity. Using the method outlined by Rust and Cooil (1994), three judges (N1–N3) were each given the interview transcripts and independently coded the three categorical items of "ability," "benevolence," and "integrity" (M1–M3) into one of the three mutually exclusive categories of "yes – this categorical item definitely emerged in this transcript," "somewhat – this categorical item somewhat emerged in this transcript," and "no – this categorical item definitely did not emerge in this transcript". Based on the judgements of the multiple coders for each transcript, a degree of agreement is obtained to quantify the rate of agreement using the proportional reduction in loss approach (Rust and Cooil, 1994). A high degree of agreement determines a high degree of reliability providing a score between 0 and 1, which is comparable to Cronbach's alpha for determining the reliability and internal consistency of the findings. Consistent with a Cronbach's alpha, a score of 0.70 or higher is an indication of reliability (Rust and Cooil, 1994). The coders were also asked to rate their degree of confidence in their coding (on a scale of 1 – not confident, to 7 – very confident). Prior to measuring inter-rater reliability using Rust and Cooil (1994), a pilot test was conducted to ascertain reliability of the coding scheme.

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Pilot test

The pilot test comprised three interviews. It consisted of an interview of each of a representative of the top management, a physician and a nurse. The same three interviews were given to each of the three coders and no identifying information of the interviewees was made available to the coders. Neither of the three coders were authors of the article and nor had either of them collected the data or transcribed the interviews. The three coders belonged to three different ethnic races, and all the three were graduate students in the Faculty of Management. The three coders coded these interviews separately. Individual discussions were held with them at the end of this activity to discuss their analysis of the interview transcripts. We found that the coders were able to identify passages in the text that distinctly referred to trust issues. There was also an acceptable level of consistency and agreement between the three of them on the presence of these attributes. On individual interaction with the coders and discussing their responses and coding schemes with them, we noticed that the coders interpreted the interview transcripts quite consistently. We were now confident that the theoretical framework was robust, and coders were trained adequately in the dynamics of trust to go ahead with the inter-rater reliability tests.

Sample for inter-rater reliability test

The sample constituted the balance 38 of 41 interviews. These were analyzed for determining the reliability of the instrument on trust that was constructed based on the work of Mayer et al. (1995). These interviews were randomly numbered from 4 to 41, and the names and designations of the respondents were hidden.

Each of the 38 interviews was to be judged by any two of the three rater-analysts. Rater-analyst N1 was given 26 interviews and rater-analyst N2 and N3 were given 25 interviews each. In short, we prepared a total of 76 questionnaires, as the rater-analysts were making 38 sets of judgments. The details of the sample are as given in the Table I. The three members of the allied staff comprised two social workers and one researcher within the organization.

TABLE I

Demographics of sample

Designation	*n*	Percentage
Senior managers	5	13.20
Physicians	3	7.89
Middle-level managers	9	23.68
Nurse-managers	3	7.89
Nurses	8	21.05
Support staff	7	18.42
Allied staff	3	17.89

Results

Results indicate that trust does emerge as a cognitive theme in times of institutionally driven radical change, and that the framework of benevolence, integrity, and ability is a reliable framework to use in order to measure trust. Trust emerged in 84.21% of the judgements with the coders demonstrating a high level of confidence in their judgements (an average of 6.38 out of 7). Only 14.03% of the judgements reported trust as being "somewhat present," and 1.75% reported trust as "not present". The "ability" category of trust was judged to be present in 50% of the transcripts, "benevolence" was judged to be present in 26.31% of the transcripts, and "integrity" was judged to be present in 23.69% of the transcripts. These judgements showed a high level of inter-coder reliability as tested using the proportional reduction in loss reliability test (see Table II). So, the conclusion with strong reliability is that trust emerges as an important cognitive factor for respondents in their view of institutionally driven organizational change (Figure 1).

TABLE II

Reliability of theoretical framework

Category	Proportional reduction in loss reliability level	Raw percentage of coder agreement (%)
Overall trust instrument	0.78	73.68
Ability	0.83	78.94
Benevolence	0.75	71.05
Integrity	0.75	71.05

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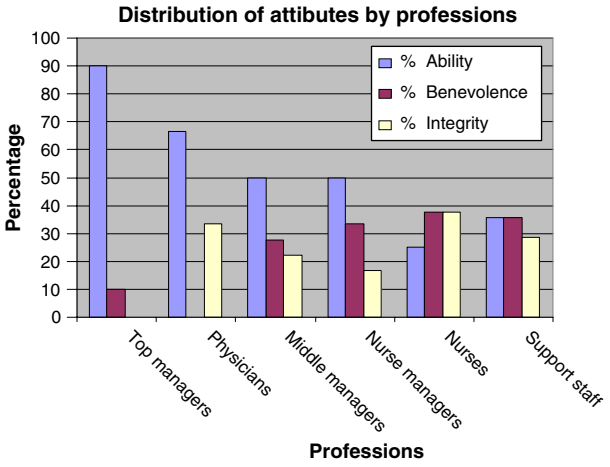

Figure 1. Diagrammatic representation of important trust elements by unit group.

TABLE III

Coder ratings of important trust elements by unit group

Unit group	Most important trust element		
	Ability (%)	Integrity (%)	Benevolence (%)
Senior managers	90	0	10
Physicians	66.67	33.33	0
Middle managers	50	22.22	27.78
Nurse-managers	50	16.67	33.34
Nurses	25	37.5	37.5
Support staff	35.71	28.57	35.71

The second research question addresses the interaction between trust and institutional logics. This research question was examined in two stages. The first stage was to examine whether the importance level of the various elements of trust (benevolence, integrity, and ability) varied across the unit groupings within the organization. The second stage was to examine whether different institutional logics underlying the drive for organizational change can be attributed to the different unit groups. If different unit groupings held different views of trust, and these unit groupings could themselves be differentiated on their guiding institutional logics, then an inference can be made that trust varies (and thus interacts with) institutional logics.

There is strong evidence that trust varies across the unit groupings within the healthcare organization. Evidence comes from the responses given by the coders when asked "According to you, which attribute (benevolence, integrity, and ability) impacted trust the most in the interview?" The results are captured in Table II. From these raw percentages, a series of chi-square tests (non-parametric tests) were conducted to measure whether any significant difference existed across the unit groupings. At this stage, the three interviews of the Allied Staff were dropped from the analysis due to their limited involvement in the implementation of the project. The first chi-square ran across all six subgroups showed that there is a significant difference in the importance placed on the different elements of trust ($p < 0.05$) (Table III).

In order to examine these differences in more detail, the six units were put into three major groups based on conceptual groupings. The first group consisted of senior managers and physicians. This group was considered the *institutional entrepreneurs* (Scott, 1995), as they are the units that are making the arguments within the health care units for the radical change.[1] The second group was the middle managers and nurse-managers who are considered to be the *implementers*, and are seen as intermediaries between the institutional entrepreneurs and the third group. Finally, the third group is the *followers*, which consist of nurses and the support staff. A chi-square test revealed a significant difference on the importance of ability at the $p < 0.01$ level across these three unit groupings. Another series of chi-square tests was run between institutional entrepreneurs and followers. There is a significant difference between these two groups on ability ($p < 0.001$) and benevolence ($p < 0.02$).

These results suggest that differences appear to be occurring across the unit groupings, with senior managers and physicians attaching greater importance to the dimensions of ability in their propensity to put trust in the government officials who are initiating the change. In other words, for those who must carry the role as leaders of change within the health care units, ability in the government officials to put necessary resources in place is regarded as the single most important factor that must be present before trust is conferred. Conversely, for those in unit groups at the lower end of the hierarchy (change followers), more importance is attached to

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the element of benevolence that must be in place before trust is conferred. There is no difference between any of the groups with respect to integrity.

While the quantitative evidence points to differences in what impacts trust, it does explain why different professional groups respond to the change initiative in differing ways. In order to further elaborate upon the understanding of these differences between professional groups in their trust for the new system, we returned to the data to conduct additional qualitative analyses. We find references to both the appropriateness of the new initiative (institutional logics) and their trust in the organizational champions. We also find that actors use different impression management techniques (Arndt and Bigelow, 2000) to support or resist initiatives on ethical grounds. On occasion, they also disguise their interests under the garb of ethical values.

Institutional entrepreneurs (managers and physicians)

For managers and physicians, efficiency and rationality overwhelmingly dominated as an appropriate institutional logic. Consider, for example, this statement by a senior manager:

> It [the radical change] will save dollars… So if you can do and look after the individual better under this [changed] system, then the resulting fact is that you can do more with the same amount of dollars you have, and I think that's the overriding, is to be effective and efficient.

Market-based logic permeates the rhetoric of the senior managers and physicians who will have incentives to control costs and allocate resources. Recall that in a conceptually consistent manner, this unit grouping also placed more importance on the ability element of trust. In other words, in order to take on the responsibility (and thus, vulnerability) of market-based exigencies, their bosses (government officials) must demonstrate ability – a technical/functional conceptualization of change that is consistent with a market-based institutional logic under this new integrated system. Their scripts dictate that a healthcare organization should be run in a professional, ''integrated'' manner, which is cost-effective in the long run. Their trust in this process of change is high as it addresses these issues of effectiveness and efficiency.

Statements that emphasized the need for exploring ''service delivery costs'' and ''how smart you can get when you have fiscal restraint'' highlight such market-based logics. These logics are consistent with the inter-rater reliability test findings, which suggest that the attribute *ability* was pivotal to their feelings of trust. This is strongly evident from the rater-analysts judging in 90% of the cases that the senior administrators are most influenced by the ability dynamics of trust. The physicians also believe that the new system will enable the provision of services ''in a better way.'' They feel that this system would enable them to ''practice medicine differently.'' They believe that an efficient delivery of these services would enhance the satisfaction and address the important issues of ''prevention'' and ''wellness'' that were currently ignored.

The physicians are also driven by managerial or corporate logics. Their norms of rationality dictate the need to provide these services ''in a better way.'' They feel that the new system would enable them to ''practice medicine differently.'' They argue that an efficient delivery of these services would enhance the satisfaction and address the issues of ''prevention'' and ''wellness'' that were currently ignored. Also, unlike the past, this new system of healthcare delivery gave them the leadership role in managing the health of the community. Remarked one of the physicians:

> Let's get involved; let's make one of the changes before they are foisted upon us. We've seen the government do a few things to physicians to give us an idea of what their power was and they were unilateral and as a group of physicians we did not like that.

This statement supports our argument that the physicians are striving to be the institutional entrepreneurs in change initiative. Sufficient literature supports this new dimension of a physician as a ''worker'' who is an active agent negotiating his existence, and not someone who is merely a professional or caregiver (Hoff, 2001). Their important position in the healthcare setup and the acute shortage of physicians in the province made them believe that they could negotiate for a system of healthcare delivery, which they also believe, is in their best interests.

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Implementers (middle-level managers and nurse-managers)

Middle-level managers and nurse-managers had mixed reactions to the market- and non-market-based indicators. For example, one member of this unit group mentioned that health care organizations need to "offer better service through integration [of structure] as opposed to better service through added dollars" (middle-level manager) demonstrating the importance of the market-based logics. However, members of this unit grouping also indicated non-market logics as being important ethical criteria for the change. "Community input" (nurse manager) and "social justice policy" (middle-level manager) are illustrations of the non-market-based institutional logics that permeated the thinking of this unit grouping in impacting their feelings toward the change.

An interesting aspect of the interviews with the implementers was their repeated mention of the conflict that occurred between physicians and nurses. A middle-level manager explains this tension in the following manner:

> There's always tension between the nurses and the doctors. It's, I don't know whether it's when they go to school they teach them to do that…the doctors perceive the nurses as some, you know, they're (there) to facilitate them and the patients and to, to assist. And the nurses, again partially because of the union mentality see themselves as slightly different.

This clash in power relationships between nurses and physicians is intrinsic to their thought process even without a change process, and it gets accentuated in times of change. In this case, the physicians seek to maximize their status and these change initiatives give them greater authority in the new system. They are therefore inclined to trust the system. The nurses on the other hand, feel threatened by the new authority made available to the physicians, as it would imply some of them working under the physicians in the clinic. They are therefore prone to resist this move as it undermines their status. There were a significant number of statements expressing distrust in one or the other professional affiliations with one of the managers referring to nurses as being "control freaks" and as a group who are "not always taught to be critical thinkers."

The middle-level managers also express concern over the need for a better system of communication, feedback, and empowerment. They speak of the need to "get people involved" and create an atmosphere conducive for more interaction and understanding amongst the various members. The appropriate behavior for the middle-level managers therefore is a holistic mix of efficiency, patient care, and strong networks of communication within the organization. As one of the middle-level managers commented:

> You don't do it by saying look I'm not here to make your coffee, you do it by building trust and all sort of other things…So the nurses have to be reasonably flexible and strong and the physicians have to be fairly accepting of the nursing role and accept them as partners in the practice.

Their mental scripts dictate that such change can be implemented successfully, only if the members of the organization trusted one another. They were at pains to express their exasperation with the difficulties of the process of change. The references to "more communication is going to be needed" (a middle-level manager), communication being "fairly regimented, fairly top-down" (a middle-level manager) and "communication is the key" (a nurse-manager) are the hallmarks of their interviews. Their beliefs on the appropriate and ethical criteria for a new healthcare system seem to vary. Recall that the results of Study I suggest that both middle-level managers and nurse-managers are most influenced by the attribute *ability* in only 50% of the judgments, as opposed to 90% of senior managers, and 66.67% of physicians. However, 33.34% judgments on nurse-managers and 27.78% on middle-level managers attribute *benevolence* as being the key trust factor. Overall, this balance between *managerial or corporate logics* and *logics of empathy and benevolence* in the middle-level managers and nurse-managers is consistent with the findings of trust that were revealed in Study I.

Change followers (nurses and support staff)

The unit grouping views the change process through a non-market-based institutional logic. They use impression management techniques and make

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consistent references to the ethicality of the new logics by arguing that these new logics may have detrimental impacts on patient-care. They express apprehension on whether the radical change will best serve the patients, or was it a conspiracy to usher market-based reforms. The content analysis of the interview transcripts by the three coders revealed how the nurses and support staff regarded the benevolence aspect of trust as most important. They need to know that the change leaders are not out to just cut costs, but also to benefit the system.

Nurses saw themselves as "the advocates for the people," and were driven by feelings of empathy and benevolence. To them the key stated issue is ensuring that the quality of care and upholding the ethos of the Canada Health Act are fundamental to any initiatives, but they do not perceive this happening. The healthcare initiatives being taken in Canada to them were inappropriate, as these were dictated primarily by economics. Taking a dig at the concept of "Wellness Model," one of them suggested that the drive for reducing hospital admissions might reduce the hospital expenses, but that was not a valid criterion for evaluating the wellness of the population. Their distrust in the system therefore stemmed from their belief that market-based logics, though inappropriate in the context of Canadian healthcare, were the driving force behind these changes. As such, they did not believe that the government was acting in the best interests of the consumers. Overall, the dynamics of trust and appropriate behavior in the context of healthcare were violated and can be understood by this statement made by a nurse:

> And it would be nice you know if you had the confidence that this project was to complement, to actually do what they are willing to do to improve the delivery of care. But I don't think that this is the ultimate goal here.

Such mistrust expressed by the nurses was a result of a violation of their norms of appropriate behavior, which strongly centered on the values of kindness, tenderness, and concern for the patients. Support staff members echoed similar sentiments on the new changes. They feared that market logics of healthcare were a gradual and silent conspiracy that was moving the system toward privatization of health services. These fears of privatization through a "two-tier" healthcare were inappropriate according to them. Remarked a support staff member:

> If you have the money you can buy your way in, or, like the politicians were doing, if you have the right connections you can get your uncle seen way ahead of. That's life, but I don't like that idea that the little people might kind of get left over with the idea the ones that can will, and those that can't…(won't).

This mistrust in the government as expressed by a member of the support staff shows her apprehension that a two-tier healthcare system was on the anvil. The government according to her was not acting in the best interests of the "little people" and was violating her norms of appropriate behavior. The norms of ethically appropriate behavior for her were non-market logics. A person from the nursing fraternity expressed concerns about the "ulterior motives of the government" and another suggested, "the government of …was trying to get out of the business of healthcare." The words used for the project by nursing staff and the support staff revolved around their mistrust using terms such as "hidden agenda," "a money saving issue," and another expressing apprehension as she was "suspicious of some of the changes that are being made."

In summary, we found that both trust and institutional logics emerge as important organizing principles in times of institutionally driven radical change. While institutional logics drive radical change, professional groups trusted the initiative to varying degrees. Organizing principles represent heuristics of interpreting information and subsequently selecting behaviors (McEvily et al., 2003). Institutional logics serve as conceptual schemas that guide the institutionally driven radical change. Organizational members interpret these logics and are able to identify a shift from a non-market to market logics. While the institutional entrepreneurs subscribe to such market logics, the change followers believe that the appropriate interpretation of healthcare should be based on non-market dynamics. The presence of two conflicting opinions on what constitutes appropriate institutional logics – market-based or quality based – creates uncertainty and political contests. In addition, trust as an organizing principle interacts with these logics and influences individual behavior. Actors use a variety of accounts and framing techniques so as to direct attention away

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from political ramifications of these change initiatives on their professional roles and instead draw attention to appropriateness of the new logics.

Discussion and conclusions

Our analysis of an institutionally driven radical institutional change in a pioneering rural healthcare organization revealed that while institutional logics may attempt to drive radical change, actors' perceptions of the ethical appropriateness of institutional logics determine their support for the change initiative. Moreover, there appear to be differences in the perception of institutional logics since they have not been taken-for-granted as yet. We also find that support of actors is also affected by the trust placed in their organizational champions to behave in a manner that is consistent with the aims of the initiative. Thus, we show that pioneering organizations face the burden of credibility since new institutional logics have no legitimate precedent.

The first implication of the study is for the literature of institutional logics to be more cognizant of the active role played by actors in evaluating these logics for their ethical appropriateness within pioneering organizations. While we find that the change is being institutionally driven from a non-market to a market-based logic on account of regulatory pressures from the government (DiMaggio and Powell, 1983; Dobbin and Dowd, 1997), we conclude that institutional logics in themselves are insufficient, more so in pioneering organizations. While senior managers and physicians firmly believe that an integrated healthcare service delivery system will not only be better for the patient but also be respectful to the taxpayer, the nurses, and support staff question the ethical appropriateness of market-driven reforms, concerned that it will lead to a less responsive healthcare system. From a practical standpoint, the senior management has to perform an important rhetorical task in persuading members on the ethicality and normative appropriateness of the change initiative due to the lack of precedent. Our findings also call for a return to old institutional theory's focus on contests and conflicts that occur within organizations (e.g., Greenwood and Hinings, 1996; Selznick, 1948, 1957) albeit with a broader view of conflicts that also accommodate perceptions of ethical appropriateness.

Second, we recommend an understanding of microprocesses of institutionally driven radical change through the lens of organizing principles, which serve as heuristics to guide action. Specifically, we advocated a role for both institutional logics and trust as organizing principles in studies of radical institutional change. We noticed that the institutional entrepreneurs and the change followers could perceive moves toward a new institutional logic based on market-based principles, and considered these changes as ethically appropriate to differing degrees. We also noticed differences in the attributes of trust and by consequence, the amount of trust the various organizational members had in the change initiative. The institutional entrepreneurs supported the change initiative as they believed that the new market-based logics will lead to a better healthcare system. In contrast, the perceived unethicality of the market-based logics in the minds of the change followers creates resentment. This resentment manifests itself in the 37.5% and 28.57% judgments of the interviews of the nurses and support staff, suggesting that the *integrity* dynamics of trust were important to them, but were perceived as lacking. They suspected that the stated and implied objectives for change were different and were therefore not inclined to support these efforts.

Third, we must be careful not to draw a linear relationship between institutional logics and trust. Although, the acceptance of an institutional logic might positively influence trust, this axiomatic relationship need not hold true always, if such logics violates the status or interests of an individual within an organization. This was clearly evidenced in the interviews of the nurses, some of who saw integrative services as beneficial to the client but resisted the change because they interpreted a lower status under the new system. We argue that such contradictions between organizing principles frequently occur in an organizational life. When these do occur, actors carefully try to use impression management techniques. While the institutional entrepreneurs justified the ethical appropriateness of these new logics by focusing on how the new system would better meet prior organizational objectives, the change followers argued that the change was driven by logics that were inappropriate as they were based on economic principles.

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The overall conclusion of the article is that new institutional logics do not simply get adopted without negotiation. Rather, they are challenged, contested, entrepreneured, and modified within the confines of an organization (Ranson et al., 1980; Reay and Hinings, 2005). In addition to the perceived ethical appropriateness of new logics, the champions should inspire trust in the eyes of the members. If trust exists, then it has an additive effect on the success of new logics. Else, both interact and co-determine the direction of change.

Note

[1] Note that government officials (who were not interviewed) are considered at the top of the change hierarchy. Physicians and top managers regard government officials as the change agents to be trusted.

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