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Institutional logics and relational shifts: permeating hierarchies and silos in the healthcare sector

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ABSTRACT

Healthcare organizations often confront multiple institutional logics that reinforce professional and departmental hierarchies and silos. Research in the field focuses on how professionals navigate such tensions through everyday practices that maintain, reinterpret or shift specific logics. In this paper, we take a practice perspective to explore the mediating capacity of values-driven practices as a bridge between different logics. Drawing on insights from a leadership programme delivered to 70 public healthcare staff across seven hospitals in South Africa, we argue that articulating values conflicts and shared values shape relational practices, which mitigate the pressures of hierarchy and conflicting logics.

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KEYWORDS Values; practice theory; institutional logics; relationality; healthcare; organizational hierarchies

Introduction

In this paper, we examine how healthcare practitioners navigate the pressures of different institutional logics through relational practices. Institutional logics research has sought to understand how organizations and individuals manage complexity from multiple logics and jurisdictional tensions (Gürses and Danışman 2021; Smets and Jarzabkowski 2013). In the healthcare sector for instance, the literature sheds light on how actors deal with tensions between managerial efficiency and medical professionalism (Bode, Lange, and Märker 2017; Kitchener 2002; Reay and Hinings 2009), hierarchical role divisions (Andersson and Gadolin 2020), and fragmentation between professionals (Ramsdal and Bjørkquist 2020; Van den Broek et al. 2014). Drawing on practice theory (Nicolini and Monteiro 2017,

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Schatzki 2001), we contribute to institutional logics scholarship by exploring the mediating capacity of values-driven practices. Bringing a practice lens to institutional theory offers a counter to understanding logics as rigid metaphysical forces that drive human behaviour, and elucidates the relational dynamics and everyday practices that enact logics and logics conflicts (Lounsbury, Anderson and Spee 2021, Smets et al. 2012). From this perspective we ask: how does the enactment of values-driven practices influence practitioners' experiences of conflicting logics?

In answering this question, we reflect on findings from a study of a values-driven leadership development programme (hereafter 'the programme') offered in the public healthcare sector in South Africa. Four workshops were delivered in 2019, with 70 people from seven hospitals attending the three-day programme. Participants represented multiple professional and managerial roles from an environment with the propensity for generating tensions between professionalism and managerialism, intra-professional division, and conflicting logics between teams within hospitals and between hospitals in the region. Qualitative research conducted in 2020 offers insights into how people respond to challenges working in and across their organizations, and across institutionalized hierarchies and silos. We explore how relational practices – oriented towards building values-based interpersonal relationships (as opposed to creating new systems and structures) – counter the prominence of hierarchies and silos resulting from multiple logics.

In the next section, we situate our argument at the interface between the institutional logics and practice theory literatures. We then describe the changing healthcare sector in South Africa and the leadership programme as the context of the research. In our findings, we present three key themes: 1) the relational shortcomings and professional and managerial tensions that participants experience in their hospitals; 2) the relational shifts that were stimulated during the training; and 3) the potential for values-driven practices in the workplace. In our analysis we explore how practitioners navigate the interplay between different logics through such relational practices. While the programme created a space for articulating value conflicts and shared values, this enabled new ways of relating, communicating and problem-solving across institutional silos and hierarchies. In the workplace, similar relational shifts and practices have the potential to bridge different institutional logics. Our contribution lies in exploring the mediating capacity of values-driven practices to enact new relational connections and shared meanings, which brings a fresh perspective to understanding how practitioners may navigate institutional complexity.

Theoretical framework

Institutional logics

To appreciate institutional logics scholars' move towards practice theory, it is helpful to understand the core theoretical components of institutional theory, including institutional logics. Friedland and Alford (1991, 243) describe institutions as 'supraorganizational patterns of activity... by which individuals and organizations produce and reproduce their material subsistence'. A central logic accompanies each institutional order. In their early theorization of institutional logics, Thornton and Ocasio (2008) detail six ideal-types (building on Friedland and Alford's (1991 original five), associated with specific social spheres: the family, state, market, religion, economic system, and professions. These ideal types were

not intended to represent actual social reality but offer conceptual tools to capture different patterns of social meaning (Reay and Jones 2016). Institutional logics describe 'systems of cultural elements (values, beliefs, and normative expectations) by which people, groups, and organizations make sense of and evaluate their everyday activities, and organize those activities in time and space' (Haveman and Gualtieri 2017, 1). From this perspective, individuals belong to an array of social groups including those within organizations, forming collective identities that become institutionalized in unique logics. Each logic provides a 'set of rules, identity prescriptions, and content that acts as the guidelines for appropriate action within an institution' (Toubiana 2020, 1742), influencing behaviour on both individual and organizational levels. Logics are in this sense not value-neutral but infused by, or oriented towards certain values (Gümüsay et al. 2020, Thornton and Ocasio 2008). For example, a professional logic might underscore the importance of professional standards, judgement and meritocracy, while a managerial logic legitimizes efficiency and a bureaucratic logic emphasizes hierarchy, control and positional authority (Bévort and Suddaby 2016, Ehlen et al. 2022).

The enactment of logics: a practice perspective

Developments within the field of institutional theory have been criticized for reifying institutions (and institutional logics) as a hidden metaphysical force that regulates behaviour through pregiven norms and closing off the scope for agency or change (Smets et al. 2017, Zilber 2016). In response, scholars have turned to practice theory to better account for and articulate institutional complexity, everyday workplace experiences, and how institutions are enacted or inhabited (Gehman 2021, Lounsbury et al. 2021). With roots in relational sociology (Abbott 2020; Emirbayer 1997), a practice perspective challenges the distinction between micro and macro, making sense of the world in terms of interactions or collective 'doings and sayings' that organize around particular ends (Nicolini and Monteiro 2017). From this lens institutional logics do not exist outside of practice, but transpire in and through practice (Smets et al. 2017).

This article has been corrected with minor changes. These changes do not impact the academic content of the article.Schatzki (2001, 11) defines practices as 'embodied, materially mediated arrays of human activity centrally organized around shared practical understanding'. The locus of agency is not the individual but rather interaction, or how things are done together (Hallett and Hawbaker 2021). As a specific activity becomes meaningful within a social group, it enacts and thus (re)produces particular social norms or logics (Smets et al. 2017). In this way, practices become historically situated as patterns of activities recur, gain meaning and become routine (Furnari 2014). In healthcare for instance, activities involved in nursing gain meaning in the context of wider healthcare practices and the shared understanding of what it means to be a nurse, thereby enacting what might be referred to as a professional logic of care. An institutional logic therefore offers a conceptual construct to encapsulate the patterns of shared meanings that endure through practice.

The durable patterns that emerge through processes of interacting and relating can be difficult to ignore or alter (Roseneil and Ketokivi 2016). Practices in healthcare are likely to involve a web of relations between physicians, managers, specialists, nurses, administrators, etc. (Reay and Hinings 2009) – often constituting hierarchies. This is especially evident in how the nursing profession has historically been regarded as one

of subservience to that of the medical doctor and the hospital ecosystem. Johnstone (2016) lists the perceived characteristics of the 'virtuous nurse' as, inter alia: loyalty (to doctors/hospitals); obedience (to doctors/hospitals); and compliance (with authority).

Despite such entrenched hierarchies, Frenk et al. (2010), in their review of global health systems, argue for a 'new professionalism' involving non-hierarchical relationships and interdisciplinary collaboration, based upon a common set of values and social accountability. Oliveira, Rodrigues and Craig (2021) similarly suggest that emerging conflicts can be reduced by fostering a collaborative environment across organizational structures and professions. Yet, power differences and engrained practices that sustain such hierarchy, constrain the potential of such collaboration (Noyes 2022). This raises questions about how actors may navigate historical patterns of relating and interacting, especially institutionalized hierarchical relations, or how new practices might emerge that enact and produce new relational connections and shared meanings.

Institutional logics conflicts as values conflicts

Much of current institutional logics research focuses on how multiple logics generate institutional complexity and jurisdictional struggles (Smets and Jarzabkowski 2013). In the healthcare context, the literature commonly examines the tensions between professional and managerial logics given pressures to enhance the quality of care while also reducing costs (Bode, Lange, and Märker 2017, Ramsdal and Bjørkquist 2020, Van den Broek et al. 2014). Practice theory offers a lens for making sense of such logics conflicts in two ways.

Firstly, practice theory enables us to move beyond the understanding of logics tensions as predefined static binaries to consider their dynamic contextual interplay (Zilber 2016). Whether different logics are compatible or contradictory is constructed in practice (Smets et al. 2017, 27). Healthcare settings are also not wholly determined by managerial and professional logics conflicts. Such settings entail a variety of dynamic relations, which may be legitimated (or not) through organizational hierarchies (Andersson and Liff 2018) as well as reflective sensemaking (Hallett and Hawbaker 2021). The relation between the logics of family, medicine and law, for instance, will shift depending on the situation, the presence of parents, doctors and childcare workers, and how people make sense of the particular situation (Heimer, 1999).

Practice theory enables us, secondly, to understand logics conflicts in terms of values, which is understudied in institutional research (Gümüsay et al. 2020). From a practice lens, values do not exist in some abstract 'out there' but are accomplished in practice (Gehman 2021). Gehman et al. (2013, 84) go so far as to define 'values practices' as 'the sayings and doings in organizations that articulate and accomplish what is normatively right or wrong, good or bad, for its own sake'. Values practices both describe what should be done, and 'actively intervene and enact normative realities' (Gehman 2021, 151). Such values practices are not performed in isolation, however, and generate situations where multiple norms interact and blur the boundaries between acceptable and unacceptable behaviour (Emirbayer 1997, 309). Conflicts thus emerge where different ways of doing things clash, where there is misalignment between norms or shifts in meaning (Nicolini and Monteiro 2017, Skarli 2021). This creates a 'gray area of undecidability' that opens a space for agency (Gürses and

Danışman 2021, 150). Hallett and Hawbaker (2021) describe this as the 'fork in the road' that triggers sensemaking and a shift from habitual to purposive action.

Everyday practices to navigate multiple logics as values conflicts

A growing literature examines what people do in their everyday work to manage multiple logics, and the potential for new practices or relations between logics to emerge (Bévort and Suddaby 2016, Lawrence, Suddaby and Leca 2011, Smets and Jarzabkowski 2013). Managing logics may involve avoidance, seeking a 'holistic' solution that accepts the tension, or various alternatives in between (Ashforth et al. 2014, Bode, Lange, and Märker 2017), from: 'hijacking' aspects of a logic beyond one's professional group to strengthen one's own position and dominant logic (McPherson and Sauder 2016); 'hierarchizing' one logic (e.g. managerialism) over another (e.g. professionalism) (Arman, Liff, and Wikström 2014); or 'reinterpreting' a dominant logic (Reay et al. 2017).

From the extant literature, we gain insight into how values conflicts trigger changes in practice, and vice versa. We observe, for instance, a logics conflict between care and efficiency as new practices aimed to reduce treatment costs and length of treatment are introduced in German hospitals, triggering new organizing practices by physicians to regain professional autonomy (Ehlen et al. 2022). A similar conflict between professional expertise and 'trust in numbers' is evident with the advent of new quantitative reporting practices in psychiatric care units in Sweden (Arman, Liff, and Wikström 2014). In the Turkish healthcare context, Gürses and Danışman (2021) discuss how physicians leverage their professional authority for personal gain, enacting 'rogue practices' that become embedded in the professional culture over time. Although their paper maintains the language and assumptions of logics as pre-established social structures, their case demonstrates that people do not necessarily act within the 'primary logic' of their role, but respond to the blurring of boundaries due to multiple intersecting practices and norms, including personal material interests, professional norms, state prescriptions, and societal perceptions of esteem. Physicians draw upon these existing meanings and the tensions between them to make sense of the situation. Furthermore, their new rogue practices become durable as they intersect with and shape other related practices, in this instance, payment practices involving patients and administrators alongside the training of newcomers into the profession. Although not situated in healthcare, Everitt and Levinson's (2016) study of inhabited institutionalism similarly illustrates how leaders mobilize existing values as part of their sensemaking to construct meanings of a situation that legitimizes their agendas.

Much of this literature focuses on institutional level changes, how conflicts are resolved through dominance, decoupling or hybridization (Andersson and Liff 2018), and institutional work within and through hierarchy and positions of power. Less clear, however, is how people might collaboratively respond to such values conflicts (Reay and Hinings 2009). Where and when specific practices come to matter in mitigating values conflicts is also not sufficiently understood (Hallett and Hawbaker 2021), especially in settings plagued by institutional norms that entrench hierarchical and siloed relations. In this paper, we do not examine how organizational actors directly engage with or address logics conflicts. Rather, we consider how surfacing values conflicts and shared values can shape relational practices, which in turn mitigate

the pressures of various institutional logics experienced by actors across organizational hierarchies and healthcare professions.

Research context

South Africa's democratic transition in 1994 initiated a transformation in the national healthcare sector. Prior to this date, healthcare policies favoured white people, with entry criteria into university health education courses, posts for health workers, and health facilities geared towards giving advantage to the white minority (Mayosi and Benatar, 2014), as well as to men (Van der Merwe 2016). Burch and Reid (2011) further highlight the huge discrepancies in healthcare access between urban and rural, and rich and poor communities, with 85% of the population relying on public healthcare. Subsequently, all medical schools in the country have changed their admission criteria, with approximately 60% of students admitted to healthcare courses coming from previously disadvantaged communities and of female gender (Van der Merwe 2016). This paradigmatic change aligns the emerging workforce with societal demographics, creating the potential for inclusivity and restoration of equity for patients, as well as building diversity, equity and inclusivity within the workforce.

The broadening of access to healthcare from a minority to the majority of the population naturally increased the strain on existing financial and infrastructure resources. While healthcare policies and systems changed, it has fallen upon healthcare personnel to maintain effective administration and professional care at the same time. Consequently, healthcare professionals do not only have to adapt to changing institutional logics over time (diachronically) but must also cope with competing logics in time (synchronically). The challenge remains how to support healthcare practitioners to live out organizational and individual values within existing logics (Allwood et al. 2022).

It is within this context that the Values-Driven Leadership Programme was adapted for the public healthcare sector in South Africa in 2019. The programme combines affective, ethical and relational elements through an experiential learning approach. It aims to equip participants to deal with values conflicts and to find effective solutions to ethical challenges amid various institutional pressures (Painter-Morland 2008, Painter-Morland et al. 2015). Underpinned by Mary Gentile's (2010, 2017) Giving Voice to Values approach, alongside notions of relationality from African and 20th century European philosophical traditions (Pérezts, Russon and Painter 2019), it articulates the embeddedness of personal, team, and organizational/systems leadership. The programme also offers a communicative environment for moral education and leadership development conducive for groups containing multiple cultural and philosophical orientations. In its adaptation to the healthcare context, the programme incorporates case material and clinical governance tools in combination with the values and leadership components.

Training cohorts included practitioners from different public hospitals, professional disciplines and operational units to develop individual skills and group-based approaches for managing values-based conflicts and risks. Although the programme is infused by theory, it veers away from treating either leadership or ethics in a theoretical way. In fact, the term leadership is never explicitly defined as encompassing specific skills or styles, as may be the case with many leadership development courses (Ford and Harding 2007). Rather, the programme elucidates leadership and

ethics via everyday experiences and tacit values across personal, interpersonal and organizational levels.

Within the programme, values are defined as the aspirational beliefs that express how humans agree to live and relate and determine what they regard as right or wrong in a particular situation, and the decisions they make as a result. The values informing the programme's learning approach align with what Gentile (2010, 30) refers to as 'a short list of widely shared values', namely honesty, respect, responsibility, fairness and compassion. Working with these five values as the base, the programme also incorporates conversations on professional values expressed in the Hippocratic Oath from the 5th century BC (Arenas 2010), the pledge of the World Medical Association (WMA 2017), and the ethical guidelines of the Health Professions Council of South Africa (2021). Altogether these values sets represent the values-embedded nature of the health professions in personal-relational and professional terms.

Informed by the values-driven leadership literature (e.g. Bedzow 2018, Freeman and Auster 2015, Gentile 2010, Gentile, Lawrence and Melnyk 2015), it may be concluded that a values conflict represents a situation in which an individual experiences moral discomfort, might cause harm to others, or undermines the best interests of an organization, society or the environment. There is therefore the probability that multiple and competing institutional logics can contribute to the severity of someone's experience of a values conflict. However, while values conflicts are integral to the values-driven leadership approach, the institutional logics interpretation or dimensions thereof were never explicit in the programme. Particularly relevant from a values conflict perspective is the interplay between personal/relational, professional and institutional values.

Four workshops were delivered in 2019 with between 16 and 20 participants attending each session, for a total of 70 people representing seven hospitals across two districts. Participants included physicians, nurses, pharmacists, occupational therapists, physiotherapists, and hospital administrators. Most were in middle or senior management positions. Group demographics were gender, race and language diverse and inclusive. The seven hospitals are situated in the Garden Route and Central Karoo districts of the Western Cape Province. Apart from the one regional hospital in George, which has general specialities, the other six smaller district hospitals are staffed by general medical officers, nurses, managers and allied health practitioners. The Garden Route district has a population of 627,917 (2021) spread over a surface area of 23,332 km^2 (Garden Route District Municipality, n.d.). The Central Karoo district has a population of 79,014 (2021) spread out over a surface area of 38,854 km^2 and is situated to the north of the Garden Route. Both districts are characterized by a strongly rural setting with dispersed farming hamlets and small towns, with approximately 80% of people relying on the state health service for medical care.

Research methods

A qualitative study investigated participants' experiences and perceived outcomes of the programme. Eighteen interviews and seven focus groups were conducted, with a total of 24 people from the full cohort of 70 participants, generating theory saturation (Braun and Clarke 2021, Low 2019). We included interview participants from every hospital, including managers (four), nurses (four), clinicians (six), and allied health practitioners (four). Focus groups consisted of managers from three hospitals,

clinicians from two hospitals, allied health practitioners from two hospitals, nurses from one hospital, two hospital-specific focus groups, and a facilitators focus group. Conducting the research 12–18 months after the workshops provided an opportunity to understand participants' experiences of the programme as well as in the workplace.

All interviews and focus groups were conducted online over three months in 2020. This followed ethics approval from two universities and the relevant department of health, as well as written informed consent from all participants. Interviews and focus groups lasted on average 55 minutes and video recordings were transcribed and analysed using Atlas.ti. While COVID-19 made it impossible to collect data in person, using online media is an increasingly common approach. We recognize the potential risk this approach poses to data collection, although there is little consensus on whether online methods produce less rich or reliable data (Jones et al. 2022). The availability of video features provided access to verbal and non-verbal cues, and the real-time conversations enabled spontaneity and honesty in responses, thus mitigating the risk of social desirability bias (O'Connor and Madge, 2017).

The first two authors were involved in collecting and analyzing the data. The third and fourth authors were involved in designing and delivering the workshops, and constituted one of the focus groups, offering their insights and experiences of the programme. While we work within a social constructivist paradigm that acknowledges researcher subjectivity (Mantere and Ketokivi 2013, Kalu 2019), we also recognize the need to minimize potential bias to increase the confirmability of the data, thus ensuring trustworthiness of the research (Shenton 2004). We therefore maintained this separation between the co-authors conducting the research and the co-authors who were involved in the programme. Only once the data collection and analysis were completed did the full team come together to discuss the findings and themes.

The first two authors analyzed the data following an abductive approach employing a codebook and later moving towards deeper reflexive thematic analysis (Braun and Clarke 2019). We agreed on a few general elements to code, such as: participant expectations; training impacts; how people operationalized training activities and skills in the workplace; values; emotions; successes and failures. Both researchers then coded the same transcript separately, followed by a discussion. This enabled clarification of specific codes as well as identifying other emerging codes and themes. The transcripts were then split between the researchers for further coding. Throughout the process, regular meetings were held to continually share interpretations of the data. Adoption of these well-established coding methods, frequent debriefing sessions, and scrutiny of findings by the programme facilitators, were some of the techniques used to pursue credibility, hence supporting trustworthiness of the research (Shenton 2004).

Institutional logics theory did not inform our original data analysis. However, as we coded and discussed the data, we were struck by the experiences of hierarchical and inter-professional conflicts evident in the data. This led us to explore the institutional logics and later the practice theory literatures. Through an iterative reading between the literature and data, we made sense of how participants navigate their institutional contexts through various kinds of relational practices, some reinforcing and others challenging said hierarchies. Through several iterations of engaging the data and the institutional logics and practice theory literatures, our explorations of the data moved beyond our initial codes towards more open coding and generative analysis (Braun and Clarke 2019). This allowed us to develop and engage with themes around the relational dynamics between hierarchies and values-driven practices, and through which we

discerned prominent logics (Reay and Jones 2016). Through this abductive approach, we moved away from assessing impact, and clustered and theorized the coded data to identify the relational shifts and practices illuminated through the programme (see Table 1 below).

From the data on how participants perceived their work contexts, we identified relational shortcomings, alongside managerial and professional hierarchies and silos, as key constraints that people experience. We theorized these as *the context for relational shifts*. We then returned to the data coded for experiences within the training to generate 2nd order codes and themes. We clustered these around three levels: the individual ('individual confidence to give voice to values'), the interpersonal ('sense of team') and the organizational ('holistic understanding of system'). We theorized these experiences as the development or enabling of values-driven practices and ultimately as *enablers of relational shifts*. We followed a similar analytic process engaging the data

Table 1. Summary of data analysis.

Themes	2nd order codes	1st order codes
Context for relational shifts	• Relational shortcomings	• Emotional disconnects • Conflict • Comfort zones • Difficult conversations
	• Managerial and professional hierarchies and silos	• When doctors become managers • Siloed professions • Siloed departments
Enablers for relational shifts	• Individual confidence to give voice to values	• Affirming individual values and emotions • Developing language to articulate values • Strengthening communication skills
	• Sense of team	• Being anxious together • Identifying shared values • Gaining perspective of others' problems/sense of shared problems
	• Holistic understanding of the system	• Developing problem-solving skills • Sharing across professions and organizations • Seeing different ways of doing things
Enacting relational shifts in and across organizations	• Facing values conflicts	• Communicating with respect • Active listening • Facilitating problem-solving • Role-modelling • Having difficult conversations
	• Creating relational spaces	• Talking across silos • Asking for help • Changing practices in meetings
	• Operationalizing the fuzzy	• Identifying processes that exhibit care • Identifying the underpinning relationships
	• (Re)enacting relational disconnects	• Avoiding feelings • Disagreement perceived as conflict • Shifting or denying responsibilities • Limited spheres of influence

on experiences and practices in the workplace after the programme. We organized the 1st order codes into three clusters that we theorized as ways that people *enact relational shifts* in and across their organizations. These constitute relational practices through which people may address relational shortcomings and navigate the various institutional logics tensions of their organizational contexts.

Findings

We organized our findings into three themes: the context for relational shifts, enablers of relational shifts, and enacting relational shifts in and across organizations.

Context for relational shifts

Most participants perceived the healthcare environment as one of relational disconnect and constraining silos and hierarchies. Staff find it generally difficult to share their personal emotions, and grapple with sharing their values and feelings in the workplace:

> We have to build walls around ourselves to protect ourselves from all the heartache and the horribleness that we experience. And because it exposes an extremely vulnerable side of the community that we serve, how broken it is and to just try and cope with it, very often, walls go up, we take our emotions out of the whole thing. (Interview 7)

The barring of emotional expression also seems to be institutionalized by professional training of healthcare practitioners:

> We are completely numbed to any emotional intelligence. We get moulded that way. [. . .] I think half of the ethical dilemmas that healthcare workers feel are simply healthcare workers experiencing that they're not allowed to feel how they feel [. . .] So I think med school is a big dilemma in the healthcare professionals' life, it creates us as unfeeling people. (Interview 18)

Engaged communication is further restricted by hierarchies and functional silos that exist in the hospital setting and maintained through various practices. Professional hierarchies in particular pose a threat to effective internal communication and patient care. One example from a doctor describes the relationship with nurses at a particular clinic. A previous doctor had insisted that nurses wait outside the consulting room during a consult before bringing a file into the room:

> I understand that concept, but everything has a cost and benefit. If you don't want to be interrupted, then there's no way a sister can wait outside for your entire consultation while she has a whole long list of patients to see as well, and she needs to engage with me. (Focus Group 2)

In this example, the clinic's organizing practices enact particular values that may be associated with professionalism, but which undermines efficiency while also reinforcing a hierarchical distance between doctor and nurse.

Differences between professions are also apparent in how relations within and across professions generate hierarchies. One interviewee referred to it as the forming of 'occupational clusters'. A similar view was expressed in one of the focus groups where a respondent highlighted how professional distinctions might filter into managerial roles and potentially constrain relations and practices within management teams:

> If I can come back to the ranking system, when I trained a couple of years ago, it was a very traditional thing that the general sister doesn't speak to a matron or a doctor or to a senior doctor or to the management. [. . .] You had that almost fearful respect for them. [. . .] I was never comfortable to go to someone in a management position. [. . .] But as an operational manager, it is necessary to be able to utilize those platforms, because how am I going to get my problems and my concerns across for input and assistance and knowledge from them, if I don't discuss it with them? (Focus Group 6)

Hierarchies between management and professions, and lower levels of staff within the hospital, also lead to some staff feeling excluded:

> The lower down the management, or even lower down to the cleaning staff, I get the idea, (they feel they) are not part of the hospital. (Focus Group 1)

This, in turn, can lead to problematic relationships with the public:

> Initially I felt completely overwhelmed by the publics' complaints about staff attitude and also a lot of complaints between staff members. (Focus Group 1)

A potentially negative competitive environment also exists between different departments, and tensions were observed between different hospitals and hospital divisions. Interviewees noted, for instance, clashes between hospital and clinic clerks (Focus Group 4), between an internal medicine department and a hospital (Interview 6), and generally between departments who all 'think they are the best, that they are the most important one' (Interview 2). Such tensions have implications for patient care, as one interviewee referred to the discomfort that results when a junior doctor ends up against barriers that affect patient transfers between hospitals.

Participants' descriptions of their contexts suggest relational shortcomings are reinforced by, and simultaneously reinforce various divisions and hierarchies. This resonates with descriptions of healthcare organizations as rigidly compartmentalizing roles through taken for granted norms and values (i.e. logics), and reinforcing the power of the physician (Andersson and Gadolin 2020). Our analysis suggests such divisions are accompanied by the persistent (and even institutionalized) lack of acknowledgement of values conflicts and the emotional responses these generate. On this basis, the operating logics in this organizational context may be interpreted as a dominating professional logic of expert authority, which conflicts with and undermines a logic (or practices) of care, understood in terms of how one enacts one's awareness and concerns with respect to colleagues, patients and work conditions.

Enablers for relational shifts

While the programme took place within the context described above, the workshops created a relational space (Kellogg 2009) intended to emphasize relationships and diffuse the importance of hierarchies and siloes. Through individual, peer-to-peer and group activities, the training shifted participants' orientation to themselves, to others and to the broader system. In other words, the workshop activities endeavoured to make possible 'doings and sayings' that do not simply re(enact) existing practices from the workplace.

The programme's affirmation of values and emotions (introduced through an affect-based exercise called 'happy-angry') cultivated the *confidence to 'give voice to values'*:

> It gave me more insight maybe into myself, if I'm frustrated or have emotions, where does that come from, [. . .] broadening my perspective, [being] able to deal with other people's frustration. (Interview 12)

Through 'active listening' exercises, participants practised sharing their experiences, often doing so in pairs or small groups transecting different professions and managerial levels. This strengthened individual voices to penetrate hierarchical barriers (e.g. a junior medical officer feeling more comfortable to speak up to a consultant). A nurse explains how this came about:

> My partner in most of the sessions was a doctor from another hospital. I think that gave me the confidence to really sit down and give my views, get my feelings across to someone that in general I will not discuss issues with because of the ranking system we are in. [. . .] I am a lot more assertive now to discuss problems with higher management. (Focus Group 24)

By eliciting a sense of shared values and experiences, the training stimulated an embodied, values-based *sense of team*, as indicated in the following reflection:

> You forget about your rank or your nursing or your whatever. Everybody's opinion was of value. And my experience was, whether you are a physiotherapist, a pharmacist, you are a doctor, you are a nurse, somewhere, somehow, our challenges with regards to the values of the department, are the same. (Focus Group 25)

A hospital manager similarly reflected on getting to know another hospital manager better:

> We knew about each other, but we didn't know each other [. . .] everything just became more open [. . .] the sort of values that I try to live out resonates with the values that she's trying to live out. (Interview 4)

This also emerged through group activities (such as playing Jenga) that generated embodied experiences as reminders of the difficulties of operating as a team and having to be 'anxious together' (Interview 10). One interviewee reflected on the fear of failure involved:

> The one thing that I can still clearly remember is the Jenga blocks and the way it was played. And how the tension mounted if failure was imminent (laughs). And how you've got to deal with that feeling that you let your team down. That made a huge impact. (Focus Group 21)

Finally, the training cultivated a *holistic understanding of the system*, with implications for problem-solving. The fact that every workshop included participants from different hospitals, professions and institutional roles generated a diversity of perspectives. This seemed particularly impactful for group and peer conversations, with interviewees reporting better understanding of organizational problems from others' viewpoints:

> Sometimes you only see something from the pharmacy view, and once you're there you see the situation from a doctor's perspective. It changes your perspective on how you deal with a problem. Same with nursing. You just get to work as a whole team. (Focus group 21)

Crucially, the exposure to others' experiences and practices provided insight into the relational aspects of operational or clinical challenges:

> I think this creates a platform where people become people, that you meet people. If you were wondering why clinical processes don't happen, it's because maybe we need to get to know the people who run those processes. (Interview 11)

By developing new conversational practices that affirm values and embodied experiences (such as discomfort or anxiety), new relational connections and ways of interacting across functional and hierarchical positions becomes possible. Gaining different perspectives of a situation or issue, alongside a sense of shared values with others working within the system, enacts a sense of team and a holistic understanding of the system with the potential to further disrupt hierarchies and silos. This enables a shift away from the centering view of the person, unit or hospital, to seeing the broader system and one's role in it.

That said, the research also indicated limitations to the training. Many participants noted difficulties remembering the tools and activities after a prolonged period. A few also noted struggles in the workplace when engaging colleagues who had also undergone the training, suggesting less relationship-building and alignment of values. Still, clear patterns around these three outcomes were evident, which we theorize as *enablers for relational shifts*.

Enacting relational shifts in and across organizations

Given the relational values practices (as a logic of care) stimulated during the programme, how might similar practices emerge in the workplace and enable people to better navigate values conflicts? Through our analysis of participants' workplace experiences, we theorized three practices that enact relational shifts in and across the organizations: facing values conflicts, creating relational spaces, and operationalizing the fuzzy. In some cases, these shifts suggest a sequential movement from improved communication and interpersonal relations to transforming operational processes for sustained change.

First, relational shifts are enacted through various ways of *facing values conflicts*. This involves explicitly considering values in how matters are discussed and situations framed, and taking time to acknowledge and check in with staff:

> The values, the respect and compassion has become a way of saying things in our hospital. 'Oh, that isn't really a respectful or compassionate conversation, is it?' Or, 'that has been a real respectful and compassionate way in which that situation or issue was handled'. (Focus group 19)

While articulating and 'tagging' values in conversation with others heightens the relational dimension of an issue, this also generates a language and space for others to do the same. Role-modelling different ways of interacting, and especially acknowledging mistakes and uncertainty, can demonstrate facing values conflicts:

> The relationship that I have with the colleague of mine that has been the challenge for me for so long, even that has turned to a more positive experience for the juniors who are observing this. (Interview 7)

> One of our MOs [*medical officers*] who overheard this said to me a few days later, she told her husband she really appreciated the way that conversation went – staying honest, staying truthful, but also fair to our own people. [. . .] In that way I'm seeing slight changes in our department. People [. . .] can see how you can change conversations. (Focus Group 20)

Tackling specific conflicts with a colleague by facing the issue head-on seems to be another way of changing conversations. For instance, two senior colleagues reported resolving a long-standing tension through active listening, 'dig[ging] into some of the insecurities' to really listen to each other (Interview 7).

The second relational shift occurs through efforts to *create relational space*. This involves arranging space and time for values conversations as an integrated part of everyday work. Such efforts include introducing mini-interventions into meetings, creating new opportunities to connect and collaborate, and expanding patterns of communication across departments. In one hospital, active listening activities were incorporated into staff lunch meetings to explicitly challenge norms of hierarchy by inviting conversations with one another framed as 'special guests'. Such interactions have the potential to generate relational connections and sense of being a team beyond programme participants. When used as a way of raising agenda items within a meeting (i.e. asking colleagues to share in pairs and then raise issues on behalf of one another), such small exercises can initiate a shared respect and set a different tone:

> Our heads of department group, that was the group I was most intimidated by because they're all these specialists. [. . .] I got them all doing active listening exercises at the beginning of every meeting, and slowly but surely over the course of a year, that meeting space turned into a much more respectful and compassionate space. And I think from there it filtered down into the other teams as well. (Interview 18)

While departmental structures clearly remain, these experiences illustrate how boundaries could become less explicit with greater sharing and understanding of each other's contexts. Efforts to embed these kinds of activities regularly within existing processes gained most traction in hospitals with a certain level of existing functionality, and when driven and supported by senior managers.

Finally, relational shifts may be enacted by what we term *operationalizing the fuzzy*, where operational processes change through alternative relational connections and practices. Evidence of these shifts were less common, but those that did occur demonstrate how respecting and leveraging relationships, and organizing processes to exhibit care, could help embed operational improvements.

For example, one interviewee explained how they were able to call a doctor at another hospital one night – challenging existing norms of communication between the hospitals and across hierarchies – to resolve an urgent dilemma in getting a child into an intensive care unit. In this instance, relationships built during the training made it possible to disrupt standard referral practices, which directly impact patient health outcomes. Whether similar relational connections might be generated outside of formal workshops points back to the importance of creating relational spaces in the workplace.

Relational connections similarly offered an essential 'lever' in outreach work between the large regional hospital and the smaller district hospitals. In the following passage, an interviewee shares how changes in their relationship with an outreach specialist who also attended the training led to better communication and management of patient bookings. We quote them at length as this captures the shift from experiencing values conflicts through to enacting new relational connections and changed practice:

> I thought they're full of nonsense, they come here, they want this and they want that, and they're usually complaining about, 'we're booking too many patients'. It was just a nightmare, especially this one specialist. [. . .] But as we were sharing, I could also hear some of their frustrations as operational doctors, and I heard the dedication [. . .] and it gives me much more respect. [. . .] [Now] I want to make things easy and comfortable for them to come here. [. . .] And the specialist that comes here, when there is a problem, she'll feel free to phone me and I will try and sort it out. (Interview 17)

Here we observe how operational practices are articulated in terms of shared values and an effort to exhibit care. In another example, a doctor who at first believed he needed to gather statistical information to streamline consultations and reduce patient over-bookings, decided instead to change the tacit norms in the clinic so that nurses could bring files into his office without waiting for gaps between patients. This created space and time to build a connection between nurse and doctor, and together with the patient:

> Because we broke down barriers between sister and doctor, we started working more and more as a team. And slowly but surely the number of referrals reduced, the number of follow-ups reduced. Everyone started to sort of get what was happening. Even the clerks understood what an urgent booking versus non-urgent booking was. Even the pharmacists would get involved in referring the patient to a counsellor. (Interview 14)

It is noteworthy that although only the doctor attended the training, a small purposeful shift in how the clinic is organized led to changes in others' practices and in the relational connections performed in the process. Rather than require a major change management intervention, such relational shifts involve seemingly small changes towards values-driven conversations, spaces and processes.

Nevertheless, alongside these examples, our analysis also identified certain obstacles to performing values-driven practices and relational shifts in the workplace. All participants in our research remarked about the challenges of workloads and time pressures, and resistance to change due to staff disinterest, comfort zones and transient teams. Relational disconnects may also be (re)enacted through communication patterns where differing opinions are perceived as conflict, or difficult conversations and feelings are avoided:

> If you start to initiate conversations [where], I want you to listen in an honest way to what I've got to say, and then I want to listen to an unveiled version of how you feel at the moment – not everybody feels comfortable with that sort of honesty about feelings. (Interview 7)

Crisis situations can also push behaviours back into old patterns, with some interviewees observing how a reactive management that is 'putting out fires' can close off communication and consideration of feelings.

In contrast to acknowledging conflicts and articulating shared values, efforts to avoid discomfort can maintain organizational disconnects, locating responsibilities in a respective division or person rather than generating a sense of team, as illustrated in the following reflection:

> We must realize it's not our monkey, you don't have to solve all the problems, certain times you need to back off a little bit and see how it plays out. (Interview 10)

Relational shifts across the organization can also be constrained by the limited sphere of influence of everyday interactions, which involve a bounded range of staff, teams or departments:

> There is a certain group of people I reach much easier and more regularly and that's mainly the clinical group of doctors and allied health people, and obviously my management group as well. My challenge is, how do we take it from that level to a lower level into the rest of our institution and that's where the biggest gap is. (Interview 5)

That these kinds of obstacles persist are not surprising and may be understood as part of the nature of entrenched patterns of behaviour (or institutional logics) in complex

organizations like hospitals. Values-driven practices are clearly not a panacea for responding to and overcoming such patterns. Still, our findings suggest it is possible to transform (albeit in small ways) such patterned ways of interacting and operating. The kinds of practices detailed above, if sustained and legitimated over time through ongoing accomplishment, could be interpreted as softening a logic of authority and giving space and voice to a logic of care.

Discussion

Our aim in this paper was to explore how the enactment of values-driven practices contribute to practitioners' experiences of conflicting logics. Our findings give insight into how surfacing values conflicts and shared values enact relational shifts that enable people to relate and work differently across institutional silos and hierarchies. In Figure 1 below, we propose a framework for how relational shifts, as forms of relational connection based on shared values, may be enabled and enacted in organizations.

As shown in the first block, our findings suggest the layers of authority, division and hierarchy have consequences for how people relate to and interact with one another. Behavioural expectations attached to distinct professional roles and departments, which staff enact and (re)produce in specific situations, construct logics tensions. These tensions contribute to operational but also relational and moral values conflicts for staff, generating a context rife with relational shortcomings that put values under pressure and produce affective discomfort (e.g. anger, anxiety, frustration).

The communicative context of the workshops provided an environment distinct from participants' organizations, offering tools that surface values and values conflicts, and opening a relational space for 'interactional responsiveness' (Abbott 2020). These tools focus on how to engage with and relate to others in the process of making sense of organizational realities (as shown in the second block in Figure 1), cultivating what could be described as a logic of care. This logic of care is distinguishable from the professional logic of care often associated with medical care and nursing (Dunn and Jones 2010), and rather entails caring about how to enacts one's awareness and concerns with respect to colleagues, patients and work conditions. The programme environment offers an opportunity to cultivate such a logic of care by bracketing out formal organizational divisions that are present in participants' daily practice, while giving space for voicing organizational issues. As our findings indicate, participants appreciated the opportunity to interact across departmental, organizational and

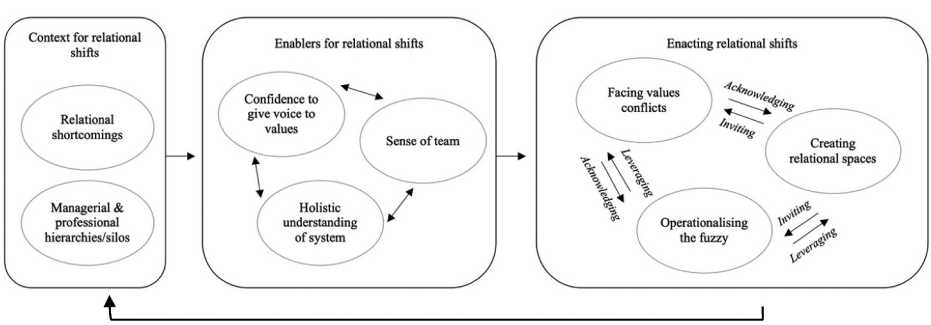

Figure 1. How relational shifts are enabled and enacted.

hierarchical boundaries. Working in a safe setting with participants' stories, emotions and personal and organizational values conflicts, can stimulate values-driven practices and relational connections oriented around shared values.

The third block depicts how such a relational space and practices might unfold within the workplace amidst ongoing organizational pressures and obstacles, including staff hierarchies, resistances and the urgencies involved in healthcare. We theorize practitioners' efforts to generate relational shifts in their teams and organizations in terms of three interconnected practices that enact shared values, namely: acknowledging, inviting and leveraging.

Acknowledging: This involves acknowledging the values conflict at stake in an intersubjective situation, the emotional discomfort that goes with it, and that action should be taken. A values conflict might represent a situation in which certain values are compromised, or personal discomfort with behaviours and practices that may undermine the profession or institution. It is in the conversations about such conflicts that interpersonal relationships begin to shift. Rather than banish feelings, it is the acknowledgment of discomfort that enacts care as shared meaningful practice. In this way, emotions are not merely symptoms of, or reactions to institutional dynamics, but contribute to 'maintaining, disrupting or creating institutions' (Voronov and Vince 2012, 61). This emerges in the data in conversations that 'tag' values either explicitly or performatively. While the 'undecidability' of values conflicts produce logics tensions as well as discomfort (Gürses and Danışman 2021), articulating values provides a shared language and relational connection that help make sense of conflicts and accompanying emotions in the workplace. Such action foremost involves facing a values conflict, which opens a path to creating new relational spaces and finding ways to operationalize relational connection.

Inviting: This involves arranging space and time and initiating relational connections. This brings into focus the necessity of active listening, upholding the dignity of the other, and seeking ways to integrate values conversations into everyday practice. It is here that interpersonal relationships become objects of care within the organization. For example, giving time in meetings to 'meet' colleagues, which can support later difficult conversations or operational changes. Practices of inviting hold the potential for connection that builds resilience within and across groups (Barton and Kahn 2019) and enable shifts in operational procedures 'from the ground up', or 'from the centre out', rather than through top-down operational interventions.

Leveraging: In leveraging, the potential for organizational culture change emerges. Changes in everyday practices can embed in the organization in ways that generate collaborative relationships and help mitigate the pressures of competing logics (Reay and Hinings 2009). Values-driven actions taken in the interpersonal space gain traction by developing trust while addressing operational and clinical issues. Here shared values connect the processes of acknowledging, inviting and leveraging. Upholding the values grows trust and enhances engagement, collaboration and productivity, while compromising the values achieves the opposite.

Theoretical contributions

This paper contributes to the growing literature interrogating the interface between practice theory and institutional logics theory (Gehman 2021, Lounsbury et al. 2021, Smets et al. 2017) by offering insights into the values practices through which

institutional logics conflicts emerge in healthcare organizations, and how they may be managed. While we cannot make claims about whether different logics are maintained, subsumed or hybridized in this study (Arman, Liff, and Wikström 2014, Van den Broek et al. 2014), our paper contributes to research into everyday practices to manage multiple institutional logics (Smets and Jarzabkowski 2013). Practices discussed in the extant literature point to various sensemaking efforts to avoid logics conflicts, seek compromises between different logics, or accept and work with the conflict (Bode, Lange, and Märker 2017). Our study elucidates how, rather than reducing the complexity generated by multiple logics, values-driven practices operate in a relational space where the discomfort of such conflicts is acknowledged. It is precisely in the context of logics conflicts that values-driven practices may be leveraged. Our proposed framework of acknowledging, inviting and leveraging offers a practice-based and processual understanding of this navigation of institutional logics conflicts.

Our findings further resonate with studies that examine how logics conflicts linked to rigid role hierarchies may be maintained or disrupted. This literature especially illustrates how physicians might use the power of their position to either maintain or redefine the shared meanings of their practice (Andersson and Gadolin 2020, Gürses and Danışman 2021). Andersson and Gadolin (2020), for instance, detail how social interactions between different professionals can shift logics through practices that disrupt entrenched role prescriptions. We see similar interactions in our study – for instance, a doctor relating differently to a nurse by introducing joint consultation sessions. Whereas Andersson and Gadolin (2020) highlight the importance of individual autonomy within such interactions, our study suggests a values-driven disposition, a kind of logic of care, might be important as well. We therefore extend this scholarship by showing how values-driven practices, underscoring the affective and values dimension of sensemaking, could cultivate relational connections as a way of converging meaning frameworks.

In addition, our paper highlights the relational spaces in and through which relational connections may be accomplished, thereby bridging studies of values practices (Gehman, Treviño, and Garud 2013) and studies of relational spaces as the 'where and when' of practice (Hallett and Hawbaker 2021;). Research into 'interstitial spaces' of institutional diversity (Furnari 2014) and 'relational spaces' of hierarchical diversity (Kellogg 2009) emphasize the importance of carving out spaces for localized, informal practices that operate 'outside of' formal hierarchical structures and institutionalized practices. We agree with Kellogg (2009) that relational spaces are constituted by relationality rather than any specific physical location. But while Kellogg's (2009) study showcases the oppositional work that transpires in such spaces – generating oppositional identities and frames in support of new operational practices – our study highlights how values-driven practices oriented around shared values and care also accomplish such spaces. Through articulating values conflicts and shared values, healthcare practitioners in our research enact normative realities and invite reflection from others on existing ways of doing things, often as part of everyday interacting. Our case further confirms Kellogg's (2009) argument that relational spaces should be inclusive and enable interaction across hierarchical and professional divisions, and we provide empirical evidence of the types of relational connections that such inclusive interaction makes possible. Our study finally indicates where such relational spaces and practices could be explicitly introduced, whether through external workshops, or

more subtly in discursive and organizational processes – in conversations, meetings and operational activities. That said, we cannot infer from our analysis the extent or sustainability of such relational connections since our qualitative data only includes the views of programme participants and their retrospective recollections of both the training and workplace experiences. Future research would benefit from ethnographic approaches to observe the interactions between practitioners (as far as is ethically possible in the healthcare context) and involving a much wider staff complement over a longer period.

Finally, to studies of institutional logics conflicts in healthcare settings, we offer insights into how a professional logic of authority and a particular logic of care (and the relationality between them) may be performed. It may be that care, as a 'logic of holistic values' (Fincham and Forbes 2015), plays a larger role than currently recognized in studies that tend to privilege attention to professional versus managerial logics. Yet such care must be understood in a relational way, as the 'careful and kind care' that is mutual, responsive and compassionate (Allwood et al. 2022).

Conclusion

This study of values-driven practices in public healthcare confirms the relationality of institutional logics in organizational life. Together, institutional logics and practice theories provide complementary and interdependent lenses on how people relate, collaborate and solve problems in the workplace. Whereas an institutional logics lens provides perspective on the dynamic interplay between organizational structures, layers, customs and procedures, values practices highlight the intersubjective connectedness among individuals and teams of different professional and functional specializations within and across various institutions. Taken together, institutional logics and practice perspectives enable interpretations about workplace wellness and the consequences for personal productivity and collaboration across organizational and professional boundaries. Our study points towards the mediating potential of relationally-embedded values-driven practices to enhance communication, information-sharing, problem-solving and decision-making in workplace settings. Navigating institutional complexity may be accomplished via relational shifts based on values-driven practices, and the ongoing work of acknowledging, inviting and leveraging values conflicts and shared values.

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Details of ethics

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