An Institutional Perspective on Rational Myths and Organizational Change in Health Care

Ruth A. Mohr

Traditionally, the community hospital in the United States has been a freestanding institution, autonomously governed by its own board, administrators, and medical staff. The trend in the last ten years, however, has been for freestanding acute care hospitals to join systems, alliances, and networks. When a community hospital merges[1] into a multihospital system,[2] the changes can be a source of considerable concern to local stakeholders. Management and governance decisions become centralized to some degree.[3] Even in the case where local management and boards retain decision-making power in specified areas, they must take into consideration the constraints that the system places on its members.

In addition to the changed decision-making role for local hospital leaders, becoming a member of a system with even some decisions

Address correspondence and requests for reprints to Ruth A. Mohr, M.P.H., Candidate, Interdepartmental Doctoral Program in Health Services Organization and Policy, School of Public Health, University of Michigan, 109 Observatory, Ann Arbor, MI 48109. This article, submitted to *Medical Care Review* May 15, 1991, was revised and accepted for publication December 3, 1991.

from the SAGE Social Science Collections. All Rights Reserved.

made "somewhere else" threatens the local community-hospital relationship. Because nonprofit hospitals have historically incorporated and represented their communities' values about health care, their importance to these communities has gone beyond that of merely being a provider of medical care services (Seay and Sigmund 1989; Starkweather 1981; Starr 1982).

The merger process itself has been described as conflict ridden and alienating (Starkweather 1981). A recent study of merged hospitals found that most experienced financial downturns, a decrease in market share, clashes of corporate cultures, decreased employee morale and productivity, and strained physician and community relations during the year that they merged (Greene 1990).

When merging with a hospital system means such potentially negative changes for local stakeholders, why would a freestanding community hospital pursue it? Most proposed explanations about why hospitals join systems are based on economic efficiency–to improve organizational efficiency, to maximize ability to achieve a stated mission,[4] to respond to market conditions (Alexander and Morrisey 1988; Schramm 1981). However, findings from empirical assessments of outcomes of mergers and system membership that start from a perspective of economic efficiency have been disappointing. Microeconomic efficiency and increased market power have not been evident either in or out of the health care field (Mueller 1980; Schramm 1981; Briggs, Frommelt, and Roth 1981; Bennett and Baxter 1981; Shortell 1988; Ermann and Gabel 1984).[5]

With system membership bringing potentially threatening changes to local stakeholders, an almost certainly painful merger process, and little likelihood of desired economic efficiencies, how can we explain why a community hospital chooses this action?

The institutional perspective provides a framework for exploring organizational action when rational action assumptions, such as economic efficiency, appear to be inadequate explanations (Scott 1987; Meyer and Rowan 1977; Zucker 1977, 1987, 1988; DiMaggio and Powell 1983; Scott and Meyer 1983; Tolbert and Zucker 1983; Tolbert 1985; Burns and Flam 1986; Parsons 1956; Oliver 1991). The organization's concern is with what its environment expects it to believe and do; for instance, economic efficiency is the correct goal and joining a system is the way to achieve it. The organization attempts to mirror these environmental expectations, whether or not the belief or practice of concern actually increases its efficiency or effectiveness (DiMaggio and Powell 1983). It does this to increase its own legitimacy and, thereby, its chances for survival (Dowling and Pfeffer 1975). Concern with legitimacy in the eyes of important members of its institutional environment can lead the

organization to pursue actions that appear to be of little usefulness to it—or even detrimental—if the stated reasons for the actions are taken at face value.

In other words, the desire by the organization for legitimacy from its institutional environment allows the expectations of external actors to condition organizational goals and actions. I argue that this can provide an explanation for the merging of a community hospital with a multihospital system in the face of available evidence that indicates that this action is likely to be painful and unlikely to result in the desired economic efficiency outcomes.

The model presented here proposes that individual organizational change (in this case, change from local control to membership in a system) can occur within an institutional paradigm through the effects of delegitimation and legitimation. The organization is conceived of as a product of the interaction between it and its environment. Specific organizational goals, and the acceptable means of achieving them, emerge from this interaction. Interest and agency also play important roles in the process.

INSTITUTIONAL ENVIRONMENTS, LEGITIMACY, AND RATIONAL MYTHS

The institutional environment is broadly defined to include the rules, belief systems, and relational networks that originate in the broader social context. Institutionalization denotes the gradual changes that take place around legitimated social processes, expectations, or actualities—and that infuse these elements with rulelike or "given" status in social thought and action (Meyer and Rowan 1977; Berger and Luckmann 1967; Zucker 1977; Scott 1987). Meyer and Rowan (1977) include "rational myths"[6] as an important category in rule and belief systems. How an organization's self-interest in survival gets played out is defined and shaped by such rule and belief systems (Scott 1987). For example, formal organizations in our society are often expected to incorporate practices and procedures that have been defined as "businesslike" by society. Specifically, organizations that incorporate rational myths (e.g., personnel departments—Baron, Dobbin, and Jennings 1986) increase their legitimacy in the eyes of their sector and society.

When there is dissonance between organization and societal value systems, growth or survival-threatening sanctions (legal, economic, or other) may be instituted against the organization by important members of its environment. Therefore, organizations tend to alter values, methods, or outputs that are in conflict with societal expectations; that is,

they increase their isomorphism with their environment (DiMaggio and Powell 1983).

Figure 1 summarizes the interaction of an organization with its institutional environment. The role of legitimacy is indicated in both the environment and the organization.

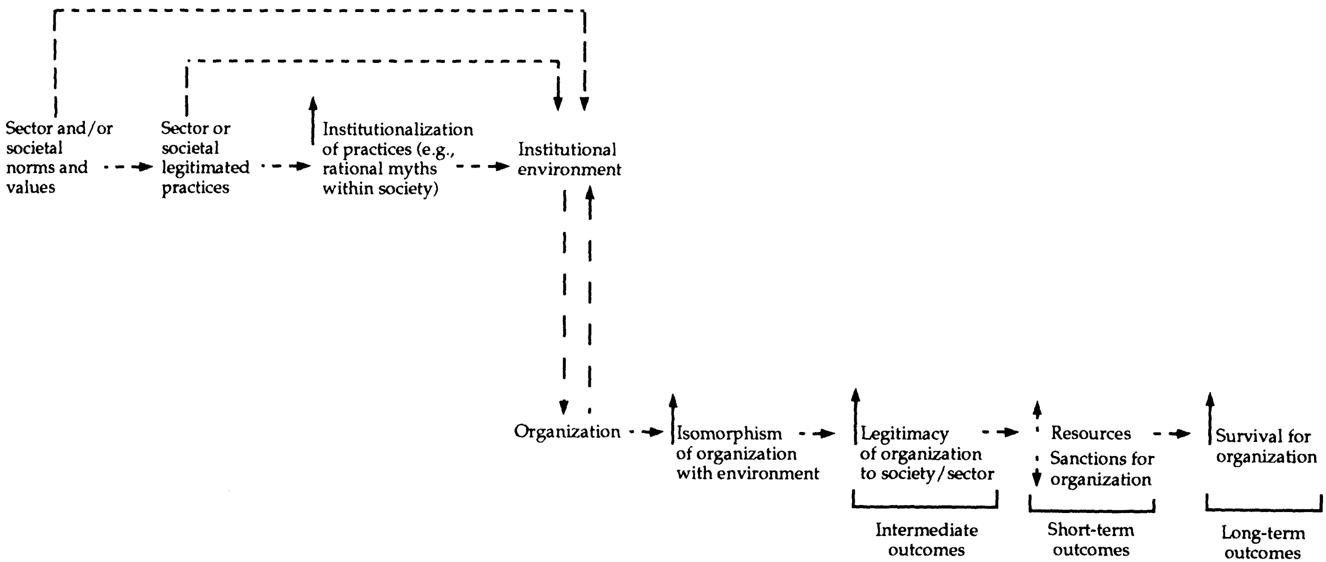
Some organizations are more sensitive to the legitimacy constraints of society or their sectors. Organizations, such as hospitals, that operate in strong institutional environments are more dependent on conformity to the rules and requirements of this environment for their success than are organizations that operate primarily in a technical environment.

I argue that, in the health care field, both the strategy of local control and the strategy of hospital membership in a multihospital system function as rational myths. The goals defined and redefined by society and the health care sector as appropriate for specific types of hospitals, and the methods identified as appropriate to reach these goals are summarized in these myths. In each approach, structure that lodges power in a specific locus is identified as the means by which hospital services are best delivered. The locus of power is different in each case. In the case of local control of a hospital, the idealized individual patient-physician relationship is translated into the structure of the organization.[7] The resulting structure of institutional autonomy protects the physician autonomy central to the idealized patient-physician relationship. This form is presented by its proponents as the best way to achieve quality health care for individual patients and, therefore, the best governance form for hospitals. Under the organizational structure of institutional autonomy, medical care costs have escalated and inequities have persisted.

On the other hand, system membership tends to shift the emphasis from reliance on professional autonomy and individual discretion to subordination of clinical practitioners (including physicians) to the administrative framework and restriction of practitioner autonomy in the interest of achieving greater system efficiency and effectiveness. This movement in health care is part of a larger societal movement to rationalize the delivery of social services (Scott 1982).[8] As noted earlier, a number of unproved assumptions (e.g., improved efficiency and financial performance) underlie choice of the strategy of membership in a multihospital system.

Neither system membership nor local control has been shown to be the best strategy for achieving maximum efficiency and effectiveness in hospital management. However, both of these rational myths are built on societal and health care sector expectations of appropriate outcomes for hospitals (albeit expectations that developed during different time

FIGURE 1 The Interaction of an Organization with Its Institutional Environment



periods). Both define appropriate ends for hospitals to pursue, and both specify the means by which these ends are to be pursued.

CHANGE AND THE INSTITUTIONAL PERSPECTIVE

To date, when change has been addressed within an institutional perspective, the focus has tended to be on the diffusion of an institutionally generated form within an organization or sector (Zucker 1977; Tolbert and Zucker 1983). The problem with this is that once an organization's structure has reflected an institutionalized element, no clear way has existed within the framework to accommodate further change—away from the originally institutionalized form to something new. Change promoted from without by a changed institutional environment is not easily accommodated when the organization is characterized as slow to change and overall quite stable (i.e., is institutionalized). And change in institutionalized beliefs and practices promoted from within the organization appears unthinkable, because these beliefs and practices possess the qualities of social facts (Zucker 1987, 1988).

Recently, however, DiMaggio (1988) has brought to our attention a mechanism through which organizations can change their institutionalized beliefs or practices, or both. He proposes that interest and agency be given explicit consideration within the institutional framework. In this view, the interest among an organization's leaders in that organization's survival generates the energy required to overcome the inertia of institutionalized patterns, thus allowing change to start and directing the change once initiated. A few empirical studies have explored aspects of the issues of agency and interest within the institutional perspective, for example, Covaleski and Dirsmith (1988), and D'Aunno, Sutton, and Price (1991).

In addition, Berger and Luckmann's (1967) work suggests that understanding the interactive quality of the construction of an organization's reality is key to understanding how change comes to occur in an organization. Because of interest in the organization's survival, its leaders pay attention to what influential members of its sector and society expect of the organization (Meyer and Rowan 1977; Scott 1987; Zucker 1987; Dimaggio 1988; Oliver 1991). These environmental expectations are framed as norms, values, legitimated practices, and institutionalized practices. This socially constructed information enters into the interactive process of reality construction between an organization and its environment. The organization, in turn, draws upon its constructed reality when setting goals and choosing methods to achieve these goals.

Following the guidance of socially constructed information, an organization is expected to increase its isomorphism with its environment and, in turn, its potential for legitimacy and survival. As a form of socially constructed information, rational myths inform an organization's decisions regarding goals, and the strategies it should implement to achieve these goals. The process of legitimation/delegitimation plays a large role in the social construction of reality by conveying knowledge of what society judges to be "right" and the reasons why it is right. When influential members of an organization's environment express disapproval of its current outcomes, methods of operating, goals, and/or values, the legitimacy of these elements decreases; they are delegitimated. When support for new outcomes, methods, goals, and/or values is expressed, these elements increase in legitimacy (Dowling and Pfeffer 1975). Change in societal or sector norms and values constitutes one source of pressure on the process of organizational legitimation and one motivation for organizational change. This concept of dynamic legitimacy is an assumption basic to organization change within the institutional perspective.

Recently, Alexander and D'Aunno (1990) proposed that change in institutional environments will fall into two general categories: change in the relative strength of the technical and institutional environments of an organization or a sector, and change in the content of beliefs held by important actors in the organization's institutional environment. In addition, they propose that, because of inherent conflict, instability, and incomplete institutionalization in sectors where the technical and institutional environments are essentially equal in strength (hybrid environment sectors), change is especially likely to take place there. Health care is an example (strong technical and strong institutional) of a hybrid environment sector.

Alexander and D'Aunno also provide a useful framework for analyzing changes in normative and cognitive belief systems that underlie institutional environments. They suggest two dimensions important for understanding belief changes and their potential effect on the institutional environment of an organization. These are the point of origin of the new belief (internal or external to the sector of which the organization is a part) and the relationship between the new and old beliefs (complementary or competing). Complementary beliefs, especially those originating in the same sector as the organization, should be accepted in a relatively short time. Competing beliefs that originate outside of the organization's sector should be accepted infrequently. It is likely that societal support for the competing belief, as well as political skill on the part of its proponents and the exploitation of weaknesses in the original belief system, will be necessary for successful exchange of

the new belief for the old. Oliver's (1991) hypothesis that institutional norms or requirements inconsistent with organizational goals will lead the organization to resist the institutional pressures is consonant with Alexander and D'Aunno's dimensions of complementarity and competitiveness.

Appliying the dimensions of point of origin and degree of complementarity is useful for understanding the history of the system membership belief within the health care sector. Belief in the efficacy of the multidivisional form originated outside of the health care sector. Multidivisional forms began in the 1920s and rapidly proliferated in the period after World War II. By 1979, it was the preferred organizational form for large non-health care corporations (Fligstein 1985). By the late 1970s, the potential efficacy of membership in multihospital systems (the most common type of multidivisional form in the health care sector) was being discussed in the health care literature (DeVries 1978; Mason 1979; Zuckerman 1979).

Belief in the efficacy of system membership originated, then, outside of the health care sector but entered this sector some time ago. Based on Alexander and D'Aunno's framework, the process leading to increased acceptance of the multidivisional form by hospitals (a competing form that originated outside of the health care sector) includes (1) exploitation of the weaknesses in the original local control form, (2) skillful political maneuvering by proponents of the competing form, and (3) perceived societal support for the new form. All of this takes time; the multidivisional form would not be expected to diffuse rapidly in the health care sector—if, indeed, it managed to survive.

This explanation of the evolution of legitimacy for a competing belief complements Zucker's (1988) explanation of the resistance of a sector to delegitimating an old belief and the eventual transition to a new belief. Zucker argues that connections among elements or actors in the social system will slow the pace of change. Once a change occurs, however, the extent of change will be much greater than if the system were less coherent. Therefore, a sector with significant connections among its elements or actors should respond more slowly to a new idea, value, or practice than will one with fewer connections. Such a sector will be slow to change the beliefs (e.g., rational myths) that it supports. On the other hand, once the change takes hold, it will have a more widespread effect throughout the sector than it would if there were few connections between sector participants.

Health care is a sector with many connections between actors and elements (e.g., numerous professional groups with codes of ethics and standards of practice, regulatory bodies, networks, schools for preparation of clinical and administrative practitioners, etc.). Delegitimation of a

rational myth will be expected to take longer within the health care field than in a sector with fewer connections between actors and elements. The multiple connections will tend to stabilize and support the existing belief.[9] On the other hand, once the belief has been delegitimated by influential members of the sector, pathways are already in place to disseminate information supporting new beliefs (e.g., in programs for preparation and continuing education of practitioners, practitioner-focused publications, federal legislation, etc.). The transition to the new beliefs sectorwide may, in the end, seem like an "overnight" phenomenon.

RATIONAL MYTHS AND CHANGE IN HOSPITAL MANAGEMENT STRATEGY

This section applies an institutional perspective of change to the question of how a freestanding hospital moves from one rational myth strategy of management (local control) to another (system membership). Emphasis is on the process by which change in societally legitimated elements can lead to change in the strategy of an individual organization. Modifiers of this process and alternative outcomes are briefly discussed.

SETTING THE STAGE

Organizations are expected to be more open to making changes when their environment is highly uncertain (Hannan and Freeman 1984; Oliver 1991). The 1980s was a period of great resource uncertainty in the U.S. health care sector, especially for acute care hospitals. The introduction of Medicare's prospective payment system (PPS) and other occurrences associated with the decade (e.g., federally mandated peer review organizations, growing numbers of uninsured persons, the aging population, the acute shortage of nurses in many locales) has been described as "frame-breaking change encompassing a sharp departure from the past" (Shortell, Morrison, and Friedman 1990, 25; from Tushman, Newman, and Romanelli 1987).

THE MAIN EVENT

As noted earlier, an organization is expected to increase its isomorphism with its environment and, in turn, to increase its own legitimacy and survival potential by following the guidance of socially constructed information. By the early 1980s, the ability of the long-standing hospital

management strategy of local control to achieve efficient and effective delivery of medical services had been called into question by the health care sector. Zuckerman (1979) raised the issue of waste of scarce resources through competition among freestanding hospitals. DeVries (1978) and Mason (1979) viewed the independent community hospital as an organization both unable to meet the needs of its community due to lack of resources, and unable to cope with the complexities of the modern-day health care field. Scott (1982) noted the increasing external pressures for cost containment. New, socially constructed information regarding the best way for a hospital to achieve its objective of service delivery (based on sector and societal delegitimated and legitimated elements) was introduced into the process through which a hospital constructed its reality (Berger and Luckmann 1967). Reality, then, was played out within the individual organization through setting goals, choosing methods for achieving those goals, and reassessing earlier goals and methods.

> *Proposition 1.* When the community hospital incorporates sector and societal disapproval of its operating method (local control) and related outcomes into its social reality, it will perceive local control as a failed or inadequate strategy.

When legitimations upon which an organization's constructed social reality rests are threatened or collapse, the organization is expected to search for a new understanding of how the world works (Scott 1984). Societally legitimated elements also act as constraints on the choices available to organizations to fill the void left by the delegitimated elements (Dowling and Pfeffer 1975; Laumann, Galaskiewicz, and Marsden 1978).

> *Proposition 2.* When the community hospital perceives local control as an inadequate or failed management strategy, it will search for a new management strategy more in line with the expectations of its sector and society.

The original autonomous form was justified by widespread beliefs concerning the special needs and requirements of the individual patient-practitioner relationship. Delegitimation of these beliefs by conflicting claims and alternative rationales (e.g., competition wastes scarce resources, the health care field has become too complex for the old ways of management, economic efficiency should be a concern of community hospitals) opened the door for competing organizational forms. This was especially true (as noted by Scott 1984, 25) for competing "mainstream forms that dominate the American economic landscape and are viewed as the very symbols of rationality in a capitalistic system" (e.g.,

multidivisional form represented in the health care sector by multihospital systems).

Membership in a multihospital system is relatively new as a management strategy in the health care field. As noted earlier, it is a competing belief that originated outside of the health care sector some time ago. As a competing belief, it would not have been expected to diffuse rapidly throughout the health care field (Alexander and D'Aunno 1990). However, as Zucker (1988) pointed out, in sectors with many ties between elements (like health care), once a change in belief takes hold it is expected to diffuse widely. This appears to be the case with system membership. Associated with cost containment and efficiency, it was gaining in approval by the late 1970s (DeVries 1978; Toomey 1978; Mason 1979; Zuckerman 1979; Johnson 1982; Barret 1982; Brown 1982). Therefore, hospitals that pursued merger with hospital systems in the 1980s could be expected to increase their degree of isomorphism with their sector's expectations (i.e., institutional environment).

Threat-rigidity thesis adds a useful complementary dimension to institutional theory for organizations in crisis (e.g., facing resource scarcity, competition, reduction in market). It proposes that such organizations will exhibit decreased behavior concerned with actively searching for a solution, and will be more open to solutions that are easily available to it, for instance, those dominant in the culture (Staw, Sandelands, and Dutton 1981).

> *Proposition 3.* The rational myth of system membership will become a strategy candidate when it is legitimated by the health care sector and "easily available" to the community hospital in crisis.

Berger and Luckmann's (1967) discussion of ways in which societies handle competing beliefs provides a starting point for considering the potential outcomes from the competition among belief systems in an organization. While one might expect the originally institutionalized belief (e.g., local control) to prevail when faced with a competing belief, two factors will tend to undermine this. First, the pluralism of belief systems in our society promotes skepticism and innovation, which are inherently subversive of the reality taken for granted in the status quo. This subversive effect is active at both the societal and organizational levels. Thus, when changes in norms or values at the societal or sector level lead to the delegitimation of one belief system and increased legitimation of another, the newly legitimated belief would be expected to prevail.

However, Berger and Luckmann suggest that there are alternatives to the pure dominance of one belief system over another. For example,

organizations may integrate the old with the new belief system. Figure 2 summarizes the sequence of events hypothesized when the ongoing reality construction of the hospital with its sector leads it to perceive that the local-control belief has failed it.

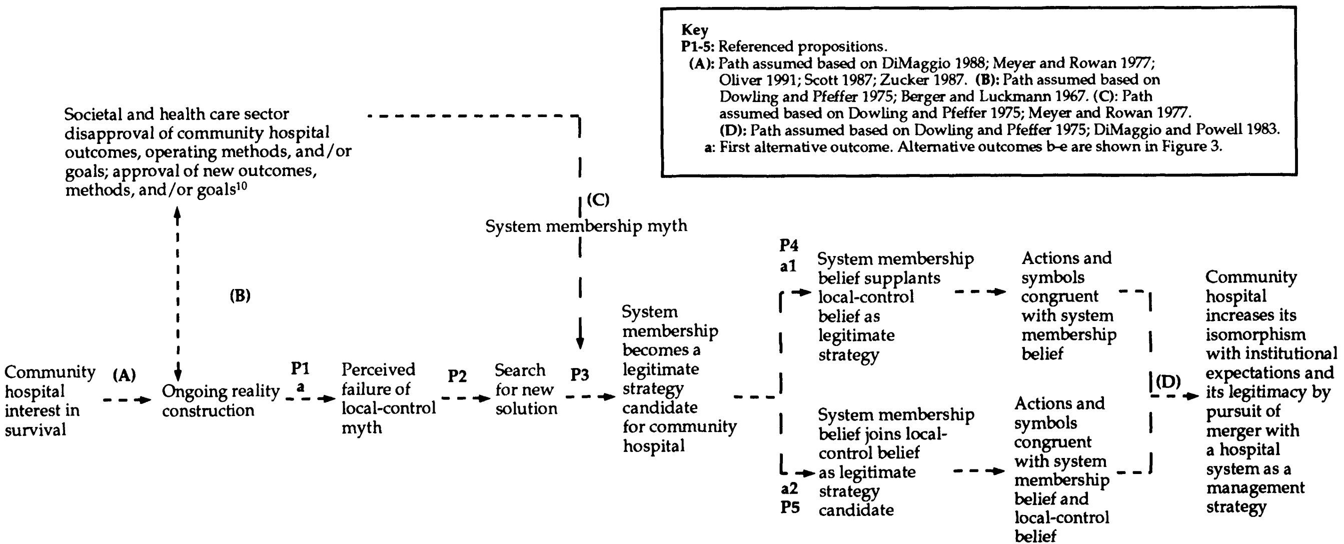
Figure 2 presents two alternative explanations that need to be explored (a1 and a2). The competing merger belief may be integrated into the existing community hospital belief system. In this scenario, one would still expect the occurrence of deinstitutionalization of the original rational myth and legitimization of the new belief. However, the outcome would be an amalgamation of the two rather than a replacement of one by the other. This model is consistent with that proposed by D'Aunno, Sutton, and Price (1991), Oliver (1991), and Meyer and Rowan (1977). It is likely to occur when competing influential members of an organization's institutional environment strongly support conflicting beliefs. Two examples of amalgamation of the local-control and system membership beliefs are (1) hospital membership in an alliance (D'Aunno and Zuckerman 1987; Zuckerman and Kaluzny 1991) or (2) a merger in which the originally freestanding hospital negotiates the retention of a greater than usual degree of local decision-making power.

When influential members of the institutional environment are consistent in their disapproval of current practices and their approval of new goals, methods, or outcomes, the competing belief is expected to replace the original belief (Meyer and Rowan 1977; DiMaggio 1988; Oliver 1991). In this case, the community hospital would be expected to pursue merger with a multihospital system but without putting an emphasis on retaining as much local control in decision-making as possible.

Proposition 4. When influential members of the community hospital's institutional environment are consistent in their disapproval of current practices associated with the local control myth and in their approval of goals, methods, and outcomes associated with the myth of system membership, the community hospital will replace the local control myth with the system membership myth.

Proposition 5. When influential members of the community hospital's institutional environment send conflicting messages regarding their disapproval of elements associated with the local control myth and their approval of goals, methods, and outcomes associated with the myth of system membership, the community hospital will replace the local control myth with the belief that joining a multihospital system is desirable, but that the hospital should retain a high degree of local autonomy (i.e., an

FIGURE 2 Hypothesized Sequence of Events When System Membership Rational Myth Successfully Competes with Local-Control Rational Myth



amalgamation of the local control and system membership myths).

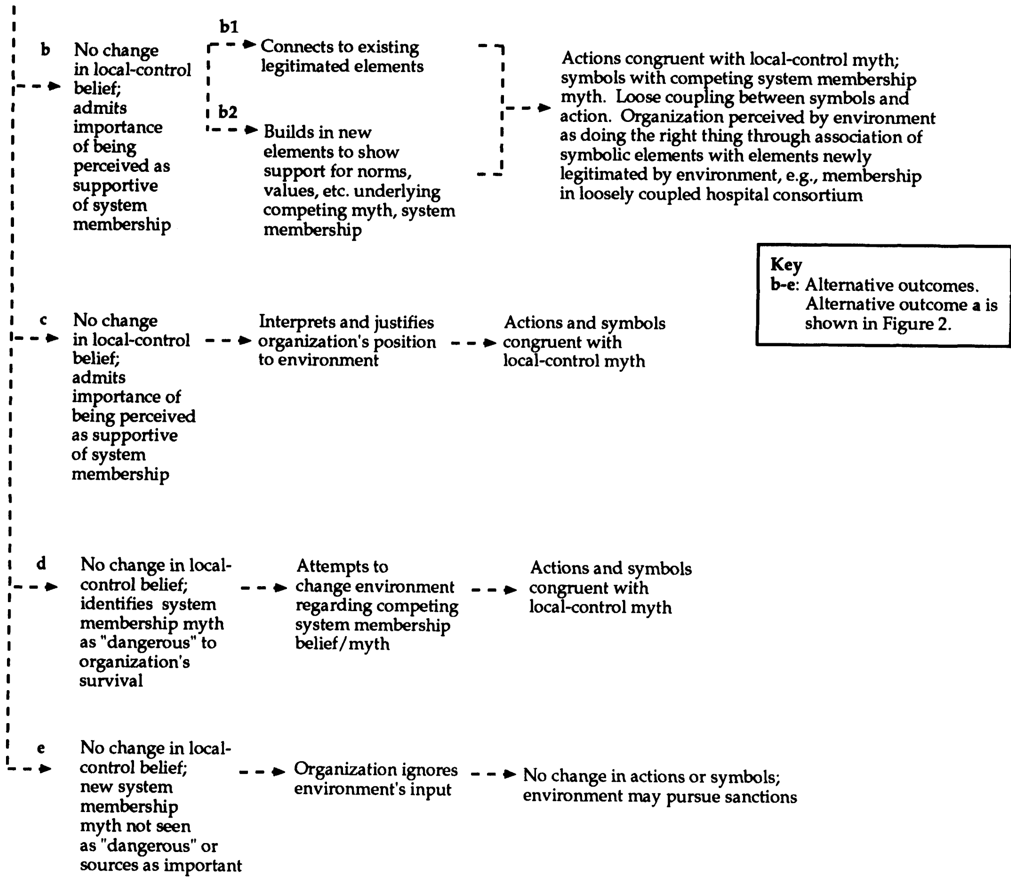
Segregation of the new belief is an alternative outcome of competition between belief systems in an organization (Berger and Luckmann 1967). This is most likely when the original belief system is not perceived by the organization to have failed it, but the environment is perceived to support a new belief. Examples of organization actions in this category are: building connections to symbolic elements that show support for the norms and values underlying the new belief (system membership) without changing the organization's commitment to the old belief (local control)—for example, joining a loosely coupled consortium of hospitals, and admitting the importance of the new belief for some actors in the sector but justifying to the environment why the original belief system is best for "this" organization.

Organizations may elect to ignore the environment's expectations or to try changing them to support its practices, and so on. However, if the organization wishes to increase its own legitimacy in the eyes of the environment, then ignoring the information is not an option. Changing society's—or even a sector's—definition of what is legitimate is quite difficult. Most organizations will either adapt to legitimacy constraints or attempt to link their output, methods, goals, and values to those that appear to be already strongly legitimated (Dowling and Pfeffer 1975). Figure 3 presents these alternative outcomes of competition between an original belief system (e.g., local control) and a new belief (e.g., system membership).[11]

MODIFIERS OF THE BASIC PROCESS

The leadership of the organization (e.g., CEO and board of trustees) represents it in the process of reality construction with its external environment. These leaders bring intraorganizational elements into the reality construction process. These elements include the organization's ideological and strategic orientations, its information processing structure, the outcomes of previous actions, and the "retained sets" of past actions: for example, memories, archival records, and organizational structure (Thomas and McDaniel, Jr. 1990; Meyer 1982). Other inputs are the values of the elite inner circle—all of those who always participate in basic organizational decisions (Hage and Dewar 1973); the personal agendas (self-interest) of the organization's leadership (Schramm 1981; Shortell, Morrison, and Friedman 1990); and the power relationships between the organization and the members of its environment

FIGURE 3 Alternative Outcomes of Competition between Local-Control Rational Myth and System Membership Rational Myth



(Pfeffer and Salancik 1978; Hasenfeld 1983; French and Raven 1959; Oliver 1991).

These potentially important modifiers of the basic reality construction process between an organization and its institutional environment need to be assessed in the individual cases to determine the extent of their influence within the reality that is constructed. They may (1) keep an organization from understanding what its institutional environment expects from it; (2) keep it from understanding the consequences of choosing not to comply with expectations; (3) lead it to determine that the disapproving/approving members of its institutional environment are not of consequence to it; or (4) lead it to determine that the new belief is dangerous to its survival. If the modifiers have these effects, then the expected outcome may well reflect the additional alternatives presented in Figure 3 (b–e) rather than one of the two hypothesized in Figure 2.

CONCLUSION

In the introduction, the question was posed: Why would a free-standing community hospital choose to merge with a hospital system, given the lack of evidence of desirable outcomes for the community hospital? An institutional perspective was used as the theoretical framework for exploring the question, since a rational-action perspective does not appear to be adequate for understanding the situation.

The model proposes that organizational change can occur within an institutional paradigm through the action of delegitimation and legitimation. Support is provided for the role of interest. Because leaders of the organization are interested in its survival, they engage in an ongoing interaction and a process of reality construction with influential members of the organization's institutional environment. Interest is also important from the environment's perspective. Because influential members of the institutional environment want things to be different, they support (or do not support) selected beliefs and practices. This leads to change in the environment's input to an organization's reality construction process.

Agency of the organization is also important. The strategic outcome chosen is not a foregone conclusion but is expected to be one of a predicted set influenced by the action of modifier variables on the basic organization-environment reality construction process. These modifier variables include elements specific to this organization and to its history of how it does things, leader self-interest, and organization-environment power relationships, for instance, degree and direction of resource dependency (Oliver 1991).

Organizational agency is also involved in the implementation of the chosen strategy. Each of the outcome strategy options (except for ignoring the environment's input), requires that the organization do something, for example, integrate myths in some manner, replace one myth with another, or interpret the organization's position to the environment. Overall, the individual organization enjoys a good deal of latitude in both the choice and execution of strategy.

In the case of the freestanding community hospital posed earlier, the rational myth of local control is proposed to be delegitimated and either replaced by or amalgamated with the rational myth of system membership. Because of this, the hospital could choose merger with a system as a management strategy option. It could decide to change its form of structure and control.

System membership is, of course, just one example of a belief or rational myth. If the state, as an influential member of the health care sector, disapproves (delegitimates) merger of a community hospital with a system (e.g., via antitrust rulings), then a belief that does meet the criteria of influential members would be expected to move into the void created by the demise of merger with a system. This does not need to be a totally new belief, but it does need to meet the legitimation criteria and to be available to be chosen—to be part of the extant "primeval soup" (Kingdon 1990).

This model of change has generic application in the consideration of organization decision making. For example, the same process of organization reality construction proposed in the choice of system membership—consideration of expectations set forth by important societal or sector members of the organization's environment, the search for a new solution, and the discovery of a new legitimated management strategy—potentially occurs in decision making related to membership in alliances and interorganizational networks (Zuckerman and Kaluzny 1991) and other cases of diffusion of innovation (McKinney, Kaluzny, and Zuckerman 1991).

Institutional theory captures a significant dimension of social and organizational experience that other theories neglect: that of an interactive reality construction that allows the expectations of external actors to condition an organization's goals and actions. If interest and agency can be given roles without forfeiting the emergent quality of the institutional perspective, then the scope of the perspective's use can be expanded. Analysis of interconnections among the elements of a sector can help refine the definition of influential members of an institutional environment from an individual organization's perspective. The roles of interest and agency can then be better tested in individual cases. This may help us understand better why and how delegitimation and legitimation

occur and, from there, how organizational change emerges out of an organization's interaction with its institutional environment.

ACKNOWLEDGMENTS

I would like to thank Thomas A. D'Aunno, Jeffrey A. Alexander, Fred Munson, the anonymous reviewer, and the journal editor for their helpful comments and suggestions. Thanks also to the participants and team members of the Evaluation of Hospital Consolidations study, funded by the W.K. Kellogg Foundation, who inspired me to ask "Why?".

NOTES

1. Merger is used here to mean the joining of two or more firms into one through acquisition or mutual initiative (Schramm 1981).
2. A system is defined as two or more hospitals with a common form of ownership (Shortell, Morrison, and Friedman 1990).
3. The extent of centralization of control practices varies across systems, but does not appear to be predictable by type of ownership (Alexander and Fennell 1986). Recent research supports the thesis that multidivisional organizations vary centralization of selected control practices to accommodate environmental change (Alexander 1991).
4. The mission of profit-making firms is to maximize profit. Nonprofit firms, on the other hand, are expected to maximize a utility function specific to the stated mission of the firm. For example, Catholic hospitals will maximize the provision of health care services to the Catholic community and nonprofit community hospitals will maximize provision of services to the poor (Alexander and Morrisey 1988).
5. Population ecology is another, less common, perspective on organizational change. This perspective argues that the distribution of organizational forms is largely determined by the environment with little or no agency on the organization's part (Hannan and Freeman 1977, 1984; Aldrich 1979; Alexander and Amburgey 1987; D'Aunno and Zuckerman 1987). Under this perspective, mergers and other types of restructuring are proposed to take place as part of an organization's attempt to maintain stability in light of perceived performance gaps (Jaeger, Kaluzny, and Magruder-Habib 1987a, 1987b). Mergers have been specifically proposed to give organizations the excess capacity and slack resources necessary to operate in environments of instability and turbulence (Alexander, Kaluzny, and Middleton 1986). However, outcomes related to organizational restructuring have not been assessed empirically using this perspective; therefore, this article focuses its attention on assumptions of the rational action perspective.
6. Rational myths are an example of institutionalized practices that develop from socially legitimated elements. They are rational in that they identify specific social objectives as technical ones, and specify in a rulelike manner the

appropriate means to achieve these technical objectives. They are myths in that their assumed efficacy is not proved, but is based on the fact that the beliefs are widely shared or are supported by individuals or groups that the sector (or society) has granted the right to determine such matters. Scott (1987) contends that elaboration of such beliefs and rules provides a normative climate within which formal organizations should flourish.

7. The initial purpose for many locally controlled hospitals was to meet the needs of specific culturally diverse groups of patients and physicians, for example, Catholics, Jews, blacks (Starr 1982). Institutional autonomy grew to protect the professional autonomy of the physicians and served to preserve the concept of an idealized patient-physician relationship. In this idealized relationship, emphasis is placed on the needs of the individual client, and primary responsibility is placed on the physician as the person granted the greatest discretion in decision making (Scott 1982).

8. The hybrid nature of the hospital environment—strong technical and strong institutional aspects, Alexander and Scott (1984); Alexander and D'Aunno (1990)—supports the growth of rationalized organization structures. Traditionally, the professional staff has dealt with the requirements of the technical aspects of the environment (e.g., infection control committees) and administrators have focused on the requirements of institutional aspects of the environment (e.g., dealing with external regulatory agencies). One of the outcomes of the increasingly turbulent times that hospitals are experiencing is a growth in the importance of the administrator's mediating function between the hospital and its institutional environment. This, in turn, has led to growth in the power of administrators and an increased emphasis on the managerial ideology of "expected business-like" practices (Scott 1984; Alexander and D'Aunno 1990).

9. Connectedness in the health care sector generally involves uncoordinated and not always obvious linkages. Scott's (1983) concepts of fragmentation (degree to which there exist multiple uncoordinated linkages between units at two differing levels, e.g., needs of hospitals and practitioner preparatory program curriculums) and federalization (degree to which there exist multiple uncoordinated linkages from two or more "higher" levels impinging on a third, e.g., federal and state funding requirements on hospitals) are important to the consideration of the concept of connectedness in this sector.

10. The health care sector and U.S. society are presumed to be subject to the same general ongoing process of reality construction as has been proposed for hospitals. Over the last decades this process has led society, as well as organizational sectors, to expect businesses to be concerned about efficiency and economic outcomes and to institute accepted rational management practices.

11. This proposed scenario of outcomes was enriched by Tschirhart's discussion (1990) of substantive and symbolic strategies for management of legitimacy.

REFERENCES

Aldrich, H. *Organizations and Environments.* Englewood Cliffs, NJ: Prentice Hall, 1979.

Alexander, J. A. "Adaptive Change in Corporate Control Practices." *Academy of Management Journal* 34, no. 1 (1991): 162–93.

Alexander, J. A., and T. L. Amburgey. "The Dynamics of Change in the American Hospital Industry: Transformation or Selection?" *Medical Care Review* 44, no. 2 (Fall 1987): 279–321.

Alexander, J. A., and T. A. D'Aunno. "Transformation of Institutional Environments: Perspectives on the Corporatization of U.S. Health Care." In *Innovations in Health Care Delivery.* Edited by S. S. Mick and Associates. San Francisco: Jossey-Bass, 1990.

Alexander, J. A., and M. L. Fennell. "Patterns of Decision-Making in Multihospital Systems." *Journal of Health and Social Behavior* 27 (March 1986): 14–27.

Alexander, J. A., A. D. Kaluzny, and S. C. Middleton. "Organizational Growth, Survival and Death in the U.S. Hospital Industry: A Population Ecology Perspective." *Social Science and Medicine* 22, no. 3 (1986): 303–308.

Alexander, J. A., and M. A. Morrisey. "Hospital Selection into Multi-Hospital Systems: The Effects of Market, Management, and Mission." *Medical Care* 26, no. 2 (February 1988): 159–76.

Alexander, J. A., and W. R. Scott. "The Impact of Regulation on the Administrative Structure of Hospitals: Toward an Analytic Framework." *Hospital & Health Services Administration* 29, no. 3 (1984): 71–85.

Barret, D. "Multi-institutional Systems: The Trend Line for Multi-institutional Systems Can Only Go Up." *Hospitals* 56 (1 April 1982): 81–84.

Baron, J. N., F. R. Dobbin, and P. D. Jennings. "War and Peace: The Evolution of Modern Personnel Administration in U.S. Industry." *American Journal of Sociology* 92, no. 2 (1986): 350–83.

Bennett, J. E., and J. W. Baxter. "Program Consolidation and Hospital Merger: Beware the Conventional Wisdom." *Topics in Health Care Financing* 7, no. 3 (Spring 1981): 35–45.

Berger, P. L., and T. Luckmann. *Social Construction of Reality.* New York: Doubleday, 1967.

Briggs, F. R., J. J. Frommelt, and J. H. Roth. "How Hospital Consolidations Affect Revenues." *Topics in Health Care Financing* 8, no. 1 (Fall 1981): 21–37.

Brown, M. "Multihospital Systems in the '80s—The New Shape of the Health Care Industry." *Hospitals* 36 (1 March 1982): 71–74.

Burns, T. R., and H. Flam. *The Shaping of Social Organization: Social Rule System Theory and Its Applications.* London, England: Sage Publications, 1986.

Covaleski, M. A., and M. W. Dirsmith. "An Institutional Perspective on the Rise, Social Transformation, and Fall of a University Budget Category." *Administrative Science Quarterly* 33 (December 1988): 562–86.

D'Aunno, T. A., R. I. Sutton, and R. H. Price. "Isomorphism and External Support in Conflicting Institutional Environments: A Study of Drug Abuse Treatment Units." *Academy of Management Journal* 34, no. 3 (1991): 636–61.

D'Aunno, T. A., and H. S. Zuckerman. "The Emergence of Hospital Federations: An Integration of Perspectives from Organizational Theory." *Medical Care Review* 44, no. 2 (Fall 1987): 323–43.

DeVries, R. A. "Strengths in Numbers." *Hospitals* 52 (16 March 1978): 81–84.

DiMaggio, P. "Interest and Agency in Institutional Theory." In *Institutional Patterns and Organizations.* Edited by L. G. Zucker. Cambridge, MA: Ballinger Publishing Company, 1988.

DiMaggio, P. J., and W. W. Powell. "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields." *American Sociological Review* 48 (1983): 147-60.

Dowling, J., and J. Pfeffer. "Organizational Legitimacy: Social Values and Organizational Behavior." *Pacific Sociological Review* 18, no. 1 (1975): 122-36.

Ermann, D., and J. Gabel. "Multihospital Systems: Issues and Empirical Findings." *Health Affairs* 3 (Spring 1984): 50-64.

Fligstein, N. "The Spread of the Multidivisional Form among Large Firms, 1919-1979." *American Sociological Review* 50 (1985): 377-91.

French, J. R. P., Jr., and B. Raven. "The Bases of Social Power." In *Studies in Social Power.* Edited by D. Cartwright. Ann Arbor, MI: Institute for Social Research, University of Michigan, 1959.

Greene, J. "Do Mergers Work?" *Modern Healthcare* 20, no. 11 (19 March 1990): 24-34.

Hage, J., and R. Dewar. "Elite Values versus Organizational Structure in Predicting Innovation." *Administrative Science Quarterly* 18, no. 3 (September 1973): 279-90.

Hannan, M. T., and J. Freeman. "The Population Ecology of Organizations." *American Journal of Sociology* 82, no. 5 (1977): 929-64.

———. "Structural Inertia and Organizational Change." *American Sociological Review* 49 (April 1984): 149-64.

Hasenfeld, Y. *Human Service Organizations.* Englewood Cliffs, NJ: Prentice-Hall, 1983.

Jaeger, B. J., A. D. Kaluzny, and K. Magruder-Habib. *Multi-Institutional Systems Management: Concepts and Cases.* Arlington, VA: AUPHA Press, 1987a.

———. "A New Perspective on Multi-institutional Systems Management." *Health Care Management Review* 12, no. 4 (1987b): 9-19.

Johnson, R. L. "New Systems Taking Over as Field's Keystone." *Modern Health* 12 (January 1982): 47-50.

Kingdon, J. W. "How Do Issues Get on Public Policy Agendas?" Paper presented at Interdisciplinary Organizational Studies Seminar. University of Michigan, September 21, 1990.

Laumann, E. O., J. Galaskiewicz, and P. V. Marsden. "Community Structure as Interorganizational Linkages." *Annual Review of Sociology* 4 (1978): 455-84.

Mason, S. A. "The Multihospital Movement Defined." *Public Health Reports* 94, no. 5 (September-October 1979): 446-53.

McKinney, M. M., A. D. Kaluzny, and H. S. Zuckerman. "Paths and Pacemakers: Innovation Diffusion Networks in Multihospital Systems and Alliances." *Health Care Management Review* 16, no. 1 (1991): 17-23.

Meyer, A. D. "Adapting to Environmental Jolts." *Administrative Science Quarterly* 27 (December 1982) 515-37.

Meyer J. W., and B. Rowan. "Institutionalized Organizations: Formal Structure

as Myth and Ceremony." *American Journal of Sociology* 83, no. 2 (1977): 340-63.

Mueller, D. C., ed. *The Determinants and Effects of Mergers: An International Comparison.* Cambridge, MA: Oelgeschlager, Gunn, and Hain Publishers, Inc., 1980.

Oliver, C. "Strategic Responses to Institutional Processes." *Academy of Management Review* 16, no. 1 (1991): 145-79.

Parsons T. "Suggestions for a Sociological Approach to the Theory of Organizations—Part I." *Administrative Science Quarterly* 1 (June 1956): 63-85.

Pfeffer, J., and G. R. Salancik. *The External Control of Organizations: A Resource Dependence Perspective.* New York: Harper & Row, 1978.

Schramm, C. J. "Hospital Consolidation: Lessons from Other Industries." In *Multihospital Systems: Policy Issues for the Future.* Edited by G. E. Bisbee, Jr. Chicago: The Hospital Research and Educational Trust with support from the Robert Wood Johnson Foundation, 1981.

Scott, W. R. "The Adolescence of Institutional Theory." *Administrative Science Quarterly* 32 (December 1987): 493-511.

———. "Conflicting Levels of Rationality: Regulators, Managers, and Professionals." Unpublished manuscript, 1984.

———. "Managing Professional Work: Three Models of Control for Health Organizations." *Health Services Research* 17, no. 3 (1982): 213-40.

———. "The Organization of Environments: Network, Culture, and Historical Elements." In *Organizational Environments.* Edited by J. W. Meyer and W. R. Scott. Beverly Hills, CA: Sage Publications, 1983.

Scott, W. R., and J. W. Meyer. "The Organization of Societal Sectors." In *Organizational Environments.* Edited by J. W. Meyer and W. R. Scott. Beverly Hills, CA: Sage Publications, 1983.

Seay, J. D., and R. M. Sigmund. "Community Benefit Standards for Hospitals: Perceptions and Performance." *Frontiers of Health Service Management* 5, no. 3 (1989): 3-39.

Shortell, S. M. "The Evolution of Hospital Systems: Unfulfilled Promises and Self-fulfilling Prophesies." *Medical Care Review* 45, no. 2 (1988): 177-214.

Shortell, S. M., E. M. Morrison, and B. Friedman. *Strategic Choices for America's Hospitals: Managing Change in Turbulent Times.* San Francisco: Jossey-Bass, 1990.

Starkweather, D. B. *Hospital Mergers in the Making.* Ann Arbor, MI: Health Administration Press, 1981.

Starr, P. *The Social Transformation of American Medicine.* New York: Basic Books, Inc., 1982.

Staw, B. M., L. E. Sandelands, and J. E. Dutton. "Threat-Rigidity Effects in Organizational Behavior: A Multilevel Analysis." *Administrative Science Quarterly* 26 (December 1981): 501-24.

Thomas, J. B., and R. R. McDaniel, Jr. "Interpreting Strategic Issues: Effects of Strategy and the Information-Processing Structure of Top Management Teams." *Academy of Management Journal* 33, no. 2 (1990): 286-306.

Tolbert, P. S. "Institutional Environments and Resource Dependence: Sources of Administrative Structure in Institutions of Higher Education." *Administrative Science Quarterly* 30 (March 1985): 1-13.

Tolbert, P. S., and L. G. Zucker. "Institutional Sources of Change in the Formal Structure of Organizations: The Diffusion of Civil Service Reform, 1880-1935." *Administrative Science Quarterly* 28 (March 1983): 22-39.

Toomey, R. E. "The Strengths of Systems." *Hospital Progress* 59 (November 1978): 57-59, 78.

Tschirhart, M. "Strategic Management of Organizational Legitimacy among Multiple Constituents." Dissertation Proposal, University of Michigan, School of Business, 1990.

Tushman, M. L., W. H. Newman, and E. Romanelli. "Convergence and Upheaval: Managing the Unsteady Pace of Organizational Evolution." *California Management Review* 29, no. 1 (1987): 1-16.

Zucker, L. G. "Institutional Theories of Organization." *Annual Review of Sociology* 13 (1987): 443-64.

———. "The Role of Institutionalization in Cultural Persistence." *American Sociological Review* 42 (October 1977): 726-43.

———. "Where do Institutional Patterns Come From? Organizations as Actors in Social Systems." In *Institutional Patterns and Organizations.* Edited by L. G. Zucker. Cambridge, MA: Ballinger Publishing Company, 1988.

Zuckerman, H. S. "Multi-institutional Systems: Promise and Performance." *Inquiry* 16 (Winter 1979): 291-314.

Zuckerman, H. S., and A. D. Kaluzny. "Strategic Alliances in Health Care: The Challenges of Cooperation." *Frontiers of Health Services Management* 7, no. 3 (Spring 1991): 3-23.