The Creation and Survival of an Academic Health Science Organization: Counter-Colonization Through a New Organizational Form?

September 2013

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The Creation and Survival of an Academic Health Science Organization: Counter-Colonization Through A New Organizational Form?[1]

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Abstract

This paper describes and analyses the creation and development of an Academic Health Science Centre (AHSC) as a major organizational innovation diffusing in the health knowledge economy, internationally. Drawing on an institutionalist model utilized in an earlier study of a failed merger in the USA (Kitchener, 2002), we explore empirically why the creation of this new AHSC in the UK produced very different organizational outcomes. Whereas institutionalist framing predicts 'sedimented' instability and repeated contest between managerialist and embedded (and ultimately, dominant) professional logics, the higher levels of clinical-academic engagement in our case exerted 'upwards' institutional pressure, creating a more stable, collaborative form. Our paper challenges and develops the institutionalist model, and explores the possibility of 'counter-colonization' through a new organizational form invented in the academic-clinical domain.

Keywords: institutional theory, interorganizational networks, knowledge work, organizational change, organizational forms, professionals

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Introduction

The creation of knowledge-mobilising organizations is of increasing importance in a developing knowledge economy. Linked to societal needs to drive economic growth, governments have sought to steer science policy within a so-called 'triple helix' of university-industry-government collaboration (Etzkowitz & Leydesdorff, 2000). In this context, the recent innovation of Academic Health Science (AHS) organizations in the biomedical and life sciences sector is expected to play an important strategic role. Intended to intensify knowledge exchange and mobilisation, these organizations are complex 'hybrid' settings, integrating world-class universities and major hospitals, designed to combine divergent missions of biomedical research, clinical care, and professional education.

While much previous work has explored the dynamics of Knowledge Intensive Firms (Alvesson, 2004; Starbuck, 1992), the creation of a new organizational form to intensify knowledge mobilisation is of particular interest for organizational scholars. Despite the growing importance of emerging AHS organizations diffusing internationally, they are under-researched, particularly from a social science perspective. A notable exception is Kitchener's (2002) organizational study of a failed AHS merger between University of California San Francisco (UCSF) and Stanford University. Drawing on institutional theory, Kitchener (2002) analyses the merger-demerger process as driven by escalating contest between a managerialist logic and a 'semi-submerged' but embedded professional logic. This unstable, 'sedimented' configuration led to repeated clashes, with attempts to bridge these logics and their associated actors ultimately failing. Similarly, Kastor's (2004) historical account of governance 'turmoil' in two AHS settings (at the University of Pennsylvania and Johns Hopkins University) finds they were undermined by conflict and crisis, although arising from clashes between divergent clinical and academic logics.

By contrast, in our empirical study of the creation of a new Academic Health Science Centre (AHSC) in the UK, we find higher levels of professional engagement exerted strong 'upwards' institutional pressure. Whereas institutionalist framing predicts 'sedimented' instability and contest, our case displays a very different process and outcome. Instead of contest between dominant managerialist and repressed professional logics, we find a process of professional 'counter-colonization' overtook and subsumed managerialist logics, producing a new organizational form invented in the professional domain.

Our paper contributes to the literature by elucidating relational dynamics of institutional work operating at meso and macro levels. Whereas recent developments in

institutional work reveal important, yet often 'invisible' aspects of professional practices and emotions at micro levels (Currie, Lockett, Finn, Martin, & Waring, 2012; Lawrence, Suddaby, & Leca, 2009; Voronov & Vince, 2012), our analysis reveals that the macro and meso levels of analysis also need to be taken into account, including the diffusion of new and professionally dominated organizational forms. We comment on the cognitive and emotional aspects of undertaking such institutional work that has been under-explored in much of the literature (Lawrence et al, 2013).

We firstly situate our study in policy and theoretical literature, before describing our research methods and empirical case of a new, prestigious AHSC in the UK. Using Kitchener's (2002) four-stage model as an analytic framework, we compare our findings to his earlier study. In discussing why the institutionalist explanations advanced by Kitchener (2002) were not replicated in our site, we argue that our finding of 'counter-colonization' of the managerial domain results from strong professional influences at macro and meso levels. Specifically, we highlight: firstly, the *lateral, professionally dominated diffusion* of the novel organizational form of the AHSC from elite exemplars internationally; secondly, powerful and expanding *'upwards' institutional pressure* produced through strong professional engagement at the meso level; thirdly, the nature of the institutional work undertaken in enacting the AHSC form locally, including emotional and cognitive elements.

Literature review – policy and theoretical emplacement

AHSCs have long been established in the USA and Canada. However, this organizational form is now spreading internationally in Europe, Asia and Australia (Davies, 2009; Fisk et al., 2011). AHSCs are major and novel knowledge-intensive organizations diffusing in the healthcare sector, with a tripartite mission of translating research into clinical practice, improving patient care, and advancing the quality of education and training (Watts, 2009). Their core components are usually a medical school, associated clinical facilities and other health professional schools (Blumenthal, 2005); however, in our case, the AHSC also brought in contributions from faculties across the university, including the humanities.

AHSCs' focus on knowledge mobilisation is part of an expanding economic and public policy emphasis on integrating research, education and service delivery at organizational and system levels (Walshe & Davies, 2013). Within the health sector, 'translational research' is an important policy and academic theme (Department of Health, 2011), intended to rapidly translate new scientific knowledge from 'bench to bedside' (HM Treasury, 2006). In order to intensify knowledge mobilization across

institutional boundaries, the UK Department of Health established five prestigious AHSCs in 2009, connected to research-intensive universities. This set of new AHSCs were intended to 'transform healthcare' by accelerating knowledge translation from 'world-class' research into clinical and commercial impact (Department of Health, 2008).

In spite of such (potential) importance, much of the literature on AHSCs consists of opinion pieces and descriptive case studies focusing on governance and structural arrangements (Weiner, Culbertson, Jones, & Dickler, 2001), as well as rich descriptions of responses to external challenges (Abdelkak, 1996; Blumenthal & Meyer, 1996; French, Ferlie, & Fulop, 2013; Lozon & Fox, 2002). Most of this literature does not draw on organizational or social science theory. But one important exception is Kitchener's (2002) study of the failed merger between the AHS organizations at Stanford and UCSF. His paper examines how a managerialist and market-focused logic mobilised a 'myth-like' innovation of merger, intended to save costs and increase referrals. This logic largely drew upon commercial ideas that were 'oversold' by management consultants and non-executive directors; however these ideas were persuasive as 'managerial myths' that attempted to create new bases of legitimacy.

Kitchener (2002) explores the possibility that this merger could shift a traditional professional-bureaucratic logic to a market-managerial logic. Yet his account describes institutionalised conflict between a challenging managerial group, and an embedded clinical group. The newly merged organization's management style was top-down and authoritarian, running against more consensual styles of these professionalised organizations. Despite tactically conforming in the short term, 'semi submerged' but powerful professional groups (especially clinical academics) rejected the 'merger myth'. Loosely coupled groups (such as research and education) were similarly disengaged, reflecting enduring professional autonomy and low buy-in to the merger. As a consequence, the operational delivery mechanism of 'integrated service lines' became dysfunctional and quickly collapsed. Compounding these difficulties, projected cost savings and anticipated revenue streams proved over-optimistic. The merger lasted just seven months before the organizations rapidly de-merged, further adding to their financial problems.

Kitchener (2002) explains these findings theoretically in a four-stage model which he developed from the case. Firstly, the *antecedents* of market-based managerialism over professional dominance formed a core basis of legitimacy; secondly, the *mobilisation* of a managerial innovation (the 'merger myth') was driven by external change agents, such as management consultants and non-executive board members; thirdly the *establishment of myths* took place through institutional isomorphism and powerful managerial

reformers who attempted (but failed) to 'fragment and repress' the dominant professional logic; finally, *organizational outcomes* became fateful when the merger myth was 'sedimented' (Cooper, Hinings, Greenwood, & Brown, 1996) upon loosely coupled areas of professional autonomy. Crucially, this 'sedimented' configuration led to perverse and unexpected outcomes as embedded professionalised elements retained the power to buffer themselves from and eventually abort the merger process.

But is such sedimentation the only possible scenario? In Choi et al.'s (2009; 2011, 2012) studies of the Karolinska AHSC merger, in Sweden, they similarly found tensions between competing economic-managerial and professional logics; like Kitchener's (2002) case, the mobilisation of managerial logics could lead to professional disengagement and conflict (Choi & Brommels, 2009). However, in the example of one clinical department, they found professional engagement was effectively stimulated by clinical leaders' local re-interpretation of the 'merger mandate', by shared leadership approaches, and emergent (rather than managerially directed) change processes (Choi et al., 2012). Choi et al. (2011: 21) argue that combining competing institutional logics in this way involves significant managerial work, involving strong relationship-based and *"emotional pressure on physician managers in attempting to balance parallel institutional logics."*

Overall, these studies find that competing institutional logics may significantly undermine managerial ambitions for AHSC integration. Echoing Alford (1975), they point to the reaction and power of academic physicians as a major power centre. Yet Choi et al.'s (2012) findings of productive 'hybrid logics' in one clinical department suggests possible alternatives to loose coupling and sedimentation. Kitchener (2002) calls for replication studies to test his model and its relevance to other organizational innovations. Although based on a single case study, and developed in the context of a merger between existing AHS organizations (rather than the creation of a new one), his theoretical framing provides an important social science perspective for exploring the rise and potential fall of AHS organizations.

In the following section, we introduce our empirical study into the development of one AHSC in the UK, using Kitchener's (2002) model as a framework to explore organizational processes and outcomes

Methods

Eastbury AHSC (a pseudonym) consists of a leading, multi-faculty university and three prestigious National Health Service (NHS) trusts (large teaching hospitals and associated clinical services). All of these institutions have international reputations for excellence,

based on specialist (tertiary) clinical services and research, spanning physical and mental healthcare. Our data is drawn from in-depth interviews with academics, clinical leaders and managers, at intermediate (clinical directorates and academic divisions) and senior (trust executives and university governing council) levels. Interviews were conducted over a period of 26 months, from January 2010 to March 2012, during an important developmental phase in which Eastbury moved from its early formation, following its designation in March 2009, to a more established federation, formalized through a legal partnership agreement. During this developmental phase, 21 cross-cutting 'Clinical Academic Bundles' (CABs) were established as a key integrating mechanism, bringing together scientists and other academics with clinicians and managers from across the AHSC. These 'bundles' were based on assumed fit between local clinical and academic strengths, rather than consideration of scale, locations across sites, or their economic potential.

In order to explore processes of change at both senior and intermediate levels, we interviewed senior managers and leaders across the four institutions, the AHSC partnership board (including the sovereign institutions' CEOs and chairs), a partnership executive (led by senior academics, clinicians and managers), as well as senior academics and clinicians. While waiting for ethical approval to begin interviews, we analysed and coded 740 archive documents (minutes, strategy and confidential documents) covering Eastbury's formative period over a period 24 months. Our interviews initially sampled participants at senior levels and across six of the new CABs, before we purposively focused in greater depth on three CABs that revealed contrasting dimensions of how the AHSC was working in practice. This interview data was contextualized through participant observation, focused on a CAB directors' forum.

In total, we conducted 42 in-depth interviews using a semi-structured format, as well as informal interviews carried out over a period of three years. We conducted follow-up interviews with two key informants to explore changes longitudinally. Interviews were 45 to 90 minutes in duration and most were jointly conducted by two researchers (MF and EF). All interviews were recorded and professionally transcribed, and we used QSR NVivo software to assist in the management and analysis of the full dataset. Our analysis of the data firstly drew on the iterative qualitative methods proposed by Miles and Huberman (1994) to triangulate thematic codes and develop an empirically-orientated framework. We produced a project report which we fed back to the site and which formed the basis for our later papers. We then developed our earlier analysis by re-analysing the full dataset; four authors (MF, EF, CF and NF) re-analysed sets of transcripts independently, each producing narrative reports which we compared and discussed. We developed our theoretical framework from this, bringing in theoretical perspectives and specifically comparing our case with Kitchener's (2002) findings and

theoretical model.

The creation of an AHSC

Adopting an Initial Partnership Model

The UK's first AHSC at Imperial College London in 2007 (Davies, 2009) fuelled national interest in the concept and a policy decision by the Department of Health (2008) to develop and formally accredit five elite AHSCs. Eastbury AHSC had an early vision of a partnership between sovereign institutions (rather than an integrated leadership model, as at Imperial). Their formal partnership was announced in 2008 after one year of exploratory collaboration between institutions. After another year of preparation (including site visits to North American and European exemplars), Eastbury was accredited an AHSC 2009, following competition before an international panel of experts.

Collaboration across Eastbury's diverse institutions presented major challenges as well as potential benefits. Its formation coincided with a 'cold' economic climate involving significant retrenchment in public services, so financial logics were an important consideration.

> *"We come from a culture of competition…and of course the boards are very jealous, really worried about their hospitals, and they don't want to give anything up, but we have massive duplication, which is lunacy. We could generally save buckets of money which, since there's a very cold wind blowing, would make us much more resilient."* Senior clinical manager

The AHSCs' partner organizations are well established and, according to its confederation model, each organization retains its own governance arrangements, while the Eastbury partnership board formally reports to the sovereign institutions. These arrangements provide safeguards for the partner organizations, allowing greater autonomy and financial independence than in vertically integrated governance models. However, they also reflect risk aversion, evident at board levels.

> *"It was a model that (the university) argued for very strongly, our view always was that (the AHSC) shouldn't be an umbrella (for) the totality of everything that goes on in four organizations, it's more of a platform for the pursuit of particular strategic objectives…we're just not experienced enough at this to know how to do it well."* Senior academic manager

Historical differences between the hospitals were also influential. For example, the culture of one well-established hospital was perceived as wealthy, prestigious and middle class, in contrast to its neighbouring hospital, seen as poorer and working class. Accordingly there were underlying tensions between these hospitals.

> *"They have very different cultures. If Apple and Microsoft decided to get together, it's difficult to conceive, because they have very different cultures, so they would swap things but they might walk away from it. You can't walk away from this…the cultures are embedded in very long histories and coming from different places… so people walk the corridors feeling pretty paranoid and it's a major problem."* Senior clinical manager

Despite such early tensions, the AHSC did not collapse, but moved towards increasing integration. In explaining why this might be the case, we next explore the antecedents of the partnership and on the increasing engagement of senior executives, including academic and clinical leaders, operating across the confederation.

Establishing and handling the AHSC as an institutional risk.

Gaining accreditation conferred legitimacy on the partnership's ambitions to be *"in the top ten internationally"*, as well addressing perceived strong competition between institutions *("if we don't do this…we'll slide back into the second division. We have to be able to do this")*. But it was also perceived as presenting substantive as well as reputational risks.

> *"Reputationally, it is totally exposed. If it fails to deliver a successful AHSC it will damage (us) because we were legitimised as being one of the top five academic health schools in the country…. It now creates an expectation, and the danger is…there is a material risk that the AHSC actually steals space and resources, so it becomes subtractive rather than additive… (But) I think that there is a deep and profound sense of ownership of its purpose, I don't know anybody who thinks, from the university perspective, this is a poor thing."* Senior university manager

Indeed, for the university, there was anxiety that its academic mission might be eroded by merging with large NHS trusts, whose focus on delivering a high volume of clinical services was likely to be dominant.

> *"The risks in this for is losing control of the pursuit of our academic objectives, because the agenda in a largely public sector health environment is driven by all the stuff that we hear about on the news every night. We felt quite strongly that we must protect the academic heart of (this)."* Senior academic

Mobilising the AHSC myth

Accreditation followed a preparation phase in which academics and clinicians participated in workshops, conferences and working groups intended to seed the AHSC as a 'democratising' venture. One hospital had an established internal organization development team that worked to establish new clinical academic bundles.

Other established AHSCs were important external role models which were used to benchmark Eastbury's early design and development. Small deputations of executives, together with clinical and academic leaders, visited leading AHSCs, such as Johns Hopkins (*"with a degree of envy"*), along with AHSC conferences. These deputations read and circulated notable AHSC case studies, such as Kastor's (2004) account of *Turmoil at Penn and Hopkins*. Although management consultants were employed in a supporting capacity for internal projects, they did not play a significant role in developing Eastbury. Instead, AHSC leaders looked for inspiring examples of effective leadership, which they sought to emulate.

> *"I was listening for every word around models of managerial structures. (But) the key messages that were coming out of it – about leadership, not management instructions – were so powerful. There's something about people who can articulate that real world…you think, this guy knows what's he's talking about, you immediately have mutual empathy... 'Warts and all' really resonates, it probably influences me more than anything else."* Senior hospital manager

The Partnership Executive – spanning structural boundaries

As one senior doctor argued, Eastbury's complex partnership arrangement demanded a leadership style capable of managing structural ambiguity:

> *"It's riddled with ambiguity…this spider's web…a bit like the European Airbus, a collaboration of multiple EU countries making different bits of the aeroplane.* Senior doctor

Accordingly, the partnership executive developed a team-based and collaborative approach, working across formal hierarchical boundaries through persuasion and building shared commitment to the AHSC vision. These more personal aspects of the leadership team were noted by colleagues.

> *"The formal position actually means (the director) is pretty much a castrated individual, that's what the lawyers do for you. But what's happening, which is a very exciting agenda in Eastbury, is largely down to him, and the truth of the matter is that authority is much more earned than given. You could have all the executive authority that you could fantasise about, but*

if people don't want to follow you, you're in trouble. Whereas you could have very little executive authority formally, but become very influential because people want to follow you." Senior manager

So despite a formal structure seen as inhibiting, an important development was the emergence of a cadre of academic and clinical leaders in the partnership executive, committed to converting the AHSC vision into reality. They strongly identified with Eastbury, regarding the AHSC not as a 'managerial myth', but a compelling model of clinical-academic collaboration, which they trusted and sought to develop.

> *"If you look at the core team, there's very strong emotional commitment to this. I mean (the director) is an amazing bloke, we would all sort of go to the stake for him, because he's straight. There is absolutely no doubting that he's working his cotton socks off and has done for years now to achieve this. He's an absolutely stellar bloke, a fantastic leader. And the other people on the team are very strong. They all get out of bed for the right reason - you certainly feel it around the table… I mean they inevitably are sort of friendships but the purpose of it all is stronger than friendship – the dominant reason is that we've got to achieve this, totally and utterly."* Senior clinician

Such emotional commitment became increasingly important. In contrast to the more cautious managerial stance evident in the sovereign institutions, an emerging academic-clinical coalition committed to integration across the partnership, shaped strategic thinking. This was accelerated in the new mental health CABs, when the mental health trust CEO and the academic dean of psychiatry collaborated to restructure their organizations, creating seven cross-cutting mental health CABs. These CABs were tasked with developing team-based leadership models, comprised of senior clinicians (from across disciplines) academics and managers.

Other techniques used to establish collaboration included weekly meetings between partnership executives, designed to establish trust, build a shared group identity, and create an 'Eastbury mindset' for thinking about the whole AHSC.

> *"It's having all these meetings together and giving people tasks to do. (The director) dishes out these Eastbury tasks, and when you're given an AHSC task it's quite interesting, isn't it, because you have to think well hang on, this is an AHSC task, it's not about my (hospital). It's very interesting."* Senior clinician.

'Clinical Academic Bundles' – delivering the AHSC mission

CABs were designed as confederation-wide operational units, in which academic researchers and clinicians came together to operationalise the tripartite mission. 21 CABs were developed, covering all clinical specialties and academic groups. CABs were required to develop their own operating and leadership model, and to have these formally accredited within a broad operating framework.

Cardiovascular CAB

The Cardiovascular CAB was seen as a vanguard 'bundle' in which scientists, clinicians and academics across the institutions were first brought together. Led by a group of visionary cardiologists, the CAB actively established a model of collaboration. Despite a long history of competition and 'all out wars' between their units, academics and clinicians engaged passionately in creating a unifying vision and operational model.

> *"We take four cardiac units that have been in intense competition and we try and integrate all of that."* Senior clinician

Antecedent

An important antecedent here is that cardiologists across the sites recognised a risk of their units 'withering on the vine' as advances in technology shifted referrals to less specialised hospitals. They saw the AHSC as an opportunity to 'reinvent' themselves as an entrepreneurial and innovative 'world-class service'

> *"If the AHSC hadn't existed we would have had to do exactly the same things (because) the bread and butter of what we do is beginning to disappear…we couldn't continue the way we were and survive…We all saw the fact that the AHSCs suck money out of all the other hospitals…this was the only game in town. If we didn't get together and make this work, we were going to wither on the vine."* Senior clinician

Establishing an indigenous version of the 'AHSC myth'

They developed a representational model for their CAB, which they conceptualised as a heart-like 'engine' for collaboration and innovation, to connect and energise the activities of clinicians and academics across their organizational 'silos'. This became central to their approach to change.

> *"Our model was of an engine…at the centre of our CAB… a way of getting anyone who had expertise in that area, to get to know each other and to interact, basic scientists interacting with an interventional cardiologist… Anyone who's interested in heart failure is welcome to come."* Senior academic

As one cardiologist described it, they were most proud of their 'engine' model and yet anxious about it, as they saw their whole project hinged upon it.

> *"The only way you can release the creativity of the combined (institutions) is if your basic scientists get in the same room as your clinical guy. We have a great clinical heart failure guy and the first time his thematic group met he met a basic scientist who knew about cloning cells (in a related area), he didn't know the guy existed and for the first time he was sat in a room with him, that's how you suddenly get towards clinical excellence and teaching."* Senior clinician

This model was central not just to their CAB leadership style, but their approach to managing 'upwards'. They strongly resisted pressure to conform to single leadership models suggested from site visits to other AHSCs. Insisting on their team leadership model they had devised, they established a leadership group representing their different professions and clinical areas. This shared leadership model was influential in Eastbury, and later led to similarly shared patterns of leadership being adopted across all CABs.

> *"There was a big push to have individual leaders of the CABs... we were put under enormous pressure, and we said no. And interestingly they've all changed their minds. Well (the idea) came from us, but at the time we were seen as the bad boys. We have an academic lead and the clinical director, it gives balance, we added yet another clinical and academic director (from across the hospitals), and then we added the general managers from both sites and a lead nurse, and that was the group that really forged."* Senior clinician

They similarly resisted management pressure to produce operational documents and *"15,000 slides PowerPoint presentations"*, concentrating their efforts on the major challenges they perceived of building engagement and a 'culture change' needed to create a fully functioning CAB.

> *"We spent two years just giving the message that this is our vision, this is the way we're going. We started to introduce a joint audit session, joint this, joint that, to start a cultural change, and I'm proud of that… We have resisted writing big documents and we've been rather boisterous in the fact that we've said, no, we're not going to do it."* Senior academic

They established joint appointment panels for new positions, and the CAB leaders visibly wore new AHSC-branded identity badges, instead of their own institution's brand, as a simple act that *"actually makes a big difference"*. When potential internal conflicts arose within the CAB, its leadership team handled this through an 'Eastbury mindset'.

> *"One of the 'cardios' has been playing games and tried to switch from one institution to the other, and we said no, we are (the AHSC), we're not playing these games between institutions. We think as one organization. No - we're having none of it. This is about culture change…we need to think of ourselves as being a different organization."*

Mobilising leadership across contrasting models – achieving cultural change

This CAB is a positive example of a group that established a vision for itself through a strong leadership team. But how was the AHSC 'myth' mobilised in this case?

Its pattern of mobilisation was different to that identified by Kitchener (2002). Instead of senior managers, non-executive directors and management consultants being central to the 'selling', we find increasing tensions between the boards of the sovereign institutions, which were becoming anxious and risk averse, and the CAB leadership team of academics and clinicians whose enthusiasm for the AHSC overtook that of the senior managers.

> *"There was a year's delay, they were too frightened to give up anything. The clinical enthusiasm ran ahead of the managerial enthusiasm, it completely crossed over. We became very enthusiastic and the executives became very cautious and concerned, and that led to a lot of trauma. We were saying, give us an integrated budget, let us run... if we fail sack us, but let us go. But they can't, they just can't do it. And to really allow us to be world-class you have to allow us to fly and take some risks along the way… So we're coming out of this lull period, it was mayhem."* Senior clinician

An important source of influence was a trusted senior doctor working with the partnership executive, whose energy and vision for the AHSC the CAB leaders regarded as 'inspirational'. Although he came from one hospital originally, his wider role across Eastbury was seen as significant.

> *"He's the guy who's got it right, he says we will achieve nothing unless people forget that they're working on site A or site B but they're working for (Eastbury). He has a mantra which says, 'think (Eastbury)'…well if you could have him at every single meeting, it would make the entire process work."*

Similarly, they saw the AHSC idea as being mobilised not through their sovereign institutions (which the CAB leaders saw as increasingly remote, anxious, and preoccupied by bureaucracy), but through regular meetings between the partnership executive and the leaders of all 21 CABs, focused on emerging ideas about how to develop the AHSC.

> *"That should be where the powerhouse of (Eastbury) comes from, because if that group decides something and it's not allowed, there could be absolute mayhem. So I hope, slowly but surely, the CAB leaders group becomes the lead strategy group of (Eastbury) to allow things to happen. It would be very dumb of the four sovereign organizations to ignore the CAB leaders group."*
> Senior academic

Outcomes

Although historically, the four clinical units comprising this CAB had been in conflict, these groups and the academic unit came together in creating a compelling materiality to the CAB, based not on merger myth, but through interlocking systems with actual changes in behaviour.

> *"Historically there have been all out wars between the two hospitals and specifically cardiology, big time war, very, very competitive. Now they've gradually disappeared… Barriers are breaking down, and a lot of this is culture… these (clinicians) have agreed that they're going to work on both sites, and that's a massive, massive moment, when I think of the warring that's gone on."* Senior academic

Instead of the CAB buffering itself from AHSC activity, we see strong local motivation and engagement to convert the tripartite vision into 'reality'. As the professional logics in this CAB became animated and more dominant, they came into tension with increasingly cautious managerialist logics operating at board levels. Yet instead of being repressed by or conforming to managerial caution, they exerted upwards influence upon senior managers as well as laterally in other CABs, presenting a bottom-up and clinically engaged model.

Diabetes CAB

Whereas the Cardiovascular CAB brought together powerful and competing units, the Diabetes CAB was formed from a diffuse collection of smaller specialties. Its clinical and academic leaders saw the potential of their 'bundling' into a new CAB as presenting

an opportunity for establishing a more powerful presence and identity, within the AHSC and externally.

Antecedent

A key driver was the ambition of senior academics and clinicians to recreate and redefine diabetes and its related services from *"a bit of a mishmash"* of disparate services (diabetes, endocrinology, nutrition and related specialties) to a potentially powerful organizational entity, capable of winning competitive advantage.

> *"That's why we're doing it, because it gives the opportunity to recreate ourselves as an entity, which gives us visibility and a position at meetings where big decisions are made… (to be) listed by name when you go on to the AHSC websites. So for very pragmatic reasons, we want to be an entity."* Senior clinician

There was strong internal determination and ambition for the CAB driven especially by a leading academic director, supported by senior clinicians, who sought to concentrate resources across their organizational boundaries.

> *"I really pushed my colleagues, because I felt that that would be an opportunity for us to tell (executives) how to set up the CABs, rather than them tell us. When we heard about the AHSC taking away all the barriers, I said: look guys, this is the opportunity we've been waiting for."* Senior academic

Establishing an indigenous version of the 'AHSC myth'

CAB leaders sought to establish a strong unified model, pulling together *"bits out of different academic and clinical divisions, and putting them in one place.* But in contrast to cardiology's team-based approach, the diabetes CAB adopted a more hierarchical form, shaped especially by its academic director. Although this director had initially wished to lead the CAB as its sole academic-clinical director, (inspired by the Johns Hopkins model), this model was modified by AHSC executives who now promoted a shared leadership model. Accordingly, they also appointed a senior clinician (a diabetologist) as a clinical director. In this CAB, then, the leadership role was shared between a lead academic-physician and a lead clinician, both from within a single discipline, with managers in a supportive role.

> *"I said I wanted to do it on my own because I didn't want to work with the other person who (originally) put their name up. The (executives) then said we want you to have a partner, and that works…I can have the ideas and (the other director) can see how it could be made to*

happen. I mean sometimes we disagree, but deep down we don't disagree about anything fundamentally." Senior academic

Their vision was for a diabetes-focused CAB that should represent the whole spectrum of diabetes, and so be a model for other long-term conditions. Accordingly, they developed a model that put diabetes firmly at its centre, with 'feelers' out to bring in related specialties.

"The ambition is for a sort of grand Johns Hopkins' type model, (but) there's definite cultural differences in terms of how (our different groups) operate. If three football teams were to suddenly decide they were going to become one football team…" Senior clinician

Yet despite internal tensions about this model *("we've got all of ophthalmology looking suspiciously at where the leadership is taking them")*, achieving the organizational advantage of a unified CAB created strong incentives for clinicians and academics to collaborate. Core drivers, therefore, were of gaining competitive advantage and creating a powerful unified identity. This new identity powerfully linked indigenous clinical and academic interests with a new, business-orientated mentality.

"A lot of the early discussions were a bit of turf war about who was in and who was out, whose CVs are going to look good, who's got the money. What you quickly realise is that CABs become a club aware of their own identity very quickly, and it is a formative identity…a force trying to influence wider privilege for itself. I mean, essentially you become a business." Senior clinician

Mobilising leadership across contrasting models – achieving cultural change

In the diabetes CAB, its leaders strongly identified with the AHSC vision and sought to establish it through a more hierarchical leadership approach, drawing on Johns Hopkins as a source of inspiration. Nonetheless, the AHSC 'myth' was mobilised less by external influences that by an internal ambition to make use of the AHSC partnership *"taking away all the barriers"*. The AHSC was perceived as an opportunity to create locally devised model, whose core features had been pre-conceived by the academic director and colleagues.

"I've driven this, we had meetings long before we knew about the AHSC, saying that we wanted to pool into a single entity... I want to be in a position to say this is a model, because we should inform our management what we want to do and not have them tell us." Senior academic

Interestingly, while an external consultant was used in this CAB's early development (and had been experienced an 'helpful' in bringing together a range of parties and

perspectives 'into the room'), ideas for this CAB were mobilised neither by managers nor by external consultants, but by the two academic and clinical directors, regarded by some as operating in isolation from the wider CAB.

> *"It's gone from a big, wide breadth of activity to… it's suddenly condensed to a core black hole…a supernova. Hopefully (the directors) will merge into a new style and get illuminated once they've come from that position."* Senior clinician

Mobilising leadership ideas was similarly internally driven, as the voices of these role holders created a strong unified message, which some respondents described as drowning out other perspectives. This approach exercised effective control across wider meetings of CAB members.

> *"Their ability to dominate the conversation in the room, which prevents others from being able to interact or to make their own voices heard, is really quite extraordinary. They talk people out of the room and maintain a sort of verbal dominance over the meeting and its membership. To have any kind of impact at all you really need to punch your way to puncture this conversation. What you have is the 'husband' who comes home and is loud and dominant…at the same time there is the 'quiet housewife' who gets on with things behind the scenes."*

A core dynamic in this CAB is of a 'centripetal' force, pulling disparate services into a deeper concentration of resources and activity, positioning diabetes as a newly dominant player. This local interpretation of an AHSC 'myth' mobilised in this CAB is largely promoted by two powerful internal academics and clinicians, supported to varying degrees by other CAB participants.

Outcomes

Outcomes in this CAB were of increasing centralisation and dominance, driven by CAB leaders. However, there were important questions about inclusivity, voice, and the degree of authentic sign-up to the process, with some respondents expressing concern about other staff and marginal perspectives being alienated. Thus there was a sense of leaders pushing through a model which 'backroom' academics and 'grassroots' clinical staff were not authentically signed up to.

Overall, this CAB started with a weaker power base and its collection of diverse groups meant its leadership and vision developed more slowly. Yet here too we see professional logics becoming more dominant as a small grouping of senior clinical and academic leaders established a strong presence and created a combined brand, which they saw as useful in competing for resources. The CAB's development thereby reinforced professional logics and self-interests, increasing their power base.

Mental health CAB

A contrasting model in the Developmental Psychiatry CAB was based on realigned departments across the NHS mental health trust and the academic department of psychiatry. This model developed after the chief executive and academic dean reorganized their departments from geographically based (in the case of the hospital) to specialty-based 'bundles' to deliver the AHSC objectives.

Antecedent – an embryonic AHSC

An important precursor in this CAB was a historical tradition of collaboration between the academic institute and the mental health hospital, originating from their inception in the 1940s. Respondents commented that they saw this historical relationship as an 'embryonic' AHSC *("15 years ago, you wouldn't have known which T-shirt the person was wearing – NHS or academic")*. This shared history was perceived as creating 'readiness' for the AHSC, in which many staff related to both the academic unit and the hospital.

> *"There's been a long tradition of being paid nine tenths from (the university). My colleagues are all in a similar arrangement – so in a sense that is a type of embryonic AHSC model. Our academic department relies on that close relationship; they get something from us – high-calibre people who obviously apply for these jobs because of their academic component. They get a certain amount of kudos. We were ready for that and it doesn't involve a radical change of culture, it means a type of clarification of our relationships and role, and we look to both sides."*
> Senior clinician

Establishing an indigenous version of the 'AHSC myth'

The CAB brought together separate services into a novel 'bundle', but the CAB's academic and clinical leaders took a strongly relationship-focused approach, seeking to build a leadership team which represented disparate services and specialties.

> *"Well our CAB is a novel entity in the sense that it brings together forensic psychiatry into a new relationship with learning disability and developmental disorders, so bringing disparate clinical services together."* Senior clinician

Interestingly, this early approach quickly became central for how the CAB then developed.

> *"A combination of oh my gowd, how on earth are we going to make this blimmin' work. Who are our natural bedfellows intellectually; who can we actually work with? We've got good*

inputs from our colleagues; a lot of inputs from across the piste in helping us form our vision…
So we have a whole series of meetings where all those conversations take place and are kind of
collated. It's changed how the team works. Senior academic

In marked contrast to Eastbury's originally preferred single director model, this CAB's leadership team had four directors: an academic director, a service director (general manager), and two clinical directors, representing disparate services. Unusually, the manager was seen to have an equal role in this leadership team, while the two clinical directors sought to integrate their disparate services. As one clinical director explained, although her clinical department was a minor part of the CAB in terms of scale and resources, she and the other clinical director had persuasively argued for a joint appointment for the role.

> *"We didn't know each other before this, and we didn't know whether or not the AHSC would go for the idea. But our CAB is very diverse, so we thought we need people from both sides… So we had a conversation and it was a consensual arrangement we worked out between the two of us. It was just about making sure that we'd have the right sort of clinical input into it… we have a big remit in terms of making sure that all service lines (integrate)"* Senior clinician

Despite this unusual team-based approach, (most other CABs across Eastbury had appointed one academic and one academic director), the directors of this CAB believed they had created an entity which fitted with their underlying clinical ethos and historical patterns of collaborating.

> *"If you look back at our previous method of working, we were ready for this type of thing and so it suits our purpose. So on that level we're singing from the same hymn sheet."* Senior manager

Moreover, they actively worked to diffuse their team-based model of collaboration across the CAB, thereby operationalising their vision through other multidisciplinary teams.

> *"It needs to be a fairly flat hierarchy at the top. Each one of those (Eastbury) agendas needs to be driven forward within a team; everybody basically needs to be respectful of those three overriding areas and the team needs to bring those issues to the table. So the teaching, the research, the clinical excellence, producing results, measuring outcomes, all of that is abundantly clear - you need a team that can deliver and be respectful of that full range of outcomes. I don't think it can work unless the ethos permeates through to at least the middle rank of clinicians, managers and researchers."* Senior clinician

Mobilising leadership between contrasting models – dynamic models of relations
So how were the AHSC ideas mobilised in this case? The CAB leaders took inspiration from the close partnership they observed between the mental health trust CEO and the academic dean, and attempted to emulate this as a model of shared leadership.

> *"(They have) integrity, ambition, they're respectful of their colleagues and approachable, articulate. They evoke a certain amount of pride; they both credit the full range of (AHSC) activities. They articulate the aims of the whole exercise very convincingly and coherently, and they're very good advocates. It makes the whole project a lot easier to sell to the workforce."*
> Senior clinician

Despite this influence and the realignment of their departments, CAB directors expressed frustration with wider institutional arrangements as managers and core functions (such as HR and finance) were seen as slowing the CABs' potential to develop.

> *"Because of stasis, the management procedures we have in place are very un-entrepreneurial. They say all the right things but they're risk-averse…so people are afraid to fail. There's not enough feeling amongst the managers at CAB level that they've got the power to do (things). It's always, 'oh I better ask (the CEO)'. The (institutions have) not said, you know what, you make a surplus, you can reinvest: a simple concept."* Senior academic

Similarly, the institutions' arrangements for accrediting and monitoring CABs were seen, paradoxically, as obscuring the CAB's focus on delivering their key clinical and academic objectives.

> *"There is a risk we might become too focused on pleasing Eastbury, rather than addressing the priorities of the wider research and clinical establishments. There might be a temptation sometimes to focus too much on keeping local accreditation bodies sweet….(other) managers whose role in life is to keep the hierarchy satisfied with progress. But that may not be nearly so impressive to the outside world."* Senior academic

Instead, directors described the most useful ideas coming from challenging but authentic exchanges with other CAB directors in the CAB leaders' forum, whose focus on developing the AHSC model they regarded as key to their learning.

> *"Clinicians or academics would be saying, I'm having problems with dealing with my business manager, how are you guys dealing with that? Well I found that a really interesting conversation to have – until one of the Chief Executives wrote a letter saying, I hear you've been speaking out of turn. Bloody ridiculous – everyone thinks, 'sod it, what's the point?' Instead of the institutional reaction being, 'that's actually a healthy thing', it was a slap down... You want*

to know how you deal with this situation, to learn from each other: 'oh come on, that's rubbish', or 'what do you think?'" Senior clinician

Another source of mobilisation came through practical examples that produced changes in working practices and new areas of collaboration, which one academic described as 'transformational'.

> *"You're here to help people, dude, that's the mission of this (Eastbury), and that's what you need to focus on. So it's terrific, it's transformation… So I've got my idea, test that out…grow some stem cells, transplant that to a mouse model, and then I'm going to transfer that up to a human model…to my brand new absolutely world-leading treatment. I can do that now, you know. We're doing it already, just fantastic."* Senior academic

Outcomes

A key outcome for this CAB was to bring clinical and academic areas into close alignment, overcoming many (although not all) of the institutional barriers experienced by the physical health CABs. Their model of working fitted with underlying patterns of collaboration amongst clinical and academic groups

> *"For most clinicians certainly this whole exercise does make sense. It's not just a paper pushing exercise. It does make sense to try to bring people together, and I think so far we've succeeded in doing that."* Senior clinician

More broadly, this way of working facilitated links with other CABs in physical medicine, creating new opportunities for collaboration.

> *"It's really improved our links with physical medicine, absolutely crucial. A lot of the stuff we do is on brain development and, bizarrely, expertise in brain birth injury resides in psychiatry and not in neonatology. So what we've been doing is inventing techniques for detecting brain damage from a caesarean section or very preterm. So you've now got really rapid measures of your intervention, which we wouldn't have had."* Senior academic

Fateful outcomes? 'CABS Are Us'

Studying how the AHSC 'myth' was mobilised and established at CAB levels elucidates how embedded academic and clinical practices were influenced and changed through local adoption and enactment of the AHSC model. As one senior clinician argued, the CAB-based model's *"inclusivity has made it much easier to sell, it's made it quite a seductive*

concept" amongst diverse academic and clinical groups. Indeed, the partnership executive depended upon these CAB-level developments.

> *"It's fair to say that 'CABS R Us' – to use an American toy store's name. We do rely on that as being the fundamental vehicle of delivery, communication and dissemination… One of the questions I ask if I go to your CAB, I say to the nurse or research assistant, 'how is it for you, has the earth moved for you yet?' Would they say, 'I've no idea what you're talking about' or would they say, 'I think I can see where we're going - it could be quite exciting'".* Senior academic

But might these local adaptations have wider influence upon other CABs, or indeed 'upwards' towards the institutions? The declared intentions of the sovereign institutions to move from confederation model towards ever-closer integration and possible merger were significantly influenced by CABs' progress towards as well as obstacles in delivering the AHSC vision. The perceived successes of mental health CABs, in particular, in achieving Eastbury objectives became notable exemplars of effective AHSC operating.

> *"They have taught us a huge amount and they are in no small measure responsible for the optimistic and dramatic circumstances that we now find ourselves in…They don't talk about divisions, they talk about CABs. The management, clinical and academic leaders are aligned, it's extraordinary. That's not the case across the acute hospitals, so the model of the mental health CABs showed us what can be achieved. It's amazing, the enthusiasm and the commitment, it's absolute magic."* Senior clinician

Whereas the physical health CABs' stronger vertical governance arrangements within their trusts were seen as hindering these CABs' progress, stronger lateral alignment of the mental health CABs was perceived as accelerating their development. Their examples of innovating across historical divisions between mental and physical healthcare were persuasive, appearing to translate 'myth-like' AHSC ideals into tangible reality.

> *"The other thing that's stunning is that they've really embraced this mental-physical interface… They have developed a screening tool which they use in the rheumatology clinics… It's a challenge to the physical health trusts, (who) say look, we can't do this stuff, you can't move money from one trust to the other trust. So that shows the inadequacies of the model of separate trusts and that has played a major part in changing people's mindset. These institutions are all going to merge in a new organization that brings everybody into the same place. Well I call that revolutionary - it's bloody revolutionary!"* Senior academic

In contrast to notions of CABs merely implementing the AHSC's originally conceived design, CABs had created and exerted strong 'upwards' pressure upon the sovereign institutions. Through producing powerful inter-linkages between CABs and the partnership executive, emotionally-charged challenges to managerialist caution became increasingly influential. Senior managers and boards across the four institutions were persuaded to *"go further, faster…sure that our futures are bound together,"* at the time of writing proposing closer integration and public consultation on a possible merger.

> *"Everybody will go banging on about how mergers fail… (but) how else could you make the CABs work? Making the CABs work delivers the tripartite agenda. The whole raison d'être of Eastbury was the mental-physical health interface…bringing mental and physical together to a level of fulfilment that is just not known about in the NHS. We're turning the CABs into the delivery vehicle – CABs can be engine rooms, and the reason we're going to have to merge is so that the CABs can work properly. I mean, 'CABS are it', they are a necessary condition for (our) success. It turns out we've got to merge these hospitals to deliver that."* Senior academic

Unlike Kitchener's (2002) case, then, the creation and mobilisation of the AHSC idea at Eastbury was driven by senior academics and clinicians whose high levels of engagement produced strong institutional pressure, converting its 'myth-like' vision into material 'reality'. Eastbury's identity, branding and 'clever' logo were popular and quickly adopted by participants across the four institutions, with some academics, clinicians and managers preferring to put Eastbury as their 'home' institution (including in their publications.)

> *"We can't just wake up one morning and say well actually it's all off…take away this logo, we're just going to back to the way we were. It's inconceivable…it's difficult to convey the profoundness of these changes in so many dimensions."* Senior clinician

The clinical-academic innovation of CABs, then, became a key linking mechanism. Instead of creating sedimented and loosely-coupled areas of professional autonomy, CABs generated potent local ownership from clinicians and academics whose engagement at intermediate levels produced a counter-colonizing dynamic, accelerating the pace and scale of institutional change.

Discussion and conclusion

Comparing our case with Kitchener's (2002) framework – establishing a new organizational form

How might we analyse this empirical case which reveals a very different course than Kitchener suggests? Rather than operational collapse and institutional demerger, we see closer integration moving towards merger. Using Kitchener's (2002) framework, our case elucidates key distinctions between the AHSC with Kitchener's study. We summarise in Table 1 the key influences and mechanisms creating institutional change in our case.

		Corporate level	*Partnership Executive*	*Clinical Academic Bundles (CABs)*
ANTECEDENTS	*Structural influences*	4 sovereign institutions; strengthened governance arrangements; AHSC as a separate 'platform'	Overcoming structural barriers through influence & collaboration; developing leader-follower relations	*Cardiology*: Tensions with structural barriers, caution & hierarchy *Diabetes*: AHSC should 'remove all the barriers'; preferred single leader approach modified by AHSC *Psychiatry*: Strongly shaped by newly aligned academic and clinical services; team-based leadership model
	Prevailing logics	Corporate governance systems; legal logics; competition with UK rival AHSCs	Tripartite missions of academia, patient care & education; international rankings ('*top 10 globally*')	*Cardiology:* Clinical-academic excellence; entrepreneurialism & innovation *Diabetes:* Recreating a new clinical-academic entity; competitiveness & business logics *Psychiatry:* Clarifying & strengthening their original 'embryonic AHSC'; clinical-academic innovation
	Sources of influence	AHSC institutional models; North American & European exemplars	Impressive cases of leadership (e.g Johns Hopkins); cautionary case studies of AHSC failure	*Cardiology:* Inspiring medical leadership *Diabetes:* CAB academic director; Johns Hopkins leadership model; internal CAB accreditation process *Psychiatry:* Inspiring shared leadership model (CEO & dean of psychiatry); dean's previous work in AHSCs
MOBILISATION	*Change agents*	Imperial AHSC & policy push; semi-formal partnership board (some enthusiastic CEOs & Chairs); internal corporate functions	Senior academic doctors; highly visible collaboration between mental health CEO and dean.	*Cardiology:* Senior academics and clinicians working as a strongly unified team *Diabetes:* Dominant academic and clinical directors *Psychiatry:* Internal organizational consultants; CEO and dean; CAB leadership group.
	Leadership model	Hierarchical control and parallel governance arrangements; limited delegated authority to AHSC	Cadre of visibly committed group of clinicians & academics, supported by	*Cardiology:* Strong clinical-academic leadership team, supported by a *balanced* wider group, across specialties & sites *Diabetes:* Dominant, diabetes-centric pairing between academic director (strategic ideas) and clinician (with

		executive & CABs	managers. Led by 'inspiring' academic doctors.	operational techniques) *Psychiatry:* 'Flat and inclusive hierarchy' in a 4 member leadership team; consensual decision-making & wider consultation
	Relational dynamics	Shared commitment to the AHSC, but divergent views about a model; increasing anxiety and caution; some strong relationships (e.g. mental health CEO and dean)	Trust-based relations *'you can feel'*; shared leadership; sense of mutual mission, *'beyond friendships'*	*Cardiology:* Cohesive leadership and decisions *'we act as one organization'*; refusal to comply with bureaucracy, creating *'trauma & mayhem'* *Diabetes:* Hegemony of diabetes, led by academic doctor; some groups marginalized & silenced through *'verbal dominance'* *Psychiatry:* Developed strong team relations, extending to wider group; facilitation to *'hear quieter voices'*
ESTABLISHING MYTHS	*'Myth-like' adoption*	Inspired by North American AHSCs; preferred model of partnership reflects historical relations; opposes Imperial merger model	*'CABs R Us'*; Senior clinicians & academics develop innovative & inclusive CABs as the AHSC's engine room; *'Everyone is in'*	*Cardiology:* Vanguard CAB shaped as a heart-like 'engine'; embodying the AHSC *'as the middle bit driving everything else'* *Diabetes:* Creating a *'supernova'* based on a (modified) Johns Hopkins model; creating a diabetes spectrum *'as a model for every other long term conditions'* *Psychiatry:* Re-establishing a valued 'embryonic' relationship through a multi-disciplinary leadership group, reflecting core mental health practices.
	Techniques in use	Partnership agreement for AHSC as 'a platform' Early community-building gives way to governance focus	Weekly executive meetings; AHSC tasks; unusual & non-bureaucratic CAB leadership meetings.	*Cardiology:* 2-dimensional model of a heart-like engine as central to discussions; weekly meetings over 2 years; leadership group model practices of a *'changed culture'* *Diabetes:* Breadth of initial activity shrinks to core leadership *'black hole'*; verbal dominance forcing change ideas, with limited outside facilitation *Psychiatry:* Team development techniques, using internal facilitators and tools (Myers Briggs), stimulating exchange & relations
	Identity construct-ion	Sovereign institutions & confederation as a platform, not an umbrella	CABS R Us	*Cardiology:* Wearing an AHSC identify badge makes a difference: *'We are the AHSC'*; *'think Eastbury'* *Diabetes:* *'Re-creating ourselves'* as a diabetes spectrum CAB; a new & powerful entity *Psychiatry:* Clarifying relationships; *'we have always been an (embryonic) AHSC*

Table 1 - Summary of key influences & drivers

Firstly, the AHSC's *antecedents* suggested a very different logic of accelerating research translation from 'bench to bedside' to improve clinical care, rather than the rationale of cost containment apparent in Kitchener's (2002) account of merger between existing AHS organizations. Interviews suggested there was high internal clinical and academic legitimacy for the AHSC vision, 'being in the top ten in the world'. Although the AHSC was created in an economic context of financial retrenchment, a resulting austerity consciousness did not appear to affect the legitimacy of the AHSC vision. Instead, 'moving upmarket' was regarded as protecting patient and resource flows (as seen in the cardiology CAB).

Furthermore 'background' antecedents in our case were interpreted and brought into play in different ways by local actors. *Structural influences* proposed contrasting models of reinforcing (at governance levels) or overcoming institutional boundaries (in CABs and the partnership board). *Prevailing logics* across groups similarly accentuated different underlying rationales: management logics were more legalistic and risk-averse while clinical and academic logics emphasised more collaborative and 'hybrid' evolution. Orientations to key *sources of influence* also varied, with executives looking internationally to institutional models; partnership board members focused on examples of leadership in elite North American AHSCs, as well as cautionary accounts; whereas emerging CAB leaders identified 'inspiring' local leaders, along with visible, collaborative leadership.

Secondly, *mobilisation* of the organizational innovation originally arose through interactions between rival institutions. The AHSC model was imported into the UK by the self-appointed AHSC at Imperial; this led to a policy push by the Department of Health (which steers the UK health sector more actively than the more market-orientated USA system) to create and accredit a limited number of prestigious AHSCs, for which there was strong institutional competition. Well-established settings such as Johns Hopkins were regarded as legitimate role models, strongly reinforced by 'impressive' site visits. AHSC status was thus regarded as signalling world-class quality, reputation and brand, and our site did not wish to be 'pushed into the second division'.

Managerial change agents, though, were less prominent in our case. Management consultants played a supporting, but not a directing role; non-executive board members did not appear significant in mobilising change; while legal actors had a dampening effect on managerial enthusiasm for change. Conversely, the AHSC model was mobilised by internal clinical and academic leadership. Principal *change agents* were senior academic doctors and clinical-academic leaders, a few enthusiastic executives (such as the mental health trust CEO), and internal organizational development consultants, who focused on team- and relationship building. Despite managerial efforts to retain hierarchical control, these senior clinicians and academics introduced shared,

team-based *leadership models* (such as between the mental health trust CEO and the dean of psychiatry). Consequently, an expanding cadre of clinical-managerial and academic-managerial leaders developed, which formed strong alliances across institutional boundaries.

Relational dynamics, moreover, became increasingly salient in mobilising this development. Building strong relationships was seen as not merely incidental, but pivotal to converting AHSC ideals into 'a reality'. Within the partnership executive, members' emotional commitment to the AHSC vision and to each other helped establish confidence and trust, *('stronger than friendships…you can feel it around the table').* Such emotional engagement was also important at CAB levels, as seen in the 'trauma and mayhem' between the cardiologists' and their parent institutions, the mental health CAB's enthusiasm for candid and shared engagement in building trust, and internal tensions within the diabetes CAB.

Thirdly, the *establishment of myths* in our case does not appear in the form of 'oversold' managerial myths, driven by a managerialist field (see for instance, Bowles, 1997; Meyer & Rowan, 1977) but were improvised and developed internally as compelling local narratives. The AHSC vision was mainly established by a middle to upper level cadre of doctors and academics, whose enthusiasm overtook that of senior managers. Unlike the institutional myths of structures and practices described by Meyer & Rowan (1977), we find diverse practices of 'myth making' (Gabriel, 2008: 191-92; Kostera, 2008) across the AHSC, in the forms of improvised leadership models, new identity constructions, and idealistic yet plausible visions of an 'exciting' and 'revolutionary' future. To support this work, *techniques in use* established new practices that were readily identified with the emerging AHSC. Thus, while the formal authority of partnership executive and CABs had little formal authority (power was 'castrated') they established visible leadership teams that were seen as synonymous with the AHSC *('we are the AHSC').* Accordingly, emerging *identity constructions,* such as the slogan, 'CABs R Us' or the well-liked notion of having always been an 'embryonic' AHSC, seemed to reflect members' lived experiences of creating the AHSC, as much as their future aspirations.

Finally, *organizational outcomes* in Eastbury were not 'sedimented' and fateful, but supported by committed professional groupings established at CAB levels. Unlike Kitchener's (2002) account of 'service lines' that quickly collapsed, a major finding of our study is the engagement of core professional groups driving CABs as intermediate, linking structures across both the university and the hospitals. Although managerial actors were less prominent, we find productive alliances, such as between the CEO of the mental health trust and the academic dean, along with examples of clinical-academic-managerial coalitions in some CABs. These high levels of clinical-academic

engagement produced significant organizational change at CAB levels, as a consequence, exerting powerful 'upwards' pressure on the sovereign institutions, creating a more stable collaborative form. Our particular focus on the first wave of CABs may not reflect the wider picture across the AHSC (we sampled six 'early adopters' of the 21 CABs). Nevertheless, instead of professional groups being either decoupled from institutional change, or merely engaged at intermediate leadership levels, we find a powerful process of 'counter-colonization' which eventually convinced the sovereign institutions to propose fuller integration and possible merger.

In summary, these findings contrast strongly with Kitchener's (2002) account of top-down and secretive managerial 'fiat'. Whereas his account briefly mentions, but discounts, the 'social construction of a prestige cartel' as a possible motivator for AHSC construction, this narrative was strongly present in our sites and helped mobilise internal legitimacy (*'a journey of passions'*). Instead of the antecedents asserting managerial logics, we find clinical-academic logics that gained strong local legitimacy; ideas were mobilised not through managerial change agents, but through lateral diffusion of ideas, promoted by clinical and academic leaders; the AHSC model was not externally imposed as a 'managerial myth', but was internally constructed through practices of local myth-creation. Accordingly, the organizational outcomes took a very different course to Kitchener's case. We capture in Table 2 key distinctions between Kitchener's analysis and our findings.

	Kitchener's framework, based on UCSF-Sanford Merger	*Comparison of Eastbury AHSC against Kitchener's framework*
Antecedent	Ascendancy of managerialist logics over professional dominance	International AHSCs promoted clinical-academic logics which gained local legitimacy
Mobilization	Institutional change agents establish 'myth-like' innovations	'Lateral' diffusion of innovation in clinical-academic domain, promoted by UK policymakers
Establishment of Myths	Combined insititutional isomorphy & managerial agency led to merger	Upwards institutional pressure produced through strong professional engagement and managerial reactivity to external reputational legitimacy.
Organizational Outcomes	Fateful outcomes of myths 'sedimented' on submerged professional logics (loosely coupled)	Productive alliances of academic & clinical leadership create counter-colonization of managerial domain.

Table 2 - Comparison to Kitchener's (2002) framework

Wider reflections on counter-colonization within the AHSC

What might these findings elucidate more widely about institutional relations between managerialist and professional logics? In overall terms, Kitchener's (2002) institutionalist framing explores a well-recognised question of the distribution of power within healthcare systems, and of conflict between different power blocs and their associated logics. Yet recent scholarship suggests there may be highly varied patterns of relations between professional and managerial logics. In studies of the Albertan healthcare field, for instance, Reay and Hinings (2005; 2009) find long-term coexistence between professional and managerial logics with neither becoming dominant, and tactics in place to achieve pragmatic working relations and avoid conflict. Within the field of employment services, van Gestel and Hillebrand (2011) suggest an oscillating pattern, as dominant logics switch over time, linked to wider changes in political control. Another pattern, in the health management literature, focuses on the development of hybrid clinical-managerial roles at the individual level (Doolin, 2002; Ewan Ferlie & Pettigrew, 1996; Fitzgerald & Kippist, 2009), often involving identity reconstruction (Doolin, 2002; Ewan Ferlie, Crilly, Jashapara, & Peckham, 2012).

Waring and Currie's (2009) study of clinicians' reactions to new corporate knowledge management systems found that besides patterns of evasion and resistance, clinical adaptation and co-optation to new managerialist systems were also possible. One clinical setting, for example, did not use the corporate knowledge management system but developed its own clinically led system, defended on quality grounds. *"Systems that were initially centralized and anchored within management practice become decentralised and re-anchored within medical practice, marginalising hospital risk managers from their own systems'* (Waring & Currie, 2009: 772). Intriguingly, the authors suggest a pattern of 'reverse colonization' whereby professionals extend their jurisdiction, using *"the tools of colonization…to challenge the authority and gain independence from the (managerial) colonizers"* (Waring & Currie, 2009: 774). Their analysis is thus orientated towards managerialist techniques that overlap with traditional areas of clinical jurisdiction, at more micro organizational levels. But can their notion of 'reverse colonization' be extended to the AHSC as a new organizational form?

Our findings suggest a more expansive process of what we describe as 'counter-colonization' operating at the macro (AHSC) and meso (CAB) organizational levels. Importantly, this process was not just enacted at micro levels, nor merely focused on reclaiming professional jurisdictions, as Waring and Currie (2009) suggest. Like Choi et al.'s (2012) recent findings from one clinical department at Karolinska, we find the presence of professional engagement linked to emotional and relational work, actively developing the AHSC at a meso level. But our concept of counter-colonization

emphasises greater professional activity and 'bottom-up' influence than has previously been noted at more macro levels. We suggest such counter-colonization in our case involved three interlinked processes of: lateral diffusion of an organizational model by professionals; 'upwards' institutional pressure from meso levels; and cognitive and emotional aspects of enacted institutional work.

Lateral diffusion of the macro organizational model within the clinical-academic domain internationally

Successive reorganizations in UK healthcare have sought to reshape and managerialise professional work, inspired by politically-generated New Public Management (NPM) reforms (E. Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996). However, the creation of AHSCs in the UK displays a different pattern. Originating in the North American clinical-academic domain, AHSCs are based on the idea of rapidly translating scientific research into clinical practice, across institutional boundaries. This (professionally appealing) idea was especially supported by the availability of a founding organizational model, namely the AHS organizations in North America (e.g. Johns Hopkins). This elite and myth-like status of AHSCs was laterally diffused into the UK, originally through senior clinical-academic networks at Imperial AHSC, and later adopted by the management-policy domain through senior health policy networks at the Department of Health. AHSCs remain unusual as an organizational form originating in the clinical-academic domain, rather than the more typical political-managerialist inventions of NPM reforms.

The meso level: 'upwards' institutional pressure from the CABs

These lateral, macro-level influences in turn created a basis for the construction of CABs as a linking mechanism at meso-levels across the Eastbury AHSC; CABs which began to generate 'upwards pressure' on senior management and the governance level to accelerate the pace of development of the AHSC. In our previous research studying interactions between professional and managerialist logics in a healthcare setting, we found micro-level reactions can produce escalating emotionally-charged conflict rising to undermine meso-level functioning; for instance, 'ideological loading' and sustained emotions embedded in established positions may induce strong institutional pressure and organizational turbulence, potentially leading to organizational collapse (Fischer, 2008, 2012; Fischer & Ferlie, 2013). In the Eastbury case, by contrast, participants' emotional and ideological engagement may be seen as 'positively charged' towards transforming the organization. While there were instances of emotional 'trauma' and 'mayhem' in creating the AHSC, these were strongly future-oriented and ambitious (rather than defensive), geared towards ideals of creating 'an exciting future' for the emerging AHSC. Dominated by senior academics and clinicians, rather than

managers, the constructions of CABs at intermediate levels became crucial sites for advancing local ownership and vision. These developing professional logics exerted sustained and expanding institutional pressure across the AHSC, so 'counter-colonizing' the managerial domain.

Enacting institutional work: cognitive and emotional aspects

Although the idea of AHSCs as a new organizational form diffused from original North American settings such as Johns Hopkins, there was no master plan to merely replicate these original models. Instead, there was much evidence in Eastbury of participants adapting the idea to fit local relationships, of 'learning by doing', and using devices to reduce high levels of anxiety and uncertainty. Visits to international comparator sites and the sharing of vivid case studies became important vehicles for building tacit knowledge and emotional commitment to the project amongst the senior leadership team. Yet a combination of strong emotionally-invested engagement by professional groups, and their local adaptations of and identifications with CABs generated expanding 'upwards' pressure. Lawrence et al (2013) have recently drawn attention to the cognitive and emotional issues which may arise in such processes of local enactment, and call for more empirical and theoretical investigation. Within our study of such processes, the growth of emotional commitment and energy became central to the making the idea 'a reality', building on locally important values and practices. Thus, the cardiovascular CABs' 'heart like' model was devised and effectively employed as a motivating and reassuring trope. The mental health CAB similarly displayed a pattern of path dependency, re-evoking a locally valued history of 'having always been an embryonic AHSC', linking this to their invention of team-based leadership which reflected clinically important characteristics of their multidisciplinary professional work.

In summary, out case elucidates how high professional engagement at the meso level may powerfully interact with macro mechanisms, creating strong 'upwards' institutional pressure that stimulates organizational change. We propose the concept of 'counter-colonization' emphasises not merely the reclaiming of professional jurisdictions at micro levels, as Waring and Currie (2011) suggest, but more assertive professional expansions into managerial domains at meso and more macro levels.

Our study suggests a fruitful, yet under-explored area for future research may be other examples of expanding professional domains, potentially involving new organizational forms, such as partnership-based organizations. As we found in this case, such forms may be predicted to arise where elite professional groupings retain market or societal

power. Contrary to the managerialisation thesis, our study suggests certain limits to the managerial project, not least through the creation and diffusion of new organizational forms under the jurisdiction of elite professional groups.

Funding acknowledgement

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