REPUBLIC OF TURKEY
ÇUKUROVA UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
DEPARTMENT OF BUSINESS ADMINISTRATION

MICRO-LEVEL INTERACTIONS OF INSTITUTIONAL LOGICS: A RESEARCH STUDY IN THE TURKISH HEALTHCARE FIELD

Serdal GÜRSES

A Ph.D. DISSERTATION

ADANA / 2017

REPUBLIC OF TURKEY
ÇUKUROVA UNIVERSITY
INSTITUTE OF SOCIAL SCIENCES
DEPARTMENT OF BUSINESS ADMINISTRATION

MICRO-LEVEL INTERACTIONS OF INSTITUTIONAL LOGICS: A RESEARCH STUDY IN THE TURKISH HEALTHCARE FIELD

Serdal GÜRSES

Chair of Committee: **Prof. Dr. Ali DANIŞMAN**

Committee Member: **Prof. Dr. Azmi YALÇIN**

Committee Member: **Assoc. Prof. Dr. İlter ÜNLÜKAPLAN**

Committee Member: **Prof. Dr. Şükrü ÖZEN**

Committee Member: **Prof. Dr. Ünal AY**

A Ph.D. DISSERTATION

ADANA / 2017

To Directorate of Çukurova University Social Sciences Institute:

This study has been accepted as a DOCTORAL DISSERTATION in the Department of Business Administration by the following jury members.

Chair: Prof. Dr. Ali DANIŞMAN
(Supervisor)

Member: Prof. Dr. Azmi YALÇIN

Member: Assoc. Prof. Dr. İlter ÜNLÜKAPLAN

Member: Prof. Dr. Şükrü ÖZEN

Member: Prof. Dr. Ünal AY

APPROVAL
I authorize that the above signatures belong to the jury members.
…/…/2017

Prof. Dr. H. Mahir FİSUNOĞLU
Director of the Institute

NOTE: The uncited usage of reports, charts, figures and photographs in this dissertation, whether original or quoted from other sources, is subject to the provisions under the 5846 numbered Law on Intellectual and Artistic Works.

STATEMENT OF ETHICS

In this dissertation, in which I have strictly conformed to Çukurova University Social Sciences Institute Dissertation writing rules, I state that:

- I have obtained the data, information and documents presented in this dissertation in accordance with academic and ethical protocols,
- I have presented all information, documents, evaluations and results in accordance with scientific ethical and moral standards,
- I have fully acknowledged the work of others to which I have referred in my dissertation,
- I have not made any changes to the data and emerging findings,
- This dissertation is my original work,

and I accept all losses of rights, which may arise out of emergence of a contrary case.
12/06/2017

Serdal GÜRSES

ABSTRACT

MICRO-LEVEL INTERACTIONS OF INSTITUTIONAL LOGICS: A RESEARCH STUDY IN THE TURKISH HEALTHCARE FIELD

Serdal GÜRSES

Dissertation for the Degree of Doctor of Philosophy, Department of Business Administration

Chair of Committee and Supervisor: Prof. Dr. Ali DANIŞMAN
June 2017, 235 pages

This study aims to help unveil the micro-level implications of a macro-level government-led health transformation initiative in an already-established Turkish healthcare field by drawing attention to the role of institutional logics through the processes of change over time. This historical grounded theory study allowed the researcher to identify the catalog and associated characteristics of logics; namely, medical professionalism, state, business-like and rogue logics, that are available to the ground-level actors, and the great deal of professional discretion they use in the selection of which logic(s) to employ under which circumstances. While institutional theory presupposes that professionals, based on their strong professional ties, orientation, socialization and education, show close attachment to their professional or 'home' logics, the researcher, in this study, contributes to the institutional logics theory by providing evidence that they may stray from their home logics and draw from a repertoire of logics that are available to them or become slaves of a rogue logic they themselves create based on the their immediate interests and purposes. Unraveling the micro-level practices of ground level actors as they pertain to different logical orientations substantially advances our understanding of how and under what conditions certain or various combinations of institutional logics are employed during day-to-day activities.

Keywords: *Institutional logics, institutional change, Turkish healthcare field, micro-level change, ground-level practices*

ÖZET

KURUMSAL MANTIKLARIN MİKRO SEVİYEDEKİ ETKİLEŞİMLERİ: TÜRK SAĞLIK ALANINDA BİR ARAŞTIRMA

Serdal GÜRSES

Doktora Tezi, İşletme Ana Bilim Dalı

Danışman: Prof. Dr. Ali DANIŞMAN

Haziran 2017, 235 sayfa

Bu çalışma, halihazırda kurulu bir düzene sahip olan Türk sağlık alanında devlet öncülüğünde makro seviyede gerçekleştirilen bir sağlık reformunun mikro seviyedeki etkilerini kurumsal mantıkların bu değişim teşebbüsü sürecindeki rolüne dikkati çekmek vasıtasıyla ortaya çıkarma konusunda yardımcı olmayı amaçlamaktadır. Bu tarihsel temellendirilmiş kuram çalışması, araştırmacının pratik seviyedeki aktörlerin kullanımına hazır olan kurumsal mantıklar ve bu mantıklarla ilintili karakteristikler kataloğunu, ki bunlar medikal profesyonellik, devletçi, işletme-benzeri ve aykırı mantıklar olarak isimlendirilmiştir, ve aynı zamanda bu aktörlerin hangi durumlarda hangi mantıklardan yararlanma konusundaki tercihlerinde profesyonel takdir yetilerini çok büyük bir yoğunlukta kullandıklarını tespit etmesine olanak sağlamıştır. Kurumsal mantıklar perspektifinin, profesyonellerin güçlü profesyonel bağ, oryantasyon, sosyalizasyon ve eğitimlerinden ötürü kendi 'öz' mantıklarına sıkı sıkıya bağlılık gösterdikleri önkabulüne karşın, bu çalışmada araştırmacı profesyonellerin kendi öz mantıklarından uzaklaşmak vasıtasıyla kullanımlarına hazır olan mantık repertuarlarından yararlandıklarına ya da o anki şahsi amaç ve çıkarlarına bağlı olarak yarattıkları aykırı bir mantığın kölesi olduklarına yönelik kanıtlar sunmak vasıtasıyla kurumsal mantıklar perspektifine katkıda bulunmaktadır. Pratik seviyedeki aktörlerin farklı mantıksal oryantasyonlarla ilintili olan mikro seviyedeki uygulamalarını ortaya çıkarmak, belli kurumsal mantıklardan ya da birçok farklı kurumsal mantık kombinasyonlarından gün-be-gün gerçekleştirilen uygulamalarda nasıl ya da hangi koşullar altında yararlanıldığı konusunda sahip olduğumuz bilgileri büyük ölçüde geliştirmektedir.

Anahtar kelimeler: *Kurumsal mantıklar, kurumsal değişim, Türk sağlık alanı, mikro seviye değişim, pratik seviye uygulamaları*

GENİŞLETİLMİŞ ÖZET

KURUMSAL MANTIKLARIN MİKRO SEVİYEDEKİ ETKİLEŞİMLERİ: TÜRK SAĞLIK ALANINDA BİR ARAŞTIRMA

GİRİŞ

Araştırmanın Motivasyonu ve Amacı

Örgütlerin ve onların strateji, yapı, iş süreçleri ya da daha genel bir ifade ile hayatta kalma ve başarılı olmalarına direkt ya da indirekt etkileri bulunan etkin aktörlerinin, çevresel etkenlere nasıl uyum sağladıkları, uyum sağlayamadıkları durumlarda ne tür tepkiler verdikleri örgüt teorisinin giderek daha fazla ilgi çeken temel araştırma konuları haline gelmiştir. Bu konu, örgüt teorisinin çevresel koşulları örgütsel dinamizm açısından ağırlıklı olarak ele almaya başladığı, globalizmin tüm dünyaya artan bir nispette nüfuz etmeye başladığı 1980'li yıllardan itibaren daha da belirgin bir şekilde irdelenmeye başlanmıştır. Konuya nispeten dar bir çerçevede, örgüt-çevre ilişkisi bakımından yaklaşan ve çevreyi daha çok kaynak, insan gücü vb. gibi girdileri sağlayan ve örgütün potansiyel hedef kitlesine yönelik ürettiği mal ve hizmetler (çıktı) bakımından da dikkatle yönetilmesi gereken bir sistem unsuru olarak değerlendiren sistem ve durumsallık gibi çağdaş yönetim teorileri, çevresel koşulların neden birtakım olaylara diğerlerinden farklı anlamlar yüklediği ve bu önkabullerin zamanla nasıl sorgulanmadan kabul edildiği konularını, muhtemelen çağın da verimlilik ve etkinlik baskılarından dolayı yeterince irdelememiştir. Sosyo-teknik sistemler olarak adlandırılan örgütlerin aslında daha geniş sosyo-kültürel bağlamların etkisi altında faaliyet gösterdiği yeterince dikkate alınmamıştır.

Literatürdeki bu boşluğu doldurmayı amaçlayan kurumsal teori, meseleye bambaşka bir bakış açısı getirmiş ve genelde iktisadi amaçlara hizmet etmesi hedeflenen örgütlerin ve onların teknik süreçlerinin nasıl sosyal düzeyde anlam kazandığını makro açıdan irdelemiştir. Ancak bu irdeleme süreci toplumsal ve örgütsel alan seviyesinde soyut genellemelere indirgenmiş, içinde birtakım kural ve kısıtları barındıran toplumsal ve örgütsel süreçlerin aslında sosyal olarak yapılandığı görüşü hakim olmuştur. Bu görüşe göre, tüm örgütler ve insanlar kurumsal kısıtların dahilinde yapı, strateji ve süreçlerini oluşturmakta, yönlendirmekte ve muhafaza edebilmektedir.

Ancak kurumsal teori literatürü çerçevesinde, son dönemlerde örgütlerin ya da onların etkili aktörlerinin, her ne kadar bir ölçüye kadar kurumsal kısıtların etkisinde kalsalar da, bu kısıtlar dahilinde kendilerine bir manevra alanı yarattıkları ve böylece kurumları etkileyip, hatta bazı durumlarda onları değiştirebileceklerini savunan "kurumsal mantıklar" kavramı ortaya atılmıştır. Bu görüşe göre, örgütler ve örgütsel aktörler kurumların esiri değil, onları etkilemeye ve değiştirmeye muktedir unsurlar olarak ele alınmaktadır. Kurumsal mantık teorisi ile birlikte kurumsal teorinin oldukça soyut ve makro olan tümdengelimci bakış açısı, yerini mikro dinamiklerin makro düzeydeki etkilerini incelemeye yönelik tümevarımcı bir yaklaşıma bırakmıştır.

Bu bağlamda, mikro-makro ya da makro-mikro seviyedeki etkileşimleri açıklama potansiyeli bakımından kurumsal mantık araştırmalarının yönünün mikro seviyeye yönelmesi gerektiğine yönelik çağrılara (Barley, 2008; Hallett, 2010; Powell ve Colyvas, 2008; Suddaby, 2010; Thornton, Ocasio ve Lounsbury, 2012; Whittington, 2006) istinaden son dönemde bu yönde yapılan çalışmalarda gözle görülür bir artış gözlenmektedir (Goodrick ve Reay, 2011; McPherson ve Sauder, 2013; Lawrence, Suddaby ve Leca, 2011; Reay, Goodrick, Waldorff ve Casebeer, 2016; Smets ve Jarzabkowski, 2013; Smets, Jarzabkowski, Burke ve Spee, 2014; Smets, Morris ve Greenwood, 2012). Ancak bu çalışmaların üç farklı noktada kurumsal mantıklar literatürüne yeterli katkıyı sağlamadıkları düşünülmektedir. İlk olarak, mevcut çalışmalar çoklu mantıkların yarattığı mantık karmaşasının varlığında ortaya çıkan mikro seviyedeki düşünce sistemleri ve ilintili mantıkları (Friedland ve Alford, 1991) açıklama kapasiteleri bakımından kapsam ve içerik olarak yetersiz görünmektedir (Smets ve diğerleri, 2012; Thornton ve diğerleri, 2012). Bu açıdan, literatürde "kurumsal karmaşaya bireysel analiz seviyesinde uygulama bazında verilen reaksiyonlara yeterince dikkat çekilmemiştir" (Smets ve Jarzabkowski, 2013, s. 1283); bu nedenle, "kurumsal mantık araştırmaları insanlara ve pratik seviyedeki uygulamalarına daha da yakınlaşmalıdır" (Hallett ve Ventresca, 2006, s. 222). İkinci olarak, çalışmaların bir kısmı kurumsal mantıkları salt aktörler arası ilişkiler yönünden irdelemiş, aktörlerin sahip oldukları pozisyonlar ile kurumsal mantıklar arasındaki refleksif ilişkilere odaklanmıştır (McPherson ve Sauder, 2013; Smets ve Jarzabkowski, 2013; Smets, Morris ve diğerleri, 2012) ve bundan dolayı "aktörlerin gün-be-gün icra ettikleri uygulamaların mantıksal uzantıları … [ya da] mantıkların günlük uygulamalarda nasıl hayata geçirildiği konusunda çok az bilgi mevcuttur" (McPherson ve Sauder, 2013, s. 167-169). Üçüncü

olarak, çalışmalar, profesyonel grupların günlük işlerini icra ederken yararlandıkları mantıklar ile bu mantıkları refleksif olarak etkileme dereceleri ve bunu yaparken profesyonel takdir yetkilerini nasıl ve ne derece kullanabildikleri konusunda yetersizdir ve bu konuda daha çok çalışmaya ihtiyaç duyulmaktadır (Goodrick ve Reay, 2011). "Çoklu mantıkların varlığı ve profesyonellerin görevlerini etkileme potansiyelinin olduğu ortamlarda, profesyonellerin takdir yetileri ile mantıklar arasındaki ilişkiyi açıklayan daha fazla çalışmaya ihtiyaç duyulmaktadır" (Goodrick ve Reay, 2011, s. 405-406).

Özetle, mikro seviyedeki aktör ve kurumsal mantık arasındaki etkileşimler kurumsal mantıkların bir bütün olarak anlaşılması açısından önemli olmasına karşın henüz yeterince çalışılmamış bir konudur (Barley, 2008; Hallett, 2010; McPherson ve Sauder, 2013; Powell ve Colyvas, 2008; Smets ve Jarzabkowski, 2013; Smets, Morris ve diğerleri, 2012; Thornton ve diğerleri, 2012). Spesifik olarak, devlet tarafından sağlık alanlarına entegre edilen uygulamaların alan seviyesindeki yansımalarına odaklanan birkaç çalışma olmasına rağmen (Özseven, Danışman ve Bingöl, 2014; Reay ve Hinings, 2005, 2009; Scott, Ruef, Mendel ve Caronna, 2000) bu girişimlerin mikro seviyedeki uygulayıcıları olan hekimler üzerindeki pratik seviyedeki olası etki ve sonuçlarının kurumsal mantıklar bağlamında irdelenmesine yönelik kapsamlı bir çalışmaya literatürde henüz rastlanmamaktadır.

Araştırma Soruları

Bu çalışma, 2003 yılında T.C. Sağlık Bakanlığı tarafından açıklanan Sağlıkta Dönüşüm Programı (SDP) ve bu programla ilintili olarak Bakanlığın 2005 yılında uygulamaya geçirdiği Performansa Dayalı Ek Ödeme Sistemi'nin (PDEÖS) mikro seviyede uygulama düzeyindeki yansımalarına odaklanmaktadır. Yüksek derecede profesyonel nosyona sahip olan hekimlerin makro seviyeden uygulama seviyesine kadar etkileri görülen bu yeni kurumsal reçeteyi nasıl anlamlandırdıkları ve ne şekilde uygulamalarına entegre ettikleri ve bu entegrasyon esnasında ne tür mantıksal oryantasyonlar geliştirdiklerinin araştırılması bu çalışmayı motive eden temel merak konusudur. Bu çalışmada, literatürde gözlemlenen boşluklar ve araştırmanın amaçları ile ilintili olarak aşağıdaki araştırma sorularına cevap aranmaktadır.

1. Hekimlerin günlük uygulamalarına hangi kurumsal mantıklar yön vermekte, ya da uygulamaları hangi kurumsal mantıklardan beslenmektedir?

2. SDP ve PDEÖS ile birlikte sağlık alanında gerçekleşmesi hedeflenen kurumsal değişimin yol açtığı kurumsal karmaşıklığı hekimler pratik seviyede hangi stratejilerden yararlanarak çözmektedirler? Bu süreçte hangi mantıksal oryantasyonlar ortaya çıkmaktadır?
3. Hekimlerin mantıksal oryantasyonları tarihsel süreçte, SDP ve PDEÖS öncesi ve sonrası (2005 öncesi ve sonrası), ne tür farklılıklar göstermektedir?

ARAŞTIRMANIN YÖNTEMİ

Araştırmanın Dizaynı

Kalitatif araştırma yaklaşımı çerçevesinde temellendirilmiş kuram dizaynı (Glaser ve Strauss, 1967; Strauss ve Corbin, 1994, 1998) benimsenmiştir. Bu dizaynın özellikleri ve araştırmaya entegre ediliş şekli aşağıda belirtilmiştir.

Literatür Taraması: Temellendirilmiş kuram yazarları arasında araştırma yapılan konuya ilişkin literatürdeki mevcut bulgular konusunda bilgi sahibi olmanın gerekliliği bakımından ayrışmalar görülmektedir. Bu yazarlara göre, literatür incelemesi aşağıdaki iki farklı yol izlenerek yapılabilecektir:

1. Literatüre ancak geliştirilen teorinin olgunlaşma aşamalarında erişim sağlanmalıdır (Glaser, 1992, 2001, 2005; Holton, 2007). Burada amaç, araştırma bulgularını salt veriye dayandırmak ve literatürdeki mevcut bulguların araştırma bulgularını "kirletmemesini" sağlamaktır (Glaser, 1978, 1998, 2005).

2. Literatüre araştırmanın tüm aşamalarında erişim sağlanmalıdır (Charmaz, 2006; Hickey, 1997; Strauss ve Corbin, 1990). Burada amaç, araştırma bulgularını veriye dayandırırken mevcut literatür konusunda da bilgisiz kalmamaktır. Bu görüşün savunucuları literatürdeki mevcut bilgilerin 'unutulmasının' mümkün olmadığını (Schreiber, 2001), araştırmacının 'teorik bir bakire' (Clarke, 2005) olmasının beklenemeyeceğini ve çığır açtığı düşünülen bir bulgunun aslında literatürde halihazırda ulaşılmış bir bulgu olabileceğini (Lempert, 2007), bu nedenle literatür konusunda hiçbir bilgiye sahip olmadan araştırmaya başlanmasının gerçekçi olmayacağını (Bryant ve Charmaz, 2007), literatür incelemesinin temellendirilmiş kuram araştırmalarında aslında bir gereklilik olduğunu (Suddaby, 2006) öne sürmüşlerdir.

Bu çalışmada, araştırmacı literatürü göz ardı etmemiş ancak literatürdeki bulguları ya da yöntemleri de mekanik bir şekilde araştırmaya entegre etmemiştir. Araştırmacı yeniliğe açık ancak mevcut bilgilere de vakıf olarak ve onları "teorik kaynaklar" (Watson, 1994, s. 215) olarak benimseyerek çalışmaya başlamış; bu bilgilerden yaratıcı ve esnek bir şekilde çalışmayı geliştirmesi amacıyla yararlanmıştır.

Amaçlı ve Teorik Örneklem: Bilgi bakımından zengin bireylere ulaşma amacı ile yapılan örneklem amaçlı (Patton, 2015), gelişen teori tarafından yönlendirilen amaçlı örneklem ise teorik örneklemdir (Coyne, 1997; Glaser, 1978). Çalışmanın ilk aşamalarında katılımcılar amaçlı örneklem metodu, araştırma sürecinde geliştirilen kategori ve temaların yeterli olgunluğa ulaşmasına müteakip ise kategorik satürasyon sağlanması ya da araştırma konusunda yeni detaylar keşfetmek odağı ile (kartopu örneklem prosedürleri kullanmak vasıtasıyla) teorik örneklem metodu benimsenmiştir.

Mülakat, Gözlem ve Doküman Verileri: Temellendirilmiş kuram çalışmalarında veri toplama, mülakat, gözlem ve doküman araştırmaları yöntemleri teker teker ya da birlikte gerçekleştirilebilmektedir. Temellendirilmiş kuram çalışmalarında araştırmanın ilk safhalarında yapılandırılmamış mülakatlar yer alırken (genel kategori ve temaların ortaya çıkarılması için), sonraki aşamalarda mülakatlar daha odaklı bir şekilde yarı-yapılandırılmış olarak devam etmektedir (Brinkman ve Kvale, 2015; Wimpenny ve Gass, 2000). Çalışmanın ilk aşamalarında araştırma soruları amaçlı bir şekilde açık uçlu olarak tasarlanmış, sonraki aşamalarda ise gelişen kategori ve temalar tarafından yönlendirilmek suretiyle daha odaklı bir şekilde belirgin konulara yönelmiştir. Mülakatların katılımcıların doğal çalışma ortamlarında gerçekleştirilmiş olması araştırmacının gözlemlerini not etmesine olanak tanımıştır ki bu gözlemler daha sonra kaydedilen memo'lara entegre edilmiştir. Araştırmacı ayrıca 1920'den günümüze kadar çıkarılan kanun, kararname, tüzük vb. belgeleri taramıştır.

Memo Notları: Memo yazımı veri analizi sırasında ya da öncesinde araştırmacının dikkatini çeken olayların ya da fikirlerin sürekli olarak not edilmesi sürecidir (Glaser, 1978) ve bu bakımdan "fikir deposu" (Strauss ve Corbin, 1998, s. 153) ya da "bankadaki entellektüel sermaye" (Clarke, 2005, s. 85) olarak tanımlanmıştır. Çalışmanın tüm aşamalarında memo notları kullanılmıştır. Bu notlar, araştırmanın entellektüel anlamda en geliştirici yönünü oluşturmuştur. Memo notları sayesinde araştırmacı olayları ya da ortaya çıkan kategori ve temaları daha net bir şekilde düzenleme ve geliştirme olanağını yakalamıştır.

Sürekli Karşılaştırma ve Teorik Satürasyon: Eldeki mevcut verilerin içerisindeki teorik kavramların tespitine müteakip ek verilerin toplanmaya devam edilmesi ile birlikte döngülü bir şekilde analizlerin gerçekleştirilmesi sonucunda teorik satürasyona ulaşılması sürecini içermektedir (Glaser, 1978, 1992; Strauss ve Corbin, 1998). Çalışmada sürekli karşılaştırma ve teorik satürasyon yöntemleri kullanılmak vasıtasıyla bir dizi veri analizinin gerçekleştirilmesi sonucunda kategoriler ve temalar damıtılmış ve net bir şekilde ortaya çıkarılabilmiştir. Bu bakımdan, araştırmacı elde edilmeye devam edilen verilerin analiz sonuçlarının öncekileri tekrar etmeye başladığını anlamasına müteakip teorik satürasyonun gerçekleştiği kanısına varmış ve veri toplama sürecini sonlandırmıştır.

Araştırma Prosedürü: Temellendirilmiş kuram araştırmacıları analiz süreçlerinde manuel analiz tekniklerini ya da bilgisayar yazılımlarını kullanmayı tercih edebilmektedirler. Ancak özellikle bilgisayar yazılımlarının kullanımı memo notları gibi aslında çok güçlü yönleri olan temellendirilmiş kuram çalışmalarının tam kapasiteli kullanımına engel teşkil edebilmekte, onu kısıtlamakta ve tümüyle bağımsız ve özgür bir teori oluşumuna karşın daha katı ve formüllerden beslenen bir sonuç ortaya çıkarmaktadır. Böylelikle araştırmacı bu yazılımların yönlendirmelerinin esiri olmakta ve bu şekilde "teknolojik tuzaklara" düşmektedir (Glaser, 1998, s. 185-186). Bu çalışmada araştırmacı, bahsi geçen teknolojik tuzaklara düşmemek (teknolojik yazılımların neden olabileceği anlam kayıplarını en aza indirebilmek), daha önceden sahip olduğu profesyonel kalitatif kodlama uzmanlığından dolayı edindiği teorik ve pratik bilgi ve deneyimlerden yararlanmak ve aynı zamanda veri ile daha kişisel bir seviyede etkileşim sağlayabilmek adına veri analizlerini manuel olarak gerçekleştirme yolunu seçmiştir.

Veri Toplama

Öncelikle 1920'den günümüze kadar devlet tarafından çıkarılan kanunlar (24), KHK'lar (2), kararnameler (3), 5 yıllık kalkınma planları (10), TBMM tutanakları (2), yönergeler (2) ve Ulusal Sağlık Politikası (1) üzerinde arşiv taraması yapılmış ve bu verilerle devletin Türk sağlık alanına iletmek istediği kurumsal mantıklar derinlemesine irdelenmiştir. İkinci olarak, en az 30 yıl hekimlik deneyimi olan 10 farklı hekimle herbiri 2 - 3.5 saat arasında değişen ve araştırmanın sağlam temellere oturması için 3'er kez tekrarlanan mülakatlar gerçekleştirilmiştir. Ayrıca yine bu amaçlara yönelik olarak sağlık politikalarında etkin olan iki farklı üst düzey devlet yetkilisi ile her biri 45-120 dakika süren görüşmeler

gerçekleştirilmiştir. Bu katılımcılara amaçlı örneklem metodu ile ulaşılmıştır. Bu 'keşifsel' mülakatlar açık uçlu olarak geliştirilen soruların araştırmaya uygunluğunu ve bu sorular vasıtasıyla elde edilen verilerin kalitesini ve yeterliliğini anlamak ve teyit etmek ve aynı zamanda pratik seviyede hekimlerin yararlandıkları kurumsal mantıkları tespit etmek ve tanımlamak konusunda bir ön çalışma yapmak amacı ile gerçekleştirilmiştir. Üçüncü olarak, Adana'daki 5 farklı devlet hastanesinde aktif görevli 54 hekime kartopu tekniği ile ulaşılmış ve yarı-yapılandırılmış mülakatlar gerçekleştirilmiştir. Bu aşamada örneklem kütlesinin sosyal anlamda farklı görüşleri yansıtabilmesi açısından yapısının nasıl olacağı konusunda karar vermek oldukça zorlu bir görev olarak ortaya çıkmıştır. Ancak bu konuda araştırmacının bazı çıkış noktaları olmuştur. Bu bakımdan hekimlerin sosyal dünyalarını yorumlama ve buna uygun davranmalarının; sahip oldukları uzmanlık alanından, cinsiyetlerinden, profesyonel deneyimlerinden ve içinde bulundukları kültürel ya da politik bağlamlardan etkilenebileceği düşünülmüştür. Araştırmada bu potansiyel faktörleri dikkate almak ve mümkün olduğunca kontrol etmek bakımından; 23 farklı branştan hekimle mülakat gerçekleştirilmiştir, erkek ve bayan katılımcılar mümkün olduğunca eşit bir şekilde temsil edilmiştir (%36 Bayan; %64 Erkek), katılımcılar sadece deneyimli hekimler arasından seçilmiştir (hekimlik deneyimleri 21-44 yıl arasındadır), kültürel ve politik bağlam kısıtını elimine etmek için katılımcı hekimler amaçlı olarak 5 farklı devlet hastanesinden seçilerek araştırmaya dahil edilmiştir.

Veri Analizi

Üç aşamalı bir kodlama stratejisi izlenmiştir. Birinci aşama ham kodların tespitini, ikinci aşama ham kodların kategoriler altında birleştirilmesini, üçüncü aşama ise kategorilerin daha soyut ve kapsayıcı temalar altında birleştirilmesini içermektedir ki bu işlemler kalitatif araştırmalar literatüründe "tema yapılandırması" olarak nitelendirilmektedir (Saldana, 2009; Strauss ve Corbin, 1998). Veri analizleri süreci beş aşamayı içermektedir. Birinci aşama, arşiv dokümanlarının taranması ve analizi vasıtasıyla Sağlık Bakanlığı'nın 1920'de kurulmasından itibaren sağlık alanının kurumsal mantıklar bakımından evriminin irdelenmesini içermektedir. İkinci aşama, hem açık uçlu soruların rafine edilmesine hem de hekimlerin pratiklerine nüfuz eden "alet çantalarındaki" (McPherson ve Sauder, s. 186; Swidler, 1986) mantıkların tespit edilmesine yönelik bir ön çalışma niteliğindedir. Üçüncü aşama, ikinci aşamada ortaya çıkan kategori ve temaların karşılaştırmalı bir şekilde analize

tabi tutulmasını içermektedir. Bu aşamada, verilerin yeni bir kategori ya da tema üretme potansiyelinin olmadığı gözlemlendiğinden satürasyona ulaşıldığı sonucuna varılmıştır ve hekimlerin rutin uygulamalarında yararlandıkları mantıklar rafine edilerek netleştirilmiştir. Dördüncü aşama tespit edilen mantıkların farklı kaynaklar vasıtası ile doğrulanma sürecini içermektedir (Miles ve Huberman, 1994). Bu aşamada, araştırmacı, elde edilen kavramsal temaları veri setine dahil olmayan 4 farklı hekimle istişare etmiştir. Ayrıca, kurumsal mantık literatürüne hakim olan akademisyenlerle de oldukça verimli görüşmeler gerçekleştirmiştir. Son olarak, tam kapsamlı olmasa da, araştırmada elde edilen veriler önceki çalışmalarda elde edilen verilerle karşılaştırılmış ve araştırmanın benzer bulguları olduğu kadar farklı yönlerinin de olduğu gözlemlenmiştir (Reay ve Hinings, 2005, 2009; Reay ve diğerleri, 2016). Beşinci aşamada ana veri seti tekrar bir dizi analize tabi tutulmuş ve tarihsel süreçte hekimlerin hangi mantıklardan beslenerek pratiklerine şekil verdikleri tespit edilmiştir. Bu aşamada, ayrıca, hekimlerin mantıklardan yararlanma dereceleri, pratiklerin bir önceki aşamada tespit edilen mantıklar ya da onların alt karakteristik özellikleri ile uyum derecelerine göre numerik rakamlarla tespit edilmiştir.

Subjektivitenin esiri olmamak için mantıkların var olup olmamaları esastır ve bu bağlamda mantıklar ya da onların karakteristik özellikleri ile uyumlu pratiklerin varlığı “1”, olmaması ise “0” olarak değerlendirilmiştir (Dey, 1993; Maxwell, 2010; McPherson ve Sauder, 2013; Sandelowski, 2000, 2001; Sandelowski ve Jones, 1996; Sandelowski, Voils ve Knafl, 2009). Her mantığın karakteristik özelliklerinin kümülatif toplamları o mantığın pratiklere nüfuz etme derecesini göstermektedir. Araştırmanın bu aşamasında, mantıkların pratiklere farklı tarihsel süreçlerdeki nüfuz etme derecelerini resmetmek amacıyla, bu genel toplamlar 1 ile 5 arasındaki bir skala üzerinden hesaplanmıştır (Goodrick ve Reay, 2011). Bu skalada “1” pratikler ile mantıklar arasındaki uyumun en düşük seviyesini ifade ederken “5” en yüksek seviyeyi ifade etmektedir. Bu analiz aşamalarının tümünde analizlerin arşiv materyali, mülakat ve gözlem verileri ve ilgili teori ile sürekli etkileşiminin ve karşılaştırmalı olarak gerçekleştirilmesinin sağlanması ana amaç olarak benimsenmiştir ki ancak bu şekilde araştırmanın güvenilirliği sağlanabilecektir (Lincoln ve Guba, 1985).

BULGULAR

Araştırmanın arşiv taraması sonuçları ilk olarak örgütsel alanda devletçi mantığın özellikle SDP ve PDEÖS öncesinde bariz şekilde etkin olduğunu ancak sonrasında ise alan seviyesinde etkisini nispeten kaybettiğini ve alanda piyasa mantığının (Aksoy, 2007) ya da onun bir türevi olan işletme-benzeri mantığın etkisinin daha fazla hissedilmeye başlandığını göstermektedir (Özseven ve diğerleri, 2014). Bunun yanında, 1953 yılında Türk Tabipler Birliği'nin de kanun marifetiyle alana entegrasyonu, Bakanlığın hekimlerin çalışmalarının etik ve fen yönünden de norm ve profesyonel değerlere uygunluğunun kontrolüne ve geliştirilmesine önem verdiğini göstermektedir. Ancak arşiv taraması sonuçları sadece "kitapta yazanı" belirtmekte, gerçek hayatta kitapta yazanların nasıl aksiyona dönüştürüldüğünün araştırılması, yani kitapta yazanın "gerçek hayattaki tercümesi" ise ancak böyle bir çalışmanın gerçekleştirilmesi ile anlaşılabilmektedir.

Verilerin analiz sonuçları hekimlerin medikal profesyonellik, devletçi, işletme-benzeri mantıkların yanında, ilginç bir şekilde, araştırmada yeni bir mantık türü olarak ortaya çıkan ve sahip olduğu karakteristik özellikler bakımından 'aykırı' olarak adlandırılan bir mantığın etkisi altında günlük rutin işlerini şekillendirdiklerini ortaya çıkarmıştır (araştırma sorusu #1 ve #2). Aykırı mantığa göre çelişen ya da çatışan mantıkların var olduğu durumlarda aktörlerin manevra alanının genişlemesi ve ortaya çıkan gri alanının sağladığı "hareket kabiliyeti" (Kitchener, 2002, s. 410) ile birlikte aktörler bu alanda birtakım kuraldışı ya da etik olmayan davranışlarda bulunabilmektedirler. Gerçekte, örgütsel davranışın büyük oranda gerçekleştiği alan işte bu gri alandır ve bu alanda kabul edilebilir ve edilmeyen davranışların sınırları net değildir ki bu muğlaklık aktörlere hareket kabiliyeti sağlamaktadır (Kitchener, 2002; Land, Loren ve Metelmann, 2014). İşte bu durumlarda, örgütsel aktörler risklerini hesapladıkları birtakım uygulamalarda bulunmaktadırlar ve bu şekilde mevcut reçeteleri ya reddetmektedirler ya da onlardan sapma davranışları göstermektedirler (Quirke, 2013) ve hatta bazı durumlarda sistemik birtakım zarar verici ya da hileli birtakım davranışlar içerisine girebilmektedirler (Land ve diğerleri, 2014). Bu davranışlar genelde aktörlerin kendi çıkarlarını gözetme eğilimleri ile uyumlu olarak ortaya çıkabilmektedir. Bu bağlamda aykırı mantık, bu kuraldışılığı gerçekleştiren "çürük elma"dan değil bu kuraldışılığı besleyen ve "çürük bahçeyi" üreten sistemsel ve sistematik bir süreçten kaynaklanmaktadır.

Aykırı mantığa göre aktörler mevcut kurumsal reçeteleri reddederek kendi çıkarları ile uyumlu reçeteler ve bu reçetelerle uyumlu pratikler geliştirmektedirler. Bu reçete ve pratiklerin etki ve boyutları aktörlerin işlerin organizasyonu ve yapılma süreçlerindeki otonomileri ve yetkileri arttıkça daha da artabilmektedir (Quirke, 2013). Hekimlerin işlerinin içerik ve organizasyonunda tam ve kesin yetki ve otonomiye sahip oldukları bilinmektedir (Friedson, 2001; Reay ve Hinings, 2005, 2009; Thornton ve diğerleri, 2012). Çalışmada, kendi uzmanlık alanlarında mutlak hakimiyet ve otonomiye sahip olan ve bu özelliklerden faydalanan hekimlerin sağlık hizmetlerinin içerik ve sunumunda kendi maddi çıkarlarını gözetmeye yönelik birtakım pratikler geliştirdikleri gözlemlenmiş ve bu amaçla uyguladıkları pratiklerinin aykırı mantığın karakteristik özellikleri ile uyumlu olduğu düşünülmüştür. Bu bulgular farklı alanlarda daha önce gerçekleştirilen çalışmalardaki bulgularla örtüşmektedir. Buna göre:

> "Doktorlar da insandır … Hiç kimse doktorların şeytana uymanın cazibesine kapılarak kendi çıkarlarını hastalarının çıkarlarının önüne koymasına şaşırmamalıdır … kendi şahsi çıkarları doğrultusunda davranma güdüsü hekimlerin 'hasta ihtiyaçları önceliklidir' ideal düşüncesini yaşatmasını çok güç hale getirebilmektedir" (Light ve Hughes, 2001; Sulmasy, 1992, s. 922).

Yapılan arşiv analizlerinde mantıkların irdelenen dönemler (SDP ve PDEÖS öncesi [Era 1] ve sonrası [Era 2]) bakımından ayrıldığı noktanın 2005 yılı olduğu tespit edilmiştir. 2005 yılı PDEÖS'un efektif bir şekilde yürürlüğe konmasına yönelik kanun ve kararnamelerin çıkarıldığı yıldır ve aynı zamanda bu yıldan itibaren kamu hastanelerinin işletmeleştirilmesine yönelik programlar kanunlaştırılmaya başlanmıştır. Analizlerde edilen bulgular hekimlerin her iki dönemde de çoklu ve çelişen mantıkların etkisi altında pratiklerini geliştirdiklerini göstermektedir (araştırma sorusu #3). Ancak dikkat çekici bir bulgu, hekimlerin her iki dönemde de aykırı mantığın yoğun olarak etkisi altında pratiklerini şekillendirdiklerini göstermektedir. Öyle ki her iki dönemde de aykırı mantık baskın olarak gözlenmiştir. Araştırmada ayrıca iki farklı mantık kümelenmesi gözlemlenmiştir. Era 1'de en baskın mantık olarak aykırı mantık ortaya çıkmış medikal profesyonellik ile devletçi mantığın ise oldukça düşük etkiye sahip olduğu gözlemlenmiştir. Bu dönemde işletme-benzeri mantığın herhangi bir etkisi gözlemlenmemiştir. Era 2'de yine en baskın mantık olarak aykırı mantık ortaya çıkmış ve hatta aykırı mantığın hekimlerin bilişsel yapılarını ve ilgili pratiklerini daha güçlü bir şekilde etkilemeye başladığı gözlemlenmiştir. Medikal

profesyonellik ve devletçi mantıkların etkisi çarpıcı bir şekilde azalmış, ancak hekimlerin mantıksal alet çantalarına, düşük düzeyli etkisi de olsa, işletme-benzeri mantık girmiştir.

SONUÇ

Bu çalışma, mikro seviyedeki aktörlerin, alet çantalarındaki mantıklardan çoklu kurumsal mantıkların etkisi altında nasıl esnek bir biçimde yararlandıklarını resmetmektedir. Bunun yanında, mikro düzeydeki aktörlerin, nasıl ustalıkla ve amaçlı bir şekilde kendi uzmanlıklarını ve otonomilerini kullanarak mevcut kurumsal kısıtların dışına çıkabildiklerini ve kendi çıkarlarına hizmet eden aykırı bir mantık geliştirdiklerini ortaya çıkarmaktadır. Araştırmanın kurumsal teori yazını, kurumsal mantıklar perspektifi ve sağlık politikası süreçleri bakımından öne çıkan bir takım belirgin sonuçları olduğu düşünülmektedir. Araştırmanın kurumsal kuram yazını bakımından sonuçları profesyonellik ve aktörlerin kurumsal kısıtları yönetebilme yetileri ile ilgilidir.

Kurumsallaşma teorisyenlerine göre, örgütsel hayatta profesyonel grupların üyeleri görevlerini iyi niyetle yapmaktadırlar; diğer bir bakış açısı ile, profesyonelleşmenin, örgütlerde hem astların hem de üstlerin iyi niyetle davranmaları konusunda bağlayıcı bir rolü vardır (Meyer ve Rowan, 1977, s. 358; Powell ve DiMaggio, 1991). Benzer şekilde profesyonellik literatürüne göre, "Profesyonel meslekler kendilerine has profesyonel değer ya da yükümlülükler üretmektedirler ki bu değer ve yükümlülükler … onlara iyi ve kötünün ne olduğunu bildirmekte … bireylerin profesyonel bir kimlik, davranış ve pratikler geliştirmelerini sağlayarak … onları disipline edici bir *mantık* görevi görmektedirler" (Evetts, 2012, s. 5; Friedson, 2001). Araştırmada profesyonelliğin iyi niyetli davranma ya da üyelerini disipline etme konusunda bağlayıcı bir yönünün olmadığı gözlemlenmiştir.

Kurumsal teorinin ilk öncülerine göre örgütsel aktörlerin kurumsal kısıtları manipüle etme ya da değiştirme konusunda herhangi bir rolü ya da etkisi yoktur (DiMaggio ve Powell, 1983; Meyer ve Rowan, 1977; Tolbert ve Zucker, 1983). Ancak, teoriye, kurumsal mantık perspektifi bağlamında daha sonraki dönemlerde katkıda bulunanlar, aktörlerin kurumsal kısıtları sınırlı bir oranda da olsa manipüle etmeye muktedir olabileceklerini ortaya koymuşlardır (Besharov ve Smith, 2014; Oliver, 1991; Seo ve Creed, 2002; Smets ve diğerleri, 2014; Thornton, 2004; Thornton ve Ocasio, 2008). Ancak bu araştırma, yüksek derecede profesyonelleşmiş olan hekimlerin, kurumsal kısıtlar bakımından, hiç ya da sınırlı değil; oldukça yüksek düzeyde bir serbestiye sahip olduklarını ortaya koymuştur.

Araştırmanın kurumsal mantık yazını bakımından sonuçları, kurumsal teoriye yönelik sonuçları gibi, oldukça şaşırtıcıdır. Mevcut kurumsal mantık literatürü, örgütsel alana yeni bir mantık girişi olduğunda, mevcut mantıklar ve yeni mantık arasında rekabet yaşanacağını, ancak sonuçta bir mantığın galip geleceğini öne sürmektedir (Hensmans, 2003; Hoffman, 1999; Lounsbury, 2002; Thornton ve diğerleri, 2005). Araştırma, alana yeni giren işletme-benzeri mantığın, hekimlerin mevcut mantıksal oryantasyonlarını nispeten düşük düzeyde etkilediğini, önceki kurumsal mantık ya da mantıkların etkisinin azalmakla birlikte kaybolmadığını, hekimlerin ilginç bir şekilde tarihsel süreçte geliştirdikleri aykırı mantığa daha yüksek oranda bağlılık göstermeye devam ettiğini göstermektedir. Ayrıca, kurumsal mantık araştırmacıları, herhangi bir profesyonel gruba üye olan bireylerin o profesyonel grubun kendi öz mantığına bağlılık göstereceğini öne sürmektedir (Battilana ve Dorado, 2010; Ferlie, Montgomery ve Pedersen, 2016; Greenwood ve diğerleri, 2002; McPherson ve Sauder, 2013). Araştırmada, yüksek derecede profesyonel nosyona sahip olduğu düşünülen hekimlerin (Friedson, 2001; Reay ve Hinings, 2005, 2009; Reay ve diğerleri, 2016; Thornton ve diğerleri, 2012), kendi öz mantıklarına (medikal profesyonellik) çok düşük düzeyde bağlılık gösterdiklerini ortaya çıkarmıştır.

Araştırmanın literatüre olan katkısının yanında, sağlık politikası geliştirme süreçlerine olabilecek muhtemel katkıları da dikkat çekicidir. Araştırma sonuçları, sağlık alanında pratik düzeydeki kurumsal mantıkları ortaya koyarak, bir tarafta Sağlık Bakanlığı'nın politika düzenleme konusunda yararlandığı sosyal, ekonomik ve politik perspektiflerin, diğer tarafta ise bireysel düzeyde insan unsuru ve bu unsurun dinamiklerinin anlaşılmasına katkı sağlamıştır. Araştırma bulguları, mikro düzeydeki aktörlerin makro seviyeden mikro seviyeye entegre edilen girişimler ile ilgili uygulamaları ne şekilde benimsediklerini ortaya koymaktadır. Bu çalışma, hekimlerin kendilerinden beklenen davranışları gerçekleştirmekten kaçındıklarını, bu davranışlara aykırı olan ve kendi ekonomik çıkarlarını tatmin etmeye yönelik yeni bir iş yapma anlayışı geliştirdiklerini ortaya çıkarmaktadır. Buna göre, hekimler, devlet tarafından açıklanan sağlık programlarının reçetelerinin varlığında bile, kendi iş yapma süreçlerini belirleyebilmektedir.

Bu çalışma, sadece çoklu kurumsal mantıkların etkisine maruz kalan mikro seviyedeki aktörlerin nasıl, ne şekilde ve ne derecede alet çantalarındaki mevcut mantıklardan kendi amaçlarına uygun şekilde yararlandıklarını ortaya koymakla kalmayıp, ayrıca kendi kontrol alanlarındaki mutlak otonomi ve mesleki imtiyaz ve sırlarını kullanmak vasıtasıyla,

uygulama seviyesindeki aktörlerin nasıl, ne şekilde ve ne derecede kendi ekonomik çıkarlarını tatmin etmeye yönelik pratikler geliştirdiklerini ve bu pratiklerin hangi kurumsal mantığın uzantıları olduğunu açıklayarak kurama ve uygulamaya yönelik özgün katkılar sağlamaktadır.

Sonuç olarak, bu çalışmanın yazarı, kalitatif araştırmalar çerçevesinde benimsenen, oldukça sağlam ve güvenilir metodolojik yöntemler içeren bu temellendirilmiş kuram çalışması vasıtasıyla ulaşılan, gerçek hayatta örgütlerin arka planında süregelen ancak genelde açığa çıkmayan, mikro seviye uygulamaları ve onların mantıksal uzantılarını ortaya koyan bu özgün bulguların, kurumsal teoriye ve kurumsal mantık perspektifine katkı sağlayacağını düşünmektedir.

ACKNOWLEDGEMENTS

To begin, I would like to state that while this dissertation has only one author, there are several people who have provided assistance, guidance and support throughout its development process. From the beginning of my doctoral coursework, and up to now, I have truly enjoyed the tremendous support and contributions by academics, healthcare professionals, and most importantly my family. Each has contributed to the culmination of this dissertation in many unique and special ways.

I would first like to thank my Committee Chair and Supervisor, Prof. Dr. Ali Danışman, for his guidance, recommendations and mentoring throughout the development of my dissertation. I am also indebted to Dr. Miraç Savaş Turhan and Dr. İlksun Didem Ülbeği for the valuable discussions we have had regarding the contents and results of my dissertation as well as their constant encouragement and advice on how to navigate the sometimes perilous waters of the Ph.D. journey.

Thank you mom and my beloved sister, Selma Daniels, for motivating me and for always looking forward to my success. I am truly grateful to my mom for her daily prayers and for the words of encouragement not to give up; I am blessed to have her with me at all times.

I have reserved most special thanks to those who have stood beside me during this entire process; my dear family: my wife, Nur, my older son, Efe, and my younger son, Mert. Thanks beyond description belong to my understanding immediate family, to whom this dissertation is dedicated, who have patiently and unwaveringly provided me with support, love and strength at the cost of a great deal of sacrifice out of their lives. Most dear thanks and love go to my other half, Nur, as she has been an extraordinary life partner, a mom, an educator, a companion and on top of all that, an excellent proofreader; in sum, my everything, though I may not have articulated these thoughts well enough to her most times. Thank you a million times for raising and taking great care of our younger son, who was born in the middle of my Ph.D. education, and our older son, who is only a 3rd grader, while I had to be frequently away from home to complete my education and dissertation. To my children, Efe and Mert, to whom I will hopefully instill a love of learning: Dad is back home and thank you very much for the sacrifice and allowing me the opportunity, and finally, for those times having to raise yourselves while I was gone: You have truly done an awesome job!

TABLE OF CONTENTS

ABSTRACT iv
ÖZET v
GENİŞLETİLMİŞ ÖZET vi
ACKNOWLEDGEMENTS xix
ACRONYMS AND ABBREVIATIONS xxii
LIST OF TABLES xxiii
LIST OF FIGURES xxiv

CHAPTER I
INTRODUCTION

1.1. Research Problem and Justification 1
1.2. Aims and Research Questions 8
1.3. Importance of Research and Expected Contributions 10
1.4. Structure of Dissertation 17

CHAPTER II
THEORETICAL FRAMEWORK

2.1. Institutional Theory and Institutional Analysis 20
2.2. Paradoxes Identified in Institutional Theory and Institutional Analysis 26
2.2.1. Legitimacy versus Efficiency 27
2.2.2. Isomorphism versus Divergent Interests of Various Constituencies 28
2.2.3. Structural Embeddedness versus Agency and Interests 30
2.3. Institutional Logics Perspective 31
2.3.1. Institutional Complexity in the Face of Multiple Institutional Logics 34
2.3.2. Institutional Complexities at Micro Level 37
2.3.3. Micro-level Instantiations of Institutional Logics in Healthcare Field: Research Questions 40

CHAPTER III

HEALTHCARE FIELD IN TURKEY

3.1. Restructration and Organization Period, 1920-1960 44
3.2. Socialization and Diffusion Period, 1960-1980..... 51
3.3. Liberalization Transition Period, 1980-2002..... 57
3.4. Radical Liberalization Period, 2002-Present 63

CHAPTER IV

METHODOLOGY

4.1. Research Approach..... 76
4.1. Data Collection 95
4.1. Data Analysis..... 101

CHAPTER V

PRESENTATION OF EMPIRICAL FINDINGS

5.1. Nature and Characteristics of Logics Enacted at the Coalface..... 124
5.1. Change in Ground-level Logics..... 168

CHAPTER VI

DISCUSSION, IMPLICATONS AND CONCLUSION

6.1. Discussion..... 178
6.2. Implications for Institutional Logics Theory 183
6.3. Implications for Policy Development..... 187
6.4. Conclusion 193
REFERENCES 197
APPENDIX: EVOLUTION OF INTERVIEW QUESTIONS..... 226
CIRRICULUM VITAE 234

ACRONYMS AND ABBREVIATIONS

HTP – Healthcare Transformation Program

IAW – In Accordance With

IMF – International Monetary Fund

MoH – Ministry of Health

NHP – National Health Policy

OECD – Organization for Economic Co-operation and Development

PBSPS – Performance-based Supplementary Payment System

PPQCU – Province Performance and Quality Coordinating Unit

TIBA – Turkish Industrialists' and Businessmen's Association

TIIBA – Turkey's Independent Industrialists' and Businessmen's Association

TPA – Turkish Physicians Association

TRMH – Turkish Republic of Ministry of Health

TUCCET – The Union of Chambers and Commodity Exchanges of Turkey

WB – World Bank

WHO – World Health Organization

LIST OF TABLES

Page

Table 1. *Healthcare-specific Laws Enacted Spanning 1924-1960* 46
Table 2. *Healthcare-specific Laws Enacted Spanning 1960-1980* 53
Table 3. *Healthcare-specific Laws Enacted Spanning 1980-2002* 59
Table 4. *Healthcare-specific Laws Enacted Spanning 2002-Present* 64
Table 5. *The Growth of the Number of Government and Private Hospitals in Turkey (2000-2013)* 73
Table 6. *Institutional Logics and Their Associated Characteristics at Practice Level in Turkish Healthcare* 164
Table 7. *Strength of Logic Characteristics' Influence by Respective Eras* 175
Table 8. *Average Strength of Institutional Logics' Influence by Respective Eras* 175

LIST OF FIGURES

Page

Figure 1. Evolution of Institutional Theory and Institutional Analysis on the Basis of Level of Analyses (shaded) 22
Figure 2. Five-Year Development Plan Realization Process 72
Figure 3. Memo on Preliminary Understanding of Cognitive Bases for Physicians Practices 90
Figure 4. Memo on Cognitive Bases for Physicians Practices 91
Figure 5. A Streamlined Codes-to-Theory Model for Qualitative Inquiry 103
Figure 6. Illustration of Coding Process: Orientation Toward Medicine 106
Figure 7. Illustration of Coding Process: Orientation Toward Business Principles 109
Figure 8. Illustration of Coding Process: Orientation Toward Bureaucratic System 112
Figure 9. Illustration of Coding Process: Orientation Toward Interest Maximization 114
Figure 10. Participants' Logical Orientations in Era 1 171
Figure 11. Participants Logical Orientations in Era 2 172
Figure 12. Display of Logic Trends by Respective Eras 176

CHAPTER I

INTRODUCTION

1.1. Research Problem and Justification

Organizations are often confronted with various compelling demands and challenges generated and imposed by the institutional environment within the organizational field in which they are embedded (Greenwood, Raynard, Kodeih, & Micelotta, 2011; Pache & Santos, 2010). In order to cope with these contingencies, organizations must continually respond to multiple institutional demands by formulating strategic responses and striving to adapt to those contingencies, but their ability to do so is environmentally (Hannan & Freeman, 1977, 1984), and institutionally constrained (DiMaggio & Powell, 1991; Jepperson, 1991; Scott, 2001; Zucker, 1977). The environment, in the sense of institutions, is not solely regarded as a contingency-production mechanism, to which organizations must continuously adapt (as population ecology theorists suggest; see Hannan & Freeman, 1977, 1984), but rather as a socially constructed "source of meanings for the members of organizations" (Silverman, 1971, s. 19) which crafts and grooms the organizational (Scott, 2001) and/or individual decision making processes (Suddaby, Elsbach, Greenwood, Meyer, & Zilber, 2010). While responding to those institutional phenomena, organizations are heavily influenced by their "internal dynamics" (Greenwood & Hinings, 1996) as well as demands posed by their external constituencies (Thomas & Meyer, 1984; Zucker, 1977) existing in the organizational field simultaneously.

Institutional theory concerns itself with the dynamic relationships between the organizational field forces and organizational structures or organizational actors' behaviors enacted in response to those external complexities. In other words, institutional theory mainly seeks to explain organizations' or organizational actors' "impetus for action" (Zucker, 1987, s. 445) in response to external institutional pressure coming from outside the organization. Studies of institutional theory generally fall into three different, but interrelated, categories of domain: societal (macro), organizational field level (meso) and organizational level (micro). Societal-level studies of institutional theory (Meyer & Rowan,

1977; Parsons, 1956; Selznick, 1949, 1957, 1996) emphasize how institutional elements function to "integrate organizations with other organizations in society through universalistic rules, contracts and authority" (Thornton & Ocasio, 2008) and how they constitute "the more enduring features of social life" (Giddens, 1984, p. 24; also articulated in Hughes, 1936, p. 180). Embedded in highly institutionalized contexts, organizations are driven to incorporate the practices and procedures defined by prevailing rationalized concepts of organizational work and institutionalized rules in society to gain legitimacy, resources, stability, and enhanced survival prospects, independent of the immediate efficacy of the acquired practices and procedures (Meyer & Rowan, 1977). On the other hand, organizational field level studies (DiMaggio & Powell, 1983, 1991), questioning how the prevailing rationalized concepts of organizational work (i.e., myths and ceremonies) come into existence and whose interests they serve, delve more into the interrelationships between the organizational field and the isomorphic inclinations of the field inhabitants based on the influence of organizational elites (key organizational actors) and power relationships. Finally, the last and a relatively more recent approach in institutionalism focuses on micro-level processes as sources for institutional continuity and change (Battilana & Dorado, 2010; Currie & Spyridonitis, 2015; Dacin, Munir, & Tracey, 2010; Goodrick & Reay, 2011; Heaphy, 2013; Jarzabkowski, Le, & Van de Ven, 2013; Lok & De Rond, 2013; McPherson & Sauder, 2013; Pache & Santos, 2013; Reay, Goodrick, Waldorff, & Casebeer, 2016; Smets, Jarzabkowski, Burke & Spee, 2014; Smets, Morris & Greenwood, 2012). In this new stream of research, however, "the focus is no longer on isomorphism, whether in the world system, society, or organizational fields, but on the effects of differentiated institutional logics on individuals and organizations in a larger variety of contexts, including markets, industries, and populations of organizational forms" (Thornton & Ocasio, 2008, p. 100).

Along with the new focus on micro-level processes, two interrelated paradigm shifts are recently noticed in the study of institutions. First, it is clearly seen in recent studies that scholarly attention has moved from institutional stability (Berger & Luckmann, 1967; DiMaggio & Powell, 1983; Giddens, 1984; Jepperson, 1991; Meyer & Rowan, 1977; Tolbert, 1985; Tolbert & Zucker, 1983; Zucker, 1977, 1987) to institutional change (DiMaggio & Powell, 1991; Greenwood & Hinings, 1993; Greenwood, Suddaby, & Hinings, 2002; Hoffman, 1999; Scott, Ruef, Mendel, & Caronna, 2000; Suddaby & Greenwood,

2005). Increase of research exploring micro-level dynamics/responses impacting macro level institutional phenomena points out another paradigmal shift in exploration of institutional change. While a number of institutional theorists directed their theory and research on macro-level effects of institutions or institutional logics on meso- or micro-level phenomena (Friedland & Alford, 1991; Meyer & Rowan, 1977; Thornton, 2004; Thornton & Ocasio, 1999; Thornton, Ocasio, & Lounsbury, 2012), more research has recently concentrated on organizations striving to cope with multiplicity of institutional logics at the micro level (Battilana & Dorado, 2010; Currie & Spyridonitis, 2015; Dunn & Jones, 2010; Kodeih & Greenwood, 2014; McPherson & Sauder, 2013; Pache & Santos, 2013; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012), which greatly contributes to what we know and how we can better appreciate the dynamics of organizational actors' interactions with their institutional context.

As these paradigm shifts also suggests, it is commonly-agreed upon that research in macro-level analysis of institutions provide useful theoretical insights, but the overemphasis on macro-level dynamics move scholarly attention far beyond grasping the underlying dynamics of how those macro-level phenomena are generated, maintained or re-formulated at the micro-level (Suddaby, 2010). In this respect, the field's appreciation of the institutional dynamics at the organizational level is still quite limited (Powell & Colyvas, 2008; Suddaby, 2010) and we need to "better connect the relation between institutional processes and organizational characteristics so as to understand why an organization responds as it does to institutional stimuli" (Scott, 2001, p. 212). Most studies exploring organizational or field level responses to institutional phenomena report patterns of various types of responses; however, they do not delve into why those responses occur the way they do, specifically in terms of "how institutions operate through the influence and agency of individuals" (Suddaby, 2010, s. 17). In other words, which conditions allow actors to act (Battilana & D'Aunno, 2009) or which stimulants play a role in the generation of those actions still need further exploration (Greenwood et al., 2011). This gap is important to address in order to account for the micro foundations of various organizational forms and activities (Greenwood & Hinings, 1996; Hirsch & Lounsbury, 1997b; Pache & Santos, 2010; Powell & Colyvas, 2008; Raaijmakers, Vermeulen, Meeus, & Zietsma, 2015).

In an effort to respond to these calls from the institutional logics perspective, a line of research concentrated on identifying the influence of logics on the daily activities and practices of ground level actors. One of these studies was carried out in a professional service firm by Smets et al. (2012), in which authors explained how the two distinct practice-level logics; namely, fiduciary and client service, through improvisation, were blended at the ground-level to result in a hybridized practice which later resulted in a shift in the field-level logic. Another study was conducted in the justice system by McPherson and Sauder (2013), in which it was found that criminal punishment, rehabilitation, community accountability and efficiency logics were enacted by ground-level professionals with different professional orientations toward negotiation of decisions, ultimately emphasizing discretionary instantiation of available logics in an agentic fashion. The study performed in the healthcare system by Goodrick and Reay (2011) depicted how competitive and coexisting logics allowed for simultaneous influence of multiple logics on professionals' work through constellations of professional, market, corporate and state logics over time.

A companion line of work has also developed, offering a lens through which to view how logics become incorporated and are instantiated at the ground level following a government-led re-composition of a field. These studies were executed with the understanding that it is specifically important to understand how organizations, professionals, and other actors deal with, when they choose to take action on, and what strategies they enact (McPherson & Sauder, 2013) under the influence of broader-scale institutional changes, which subject organizations and organizational actors to face conflicting demands, such as those catalyzed by the passage of regulatory acts, as not much focus was directed toward analyzing if or how organizational variety emerged and was sustained in mainly government-mandated organizational fields (Marquis & Lounsbury, 2007; Raaijmakers et al., 2015; Reay & Hinings, 2009; Schneiberg & Bartley, 2001) such as healthcare (Greenwood et al., 2011). In an effort to address this gap, studies conducted in healthcare fields, recently undergoing policy-driven healthcare reforms, either concentrated on power and politics pervading organizations and importance of social positions of interdependent actors in reinterpretation and blending of professional and policy-driven managerial logics (Currie & Spyridonitis, 2015), or focused on how change of collective professional identity of social actors occurred

through their interactions with multiple actors by means of re-constellation of professional, market, corporate and state logics (Reay et al., 2016).

Two issues come to the fore following close evaluation of the research performed to date regarding practice-level interpretations and instantiations of logics at the intra-organizational level. First, the two non-healthcare studies conducted by McPherson and Sauder (2013) and Smets and colleagues (2012) delved into and reflected the negotiation and subsequent enactment of ground-level activities and practices of the organizational social actors as they related to others with same or different professions, and with the exception of the study undertaken by Goodrick and Reay (2011), the other studies performed in the health sector mainly focused on ground-level power relationships and dynamics of identity change with relation to institutional logics and did not explore how "social actors translate[d] logics into action as they engage[d] in everyday organizational work" (McPherson & Sauder, 2013, p. 166). The study undertaken by Goodrick and Reay (2011) attempted to accomplish this task on the work of the pharmacists in the U.S., but relied solely on historical archival data regarding pharmacists in the U.S., and not on daily experiences and practices of the ground-level actors, and if or how they were influenced by logics. Second, studies conducted to date are observed to be limited in scope in terms of fully depicting the belief systems and associated practices (Friedland & Alford, 1991) in doing or performing their daily activities (Smets et al., 2012) and do not provide granularity in terms of micro-level institutional logics and their sub-characteristics as they relate to healthcare, and more specifically to physicians in their daily work performances. To provide accounts from the healthcare perspective is important as healthcare organizations encompass institutional complexity characterized by multiple belief systems and associated practices (Currie & Spyridonitis, 2015; Greenwood et al., 2011; Scott et al., 2000) mainly occasioned by reform initiatives catalyzed by the government (Currie & Spyridonitis, 2015; Reay & Hinings, 2005, 2009) that places organizational actors in a situation in which they need to continuously combine, reconfigure and manipulate logics (McPherson & Sauder, 2013).

In order to address these gaps and thus to contribute to a growing body of institutional logics literature, this research concentrates on the healthcare field in Turkey, as it has recently gone through a comprehensive transformation process, implemented and enforced by the 58th, 59th and the 60th governments of Republic of Turkey (Aksoy, 2007; Özseven,

Danışman, & Bingöl, 2014). In line with the increased "corporatization" of public healthcare throughout the world (Goodrick & Reay, 2011; Light, 2000; Salmon, 1987), in 2003, the Turkish Republic of Ministry of Health (TRMH) announced the implementation of a new initiative, named 'Healthcare Transformation Program (HTP) in Turkey,' which entailed, effectively as of 2005, enforcement of a 'Performance-based Supplementary Payment System (PBSPS),' all of which were primarily geared toward injection of a "business-like healthcare logic" into a healthcare field believed to have long characterized by a deep-rooted "public service logic" (Özseven et al., 2014).

The fact that government interferes with the working dynamics of the health system brings about the issues of whether government intrusion will be successful in mobilizing the "clumsy enterprise" (Turkish Republic Ministry of Health, 2008, s. 35), in other words, enhance its effectiveness and efficiency (Arrow, 1963) or cause a downward spiral effect in the quality, effectiveness and efficiency of healthcare system (Schansberg, 2014; Shmanske, 1996) in the Turkish context. The TRMH's new outlook on healthcare policies is characterized by a combination of social, economic and policy making perspectives (Turkish Republic Ministry of Health, 2008); however, it is posited in this study that viewing any type of government initiative without taking into account the organizational theory, or more narrowly institutional logics theory, will hinder policy makers' ability to realize all of the key factors likely to have a potential in impacting the desired outcomes. "A more informed understanding could help policy makers interpret the forces shaping behaviors in settings as varied as *hospitals*, schools, and corporations—and thus help them to devise and implement more appropriate regulations" (Greenwood et al., 2011, p. 319, emphasis added). Taken together, it is postulated in this study that the current controversial state of the Turkish healthcare system can be informatively clarified through investigation of the micro-level dynamics of Turkish healthcare from the perspective of institutional logics theory.

The aforementioned organizational and organizational level changes recently experienced in the predominantly government-led healthcare field make it a fruitful area for institutional research for two reasons. This new government initiative creates logic multiplicity, by introduction of business principles (i.e., effectiveness, efficiency, profitability and customer service) into a domain which presumably was characterized by public service logics (Özseven et al., 2014), the fact of which clearly affects how the work is to be organized and

performed at the micro level. Second, prompt infusion of the new organizational field level actor, namely, Province Performance and Quality Coordinating Unit (PPQCU), meant that the already-established healthcare organizational field was being radically restructured, and that the "common enterprise" (DiMaggio & Powell, 1983, s. 148) was altered in a significant way, which required micro-level actors to absorb or perform in accordance with the new structural changes and to eventually alter their way of doing business in line with the new prescriptions or guidelines of the PPQCU.

Overall, during the span of this study, it is clearly reflected that the Turkish healthcare organizations represent a setting characterized by sustained intrusion of business principles, public service principles and increased regulatory control, resulting in heterogeneity of prescriptions healthcare professionals continually experience, confront and manage in their daily operations. Out of these healthcare professionals, specifically, physicians receive intense socialization, orientation and education in the field of medicine and are known to hold complete autonomy and control over the content and organization of their work (Friedson, 2001; Thornton et al., 2012) and thus initiatives to change their views on how their work should be accomplished are seldom successful (Currie & Spyridonitis, 2015; Reay & Hinings, 2005). It is observed in this study that physicians who are intensely socialized within certain professional norms, principles and values are as well required by government to operate within business and government principles. In such cases where there is enhanced regulatory control, competition and contradiction between logics are likely to be pronounced (Nigam & Ocasio, 2010; Scott et al., 2000), and the physicians in the Turkish healthcare context are presumed to be situated between a rock and a hard place in feeling, interpreting and managing the incompatibilites arising from the multiplicities of logics.

With its main objective being explaining the influence of the effects of higher level social orders on the daily activities of a highly-professionalized group (i.e., physicians), this research proves to be rather distinctive in that it aims to provide a high level of granularity in terms of the degree and strength of which logics and their sub-elements are 'in action' at the coalface of physician's daily work experiences. Such a study delving into how physicians decode or transfer broader level cognitive and normative orders into everyday practice (i.e., providing healthcare) is sorely missing in the institutional logics literature and this study is thus among the first explaining this phenomenon. By means of exploration of this

phenomenon, this study responds to calls stating (1) “more work is needed to unpack how local actors mediate institutional demands and the requirements of day-to-day organizational activity” (McPherson & Sauder, 2013, s. 166; for similar calls, see also Barley, 2008; Hallett, 2010; Powell & Colyvas, 2008; Smets et al., 2012; Thornton et al., 2012), and (2) more research “illuminating the relationship between agency and logics when multiple logics exist and hold potential to influence professional work … is certainly warranted” (Goodrick & Reay, 2011, pp. 405-406).

1.2. Aims and Research Questions

This research adopts a multilevel perspective that simultaneously examines the institutional and organizational context (Fox-Wolfgrannm, Boal, & Hunt, 1998) in the Turkish healthcare field, upon which a policy-led change, mainly driven by contending institutional logics, was implemented, and primarily concentrates on the interrelationships between intra-organizational dynamics of organizations and the institutional context affecting change. It seeks to explore whether or how organizational actors at the micro level experience the effects of the new institutional prescriptions they are faced with, and whether or how or to what extent those new prescriptions are materialized in their daily practices.

Selection of the Turkish healthcare system as a grounded theory study for this research has a number of advantages as it has gone through a major healthcare transformation phase, which radically changed the structure of the field and redesigned the way of how key organizational actors should operate. Typically, when established structures and/or logics of fields change in such a profound fashion, organizational actors strive to protect their interests by trying to purposely stick to the already-established practices that favor the status quo (Battilana, Leca, & Boxenbaum, 2009). In organizational contexts, change is seldom accepted without resistance, because it is a process, not an event (Burke, 2002; Connor & Lake, 1994). Attempting to change the already-established way of doing businesses radically through infusion of a new logic may be problematic, as any type of change, whether it is regarding altering the organizing principles or way of doing business in a field or a single organization, is inherently and inescapably a “human process” (Duck, 2001, s. 9). Just as institutions are “ongoing human productions” (Berger & Luckmann, 1967, s. 52) which constrain and/or “shape human interaction” (North, 1990, p. 3), organizations and

organizational fields, in essence, are products of humans or human processes as well, and individuals typically resist any potential change to commonly-shared, taken-for-granted basic assumptions (DiMaggio & Powell, 1991; Hirsch & Lounsbury, 1997b) or to the way they do things (March & Olsen, 2010). Change is, then, a processual and progressive phenomenon, and is greatly affected by cognitive human processes. In this regard, though there exist some studies attempting to explicate field level change in terms of negotiations and contests over which logic should dominate (Suddaby & Greenwood, 2005), innovative action (Jay, 2013), rhetorical strategies (Brown, Ainsworth, & Grant, 2012), role of emotions (Gilmore & Sillince, 2014; Voronov & Vince, 2012), characteristics of the organizational field (Battilana et al., 2009), actors' position in a field (Battilana et al,. 2009; Lounsbury, 2001; Phillips, Lawrence, & Hardy, 2004), role identity movements (Rao, Monin, & Durand, 2003) and professional projects (Suddaby & Viale, 2011), how change occurs through cognitive processes resulting in creation, diffusion, stabilization and maintenance of institutions (Powell & Colyvas, 2008) and the role of actors and action in this entire process still need further exploration (Battilana et al., 2009) specifically at practice level (McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013; Smets et al., 2012).

In this respect, understanding whether or not or how micro-level actors of organizations being subjected to logic multiplicity attempt to satisfy the conflicting demands these multiple logics carry with them or in some way incorporate these heterogeneous prescriptions into their daily practices becomes very important to elicit whether, and to what extent, these actors have cognitively incorporated the new way of doing business into their practices in the processes of adoption.

In line with this thought process, this research examines the micro-level dynamics of the institutional context in the Turkish healthcare field, upon which change, mainly driven by contending institutional logics, was introduced by the TRMH, and primarily concentrates on whether or how micro-level actors are affected by these changes and, in turn, reflect those changes in their daily practices. Such regulatory changes are known to disturb the socially-constructed consensus on methods of doing work and instigate introduction of new ideas or practices (Child, Lua, & Tsai, 2007; Fligstein, 2001; Greenwood et al., 2002). It is thus important to understand implications of these revolutionary policy-driven initiatives for the

ground-level actors and their practices as they perform their daily assignments. Accordingly, the below research questions guided this study:

1. How do logics become manifest and take on tangible qualities at the individual level of analysis? In other words, how are logics enacted or actualized in day-to-day organizational activity? Also related to this question is which institutional logics are available to ground level actors in everyday practice?
2. What types of practice pattern(s), if any, guided by certain institutional logics (i.e., processes of logic blending, replacement, segregation, segmenting, bridging, cooperation, hijacking, or practice improvisation as suggested by the imprinting literature), emerge during institutional change processes?
3. Do government policy initiatives or interventions implemented in an institutional context change or influence ground level actors' logical orientations? In other words, do ground level actors' logical orientations change over a period of institutional change processes?

1.3. Importance of Research and Expected Contributions

In line with the new redirected focus of institutional research into micro-level dynamics of institutional frames and their enactments or invocations at the ground level, several studies have been conducted to date, evaluating the nature of interpretations and instantiations of various institutional templates at the coalface through the useful and practical lens of institutional logics perspective (e.g., Currie & Spyridonitis, 2015; Goodrick & Reay, 2011; McPherson & Sauder, 2013; Reay et al., 2016; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012). While striving to probe into the these micro-level sources of organizational phenomena, institutional logics perspective aims toward understanding the intra-organizational dynamics eliciting individual and group organizational behavior. This particular line of research has evolved around investigating 'why individuals or groups of individuals behave the way they do?' or more broadly, 'which factors affect individual and group behavior?' With the emergence of institutional logics perspective (Friedland & Alford, 1991; Thornton & Ocasio, 1999, 2008), the line of institutional research has come to accept that in order to appreciate and appropriately interpret macro-level phenomena, its underlying

micro-level sources “where the processes of institutionalization play themselves out” (Bacharach, Bamberger, & Sonnenstuhl, 1996) must be thoroughly investigated.

In this vein, this research investigates the nature of micro-level instantiations of logics in the Turkish health context, into which ‘a new way of thinking and doing’ was infused through a government initiative as of 2005. This new government initiative involved infusion of a business-like healthcare logic into the Turkish healthcare field, which was presumed to have long characterized by public service logics (Aksoy, 2007; Özseven et al., 2014). This government-led pluralization and thus recomposition of logics brings about the need to highlight two main issues: First, this initiative causes the healthcare organizational field to experience re-structuration (i.e., reconfiguration of the common enterprise) involving inclusion of a new field-level actor (PPQCU), which radically restructured the already-established Turkish healthcare field, in other words, the “common enterprise” (DiMaggio & Powell, 1983, s. 148), requiring physicians to absorb and perform in accordance with the new structural changes and to eventually reevaluate and possibly alter the way they perform their daily work in line with the prescriptions of this new field actor, and second, it requires a cognitive change supporting the restructuring initiative on the part of the physicians as they carry out their daily routine. It has been shown that “the federal government routinely designates industry standards for an entire field which require adoption” (DiMaggio & Powell, 1983, s. 155) and regulative and normative changes move an organizational field from one cognitive frame to another (Hoffman, 1997; Reay & Hinings, 2005; Scott et al., 2000). In the Turkish healthcare government-led recompositioning case, the government implemented structural changes, which were radical and occurred at a revolutionary pace (Greenwood & Hinings, 1996; Reay & Hinings, 2005). It is not clearly known, however, whether the associated cognitive changes have occurred in the organizational-level actors’ view of the new healthcare delivery design introduced by the government. Whether or how those two competing logics identified by previous researchers, or possible existence of others which may be at odds among themselves or with others, are enacted at the practice level has not comprehensively been studied in the Turkish healthcare organizations to date.

The limited number of studies performed in the Turkish medical field show that there is indeed a departure from the deeply-established public service logics characterizing the Turkish medical field to a more business-minded logic. For instance, Özseven et al. (2014)

reported that, what they defined as ‘public service logic’ and ‘business-like logic’ simultaneously existed in the Turkish medical field, though they also realized that business-like logic was getting more and more predominant. In another study performed in the Turkish medical field, Aksoy (2007) investigated the mediating role of the Turkish Medical Association in the government-led institutional transformation period, and found that the dominant logics of the field transitioned from “societal” to “market,” in which medical treatment facilities revised their way of doing business with a change from a public service orientation to a more business-minded orientation. The results of the two studies reflect parallelism in that both show that the Turkish medical field has been going through a transformation phase, involving a move from a societal-based public healthcare service logic to a business-like healthcare logic, regardless of the perspective of various dominant actors (i.e., professional associations, policy makers, medical professionals). These studies valuably inform us of the presumable transitioning of the field from its deeply-established modes to more neo-liberal modes, and of ‘what’ occurred as a result of this transformation initiative, providing field level accounts using the lens of institutional logic perspective. What is yet to be explained, however, is ‘whether’ or ‘how’ this transitioning has indeed materialized in terms of the nature of invocations or enactments of the logics by the dominant organizational actors (in this case, physicians) at the ground level. Without understanding the ground-level dynamics of the transition as they relate to “what happens deep inside the organizations” (Whittington, 2006, p. 617), it is not possible to get a full grasp of the entire transformation process, or, if applicable, the likelihood of the sustainability of the current ‘transformed’ stage of the process. A thorough investigation of the degree of permeability of the desired business principles into the ground level production of work from the institutional logics perspective will provide government officials with the information necessary to reevaluate the current stage of the transformation process. “A more informed understanding could help policy makers interpret the forces shaping behaviors in … hospitals … and thus help them to devise and implement more appropriate regulations” (Greenwood et al., 2011, p. 319).

Thus, in order to contribute to a growing body of institutional logics literature, it is important to study the nature of organizational actors’ day-to-day practices using the lens of institutional logics perspective in terms of which logic(s) they draw from to structure their

decision making in selecting which practices to pursue when they face, or have to deal with, inconsistent or conflicting institutional templates. Previous work shows that actors' cognition and decision-making may be conditioned by influences of pluralities and inconsistencies of logics to varying degrees. It thus carries a great deal of importance to find out (1) whether key organizational actors battle for logics' dominance eventually resulting in prevailing logic achieving dominance whereas failing logics ceasing to be relevant (Garud, Jain, & Kumaraswamy, 2002; Hensmans, 2003; Hoffman, 1999; Lounsbury, 2002; Rao et al., 2003; Thornton, Jones, & Kury, 2005), (2) whether organizations or organizational level actors pretend to comply cosmetically, but continue to stick to their deeply-espoused logics (Broek, Boselie, & Paauwe, 2014; Khan, Munir, & Willmott, 2007; Townley, 2002) which are in line with practical and technical considerations (Meyer & Rowan, 1977), the practice of which is referred to as "decoupling" (Bromley & Powell, 2012; Tilcsik, 2010; Westphal & Zajac, 2001), (3) whether organizational actors, while preserving their independence, collaborate with the governmental entities toward achievement of a desired outcome (Beech & Huxham, 2003; Reay & Hinings, 2009), (4) whether they allow co-existence of those logics (Dunn & Jones, 2010; Glynn & Lounsbury, 2005; Lounsbury, 2007; Reay & Hinings, 2009; Smets et al., 2014) by means of selective coupling (Pache & Santos, 2013), (5) whether they reinterpret or rearrange logics (Goodrick & Reay, 2011; Reay et al., 2016), (6) whether they simply acquiesce (Oliver C. , 1991) to or (7) radically deviate from (Quirke, 2013) the newly-introduced logic(s). Accordingly, the findings of this study will have a great potential to be important in many fashions to both the institutional logics theory literature and to the key actors of the healthcare organizational field in Turkey. The main projected contributions of this study are stated below.

Expected contributions to institutional logics literature:

1. The findings of this study will provide empirical evidence about the important implications of intra-organizational dynamics on institutional logics, or vice versa, invoked, enacted or represented at the organization level. By means of investigation of this phenomenon, this study responds to calls stating (1) "more work is needed to unpack how local actors mediate institutional demands and the requirements of day-to-day organizational activity" (McPherson & Sauder, 2013, s. 166; for similar calls,

see also Barley, 2008; Hallett, 2010; Powell & Colyvas, 2008; Smets et al., 2012; Thornton et al., 2012), and (2) more research "illuminating the relationship between agency and logics when multiple logics exist and hold potential to influence professional work … is certainly warranted" (Goodrick & Reay, 2011, pp. 405-406).

2. It will contribute to the body of institutional logics literature in terms of macro-level processes impacting micro-level phenomena, and will thus have responded to calls for research bridging those two levels of analyses (Greenwood & Hinings, 1996; Greenwood et al., 2011; Hirsch & Lounsbury, 1997a; Kaghan & Lounsbury, 2011; Lawrence, Suddaby, & Leca, 2009; Raaijmakers et al., 2015), by means of investigating into the "closer connections between what goes on deep inside organizations and broader phenomena outside" (Whittington, 2006, p. 617).

3. It will address the dynamic relationships between the actor and the structure (Delbridge & Edwards, 2013; Heugens & Lander, 2009) in the healthcare field. Human agency is defined as "individuals competing and negotiating, organizations in conflict and coordination, and institutions in contradiction and interdependence" (Friedland & Alford, 1991, s. 240-241). Structures (including institutional logics [Delbridge & Edwards, 2013]) are referred to as "rules, resources or sets of transformation relations, organized as properties of social systems" (Giddens, 1984, s. 24) and they serve as generative mechanisms that give rise to action (Delbridge & Edwards, 2013). Structure thus should be understood as the "institutional system" or "social structure" of a society (Tang, 2011, p. 5). Exploring the relationships between these two phenomena is important, because understanding micro-level instantiations of institutional logics under the influence of institutional pressures requires a dual focus on both agency and structure in order to avoid the limitations of over and under-socialized perspectives (Granovetter, 1985). This dual focus, however, require proper attention to be paid to the fact that (1) organizations are complex in that they are made up of different functional departments, geographic units, subgroups and interest groups and thus are not unitary entities (Fligstein, 1985; Greenwood, Oliver, Sahlin, & Suddaby, 2008; Hinings & Greenwood, 1988; Pache & Santos, 2010), hence organizations' members may perceive and react differently to institutional pressures

(Scott, 2001) and (2) human actors do not create structures from nothing; they reproduce and transform them (Archer, 1995; Emirbayer, 1996), and they generally reflect on their social circumstance through these processes (Archer, 2003). Institutional complexity of organizations, driven by the existence of heterogeneity of institutional prescriptions, coupled with the complexity of human agency renders micro-level invocations of institutional logics even more problematic, requiring a better conceptualization of these relationships, more specifically in terms of the impact of agency and human action in this relationship (Powell & Colyvas, 2008; Seo & Creed, 2002).

4. This study will also prove beneficial in eliciting whether organizational actors effectively conform to, or deviate from, institutional templates at the micro-level. Empirically indicating "the circumstances under which an appeal to institutional logic can be put to strategic use" under the influences of government mandates will significantly contribute to existing explanations of the role of institutional logics literature in accounting for change (Townley, 1997, s. 280).

Expected contributions to government policy-making efforts:

1. The findings of this dissertation will assist policy makers, or government officials, in having a better understanding of why institutional logics perspective along with economics, politics, sociology, organizational psychology is crucially important when attempting to implement any field level changes enacted from a broader level (i.e., government). In relation to understanding the dynamics of healthcare (i.e., workings of the system), economics approach advocates the dominance of free market principles (Aggarwal & Bohinc, 2014; Herzlinger, 1999; Shmanske, 1996; Tinh & O'Connor, 2000), politics approach focuses on the decision-making processes (Mechanic, 1991; Tuohy, 1988), sociology approach emphasizes training, knowledge and professional socialization (Town, Wholey, Kralewski, & Dowd, 2004), psychology approach stresses motivational aspects (Shortell & Kaluzny, 2006; Wynia, 2009) whereas institutional logics theory points out the importance of institutional constituents (i.e., markets, government, family, religions, corporation,

professions and community [Thornton et al., 2012]) and logics (i.e., vocabularies of motives or guiding principles [Friedland & Alford, 1991; Scott, 2001]), which constrain and at the same time enable institutional actors' maneuvering capabilities when they face increased levels of logic multiplicity (Giddens, 1993; Granovetter, 1985; Hodgson, 2006; Holm, 1995; Scott, 2001; Seo & Creed, 2002; Suddaby & Greenwood, 2005). Previous research showed that policy-making and/or development efforts are indeed influenced by institutional logics (Bastedo, 2009). Thus, it is posited here that in order to fully appreciate and have an all-encompassing view of the workings of the healthcare system and the forces shaping the behaviors of the healthcare professionals, and thus to assist policy-makers' in developing and implementing well-informed policies, an institutional approach will prove significantly beneficial (Greenwood et al., 2011).

2. It will contribute to the understanding of whether or how influential actors at organizational level (i.e., physicians) interpret and/or materialize newly prescribed institutional prescriptions resulting from government-led healthcare reform initiatives in their daily work. From the perspective of institutional logics theory, new regulations are only one aspect of the broader institutional environment that affects organizations and their members (Matten & Moon, 2008). The institutional logics perspective, by design, accounts for multiple societal sectors shaping the cognitions and behaviors of various actors, such as markets, government, family, religions, corporation, professions and community (Thornton et al., 2012). "Individuals are not free-floating atoms outside the social context" (Pedersen, Neergard, Pedersen, & Gwozdz, 2013); they actively shape the institutions (i.e., rules, norms, values, routines, habits, traditions) while being constrained by them (Granovetter, 1985; Holm, 1995; Seo & Creed, 2002). In this manner, empirically eliciting whether physicians functioning under the concomitant influences of various institutional templates generate and enact practices line with the rules and standards set forth by the government because they regard themselves as public servants will prove beneficial. In other words, elucidating, in relation to the newly-prescribed way of doing business by the government, whether they simply acquiesce (Oliver C., 1991) or reflect isomorphic behaviors (DiMaggio & Powell, 1983) or continue to have their

own well-ordered sets of interests and preferences resulting in unique sets of practices that remain largely unchanged by the effects of those institutional prescriptions (Townley, 1997) will provide valuable insights.

3. By means of investigating the micro-level enactments or invocations of inconsistent and/or contradictory templates by physicians at organizational level within institutional logics context, this study will facilitate appreciation of whether these political decisions have the ability of generating desired outcomes. In order for a successful practice adoption, the associated cognitive changes in the actors' view toward these new practices must be achieved. Alteration or reconfiguration of existing institutional logics through regulative changes typically moves an organization from one cognitive frame to another (Hoffman, 1997; Reay & Hinings, 2005). Besides regulative forces, culture, institutions, and social relations also influence actors' cognition and actions in important and often unconscious ways (Battilana et al., 2009). Understanding adoption of government-led initiatives at the organizational level requires a broader view incorporating all institutional factors impacting the adoption. In this manner, institutional logics theory will provide a better understanding in terms of not only *whether* organizational actors adopt, but *how* they adopt (Westphal, Gulati, & Shortell, 1997, emphasis added). This study will attempt to reflect whether physicians, who actually put logics in practice, have successfully gone through a cognitive reframing in line with the government policies introduced to the Turkish health system.

1.4. Structure of Dissertation

This dissertation consists of six chapters and is organized in the following manner: Chapter I provides an introduction to the research undertaken, research problem statement and justification, importance of research and how and in what way the findings of this dissertation will contribute to institutional logics literature by providing ground level perspectives and insights of actors who actually transform logics into action using a micro-level lens as well as to policy-makers by means of analyzing the belief systems and associated practices adopted and enacted by the actors at the coalface in everyday

organizational life, which will, so this study posits, assist them in their endeavors to devise better informed context-specific policies and regulations.

Chapter II introduces the theoretical basis of the dissertation and aims to provide a thorough discussion about the evolution of institutional theory, paradoxes identified within the theory and the subsequent emerging of institutional logics perspective. It then delves further into micro-level implications of institutional logics at the organization level such as complexities multiple logics brings with them and how they may affect the practices of ground level actors across various different institutional contexts. It thereafter focuses specifically on ground-level influences of multiple logics on healthcare organizations and how ground level actors make sense of, translate, transform into action, and thereby cope with the inconsistencies and contradictions of these logics may bring with them at the ground level. Here, the focus is on enactments or invocations of logics at the ground level from different healthcare contexts to gain a good grasp of the findings of prior studies, which have already been reached in this area of research, to better inform this dissertation. Following the theoretical insights gained from the in-depth analysis of the extant institutional logics literature, existing gaps in micro-level studies of institutional logics literature motivating this dissertation are identified.

Chapter III describes the research setting in terms of its historical, political as well as institutional evolution. It also provides a detailed account of evolution of healthcare in Turkey by citing each and every significant healthcare-relevant law, regulation, policy and memorandum etc. issued by the main actor, the government. It then identifies specific periods in which government takes similar or different routes in regulating or guiding the healthcare system in Turkey. Following in-depth review of the healthcare context and its associated complexities driven by policy-led change efforts (i.e., healthcare transformation reform), this dissertation also identifies institutional implications of these efforts on the individual actors in terms of the institutional logics these change efforts attempt to communicate.

Chapter IV contains description of methodology of research and general design of the study. In this chapter, procedures for collecting data, explanation of qualitative nature of research design, specific tenets of grounded theory and data analysis protocol and procedures are discussed.

Chapter V analyzes the data obtained by the study and presents the empirical findings in relation to the research questions posed in the beginning of this dissertation.

Chapter VI addresses theoretical implications of the research findings as well as concluding remarks. This chapter is wrapped up with summary of results and conclusions.

CHAPTER II

THEORETICAL FRAMEWORK

2.1. Institutional Theory and Institutional Analysis

To understand institutional theory, one would need to review its historical pathways to see how it progressively evolved from its inception to the present. Institutional theory is thought to have originated with the works of Selznick (1949, 1957), expanded by (Meyer & Rowan, 1977), re-directed by (DiMaggio & Powell, 1983), and finally, significantly enriched with the early contributions, has taken a revised direction by coming back to its roots with the introduction of institutional logics perspective (Friedland & Alford, 1991) as a sub-theory (Thornton & Ocasio, 2008). The evolution of the institutional theory and institutional analysis specifically in terms of changes in the level of analyses is illustrated in Figure 1.

The early developments of institutional theory viewed organizations as an economy (a system of functional and technical relationships which define the availability of scarce resources open to manipulation in terms of efficiency and effectiveness) and at the same time an adaptive social structure (accommodating internal interests and adapting to outside forces) (Selznick, 1948). Organizations are organic unities having a concrete structure, characterized as cooperative systems, which require leadership efforts to administer controls and win the support (i.e., consent) of the individuals (Selznick, 1948), and they are viewed as "technical instruments, designed as means to definite goals … and are expendable" (Selznick, 1957, p. 22). Institutions, however, are the 'natural' history-bound dimensions of organizations and "are products of interaction and adaptation; they become the receptacles of group idealism; they are less readily expendable" (Selznick, 1957, p. 22). When organizations, functional or technical structures, or processes come to symbolize the community's aspirations, its sense of identity, they become value-infused, "acquire a character structure, a distinctive identity," and thus are 'institutionalized' (Selznick, 1957, 1996; Scott, 2001, p. 24). More clearly defined:

> Institutionalization is a process. It is something that happens to an organization over time, reflecting the organization's own distinctive history, the people who have been in it, the groups it

> embodies and the vested interests they have created, and the way it has adapted to its environment (Selznick, 1957, p. 18).

According to Selznick, because organizations are unitary and cooperative social systems, characterized by natural harmony and consensus, goals or procedures tend to achieve an established, value-impregnated status; in other words, they are institutionalized (1948, 1949). The goals and structure of the organization are the locus of rationality, and organizational goals, structures or practices change through organization's natural and unplanned adaptive change efforts as a response to external forces (Selznick, 1957). Social action and societal processes, however, are separate from the logic of organizational structure and policies, except as irrational constraints on the achievement of the formally rational goals of the organization (Colignon, 1999). Effective leaders holding powerful positions are the embodiment of human agency; they are able to define and defend the organization's institutional values by "formulating a systematic promulgation of ideas or ideology to define the character of the organization, to circumscribe and shape the outlook of employees, who may have divergent self-interests, and to placate its institutional environment" (Colignon, 1999, p. 6; Scott, 2001). In this early stream of institutional research, "issues of influence, power and informal structures, coalitions, and competing values were central, and the emphasis was placed on the ways in which the formal, rational mission of an organization is diverted by the operation of group interests … and the individual organization is the locus of institutionalization and the primary unit of analysis" (Greenwood & Hinings, 1996, s. 1022-1031).

Neoinstitutional theory is believed to have originated with the works of two seminal papers, "Institutionalized organizations: Formal structure as myth and ceremony" (by John W. Meyer and Brian Rowan) and "The role of institutionalization in cultural persistence" (by Lynne G. Zucker) (DiMaggio & Powell, 1991, p. 11; Scott, 2001, p. 42). In this approach, as opposed to the earlier structural-functional views suggest, "Organizations are not simply the product of increasing technical sophistication … or even of increasingly complex relational patterns; they also result from the increasing rationalization of cultural rules that provide an independent basis for their construction" (Scott, 2001, p. 43).

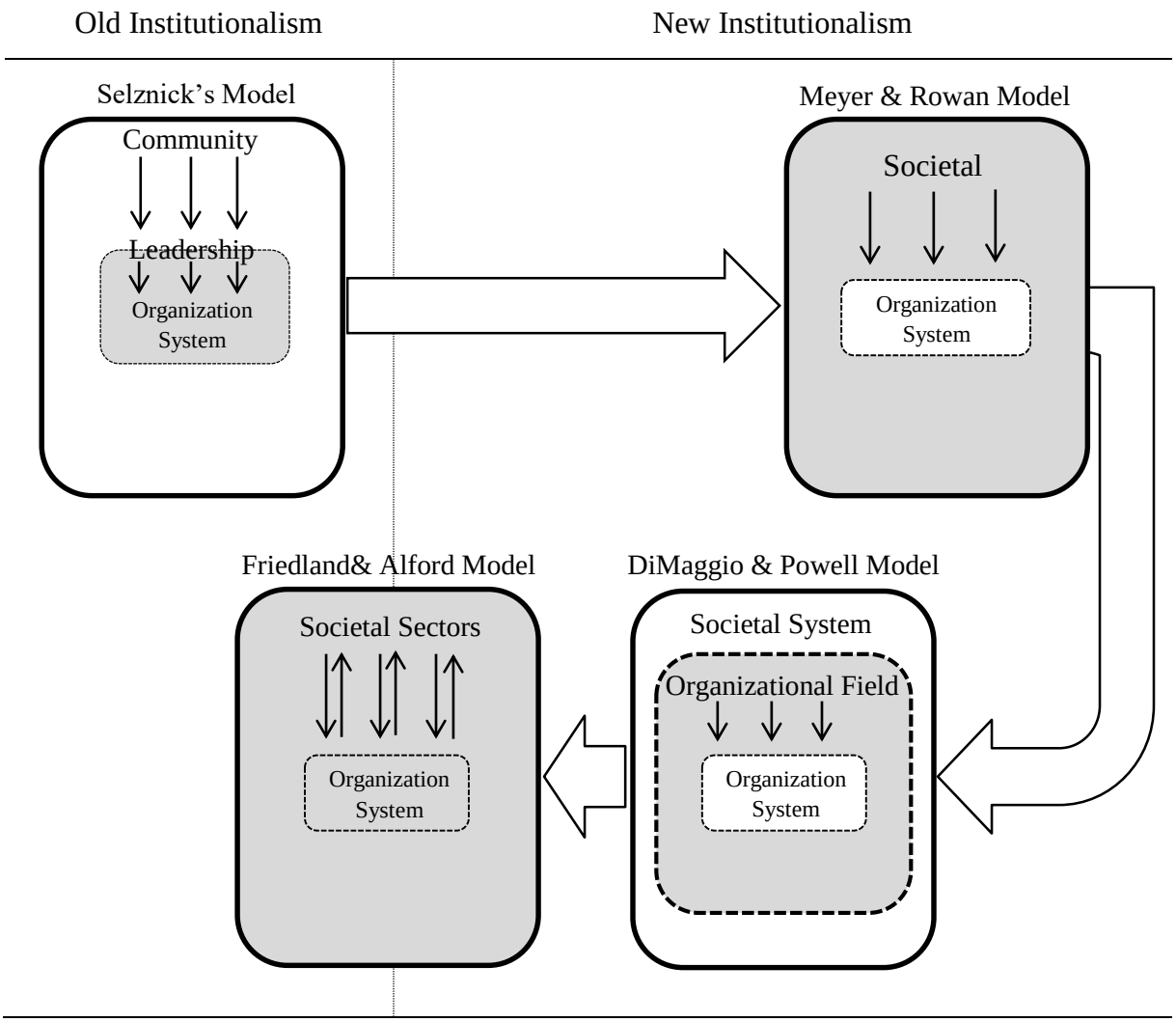


Figure 1. Evolution of Institutional Theory and Institutional Analysis on the Basis of Level of Analyses (shaded)

In this new stream of research, Meyer and Rowan (1977, p. 340-341) objected to the earlier theorization of functional-structural views, and purported that "formal structures arise as reflections of rationalized institutional rules … formal structures of many organizations … dramatically reflect the myths of their institutional environment." Here, the focus is on the societal forces, into which these institutional rules are built "as reciprocated typifications or interpretations" (Berger & Luckmann, 1967, s. 54), and on the separation of, and the gap between, the formal organizational structure and the organizational routines. Organizations are "driven to incorporate the practices and procedures defined by the prevailing rationalized concepts of organizational work and institutionalized in the society … to increase their

legitimacy and survival prospects, independent of the immediate efficacy of the acquired practices and procedures" (Meyer & Rowan, 1977, p. 340).

The three main themes of this line of research are: (1) the elements of formal organizational structures such as positions, policies, programs and procedures are manifestations of powerful institutional rules, (2) organizations become isomorphic with their environments (in line with other powerful organizations' structures and relations), and (3) organizations are loosely-coupled (actual day-to-day activities do not necessarily match organizational pre-defined structure, policies and procedures). As Meyer and Rowan (1977) posit, organizations are presumed to act on these premises to increase their legitimacy and survival prospects, to ensure uninterrupted access to required resources and to maintain stability.

In their ground-breaking article, DiMaggio and Powell (1983) furthered the work of Meyer and Rowan (1977) in terms of homogeneity of organizational structures, practices and procedures from a lower level of analysis, organizational field, pointing out to the shortcomings of their approach regarding how myths and ceremony models arise and whose interests they serve, and concluded that directing attention to organizational fields could provide explanations for these gaps. According to these authors, organizational fields, typically comprised of "key suppliers, resource and product customers, regulatory agencies, and other organizations that produce similar services or products … only exist to the extent they are institutionally defined" (DiMaggio & Powell, 1983, p. 148). Institutional definition occurs out of structuration through "increase in the extent of interaction," "emergence of sharply defined inter-organizational structures of domination and patterns of coalition," "increase in the information load," and the "mutual awareness of among participants that they are involved in a common enterprise" (DiMaggio & Powell, 1983, p. 148). At the early stages of the establishment of organizational field, there may be some diversity in the approach and form of the field inhabitants, but once an organizational field is well established, there is an inexorable push toward homogenization, which occurs through mechanisms of coercive (resulting from a government mandate or direct authority relationships), mimetic (resulting from goal ambiguity or environmental uncertainty) and normative isomorphism (resulting from professionalization through formal education and professional networks) (DiMaggio & Powell, 1983). According to these researchers,

institutional isomorphism can and will add a much needed perspective on the political struggle for organizational power through examination of the diffusion of similar organizational strategies, structures, policies, procedures, practices and processes and on the role of organizational elites and their interests in channeling these isomorphic changes. Although DiMaggio and Powell's (1983) work is an extension of, and complementary to, the work of Meyer and Rowan (1977), some of the differences between the two approaches need to be noted. While Meyer and Rowan emphasize rationalization of concepts of organizational work and institutional rules in the society, DiMaggio and Powell analyze these phenomena at the organizational field level, the fact of which moves the attention to a lower level of analysis, from macro- (societal) to meso-level (organizational field). Another divergence is about the redirection of focus from the definition of rationalization to workings of rationalization. While Meyer and Rowan define and stress the importance of myths and ceremony in rationalization, DiMaggio and Powell offer three isomorphic mechanisms to explain *how* institutional rules become rationalized and diffused. Lastly, while DiMaggio and Powell emphasize the crucial role of organizational elites in shaping the course of an institution, defining the appropriate models of organizational structure and policy, this very important topic is not on the agenda of Meyer and Rowan in their efforts to define rationalization occurring at the societal level.

The concept of institutional logics was introduced as another perspective to the field of institutional theory and institutional analyses with the work of Friedland & Alford (1991). As opposed to the previous institutional perspectives of Meyer and Rowan (1977) and DiMaggio and Powell (1983) which posit a unilateral source of rationalization (world system or society, or organizational fields), institutional logics approach acknowledges multilateral sources of rationalization in which multiple contending logics of different 'societal sectors,' such as capitalist markets, industries, corporations, professions, states, democracy, families and religions (Friedland & Alford, 1991; Thornton & Ocasio, 1999, 2008; Thornton et al., 2012) are existent and interrelated. Additionally, with its focus being solely on actions of individual and organizational actors, the institutional logics approach provides a bridge between the macro-level societal perspectives of Meyer and Rowan and the meso-level organizational field perspectives of DiMaggio and Powell (Thornton & Ocasio, 2008). In this approach, rather than isomorphism, the emphasis is put on understanding individual and

organizational behavior within an institutional context, which both constrains and also provides opportunities for human agency and change (Thornton & Ocasio, 2008). Consequently, the main question this perspective asks is how do "institutions, through their underlying logics of action, shape heterogeneity, stability and change in individuals and organizations?" (Thornton & Ocasio, 2008, p. 103).

The main assumption of the institutional logics approach is that "the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics" (Thornton & Ocasio, 2008, p. 103). Contrary to the previous two perspectives of institutionalization privileging structuration by either the societal system or the organization field and not attending to how rationalization of institutional rules come into being, institutional logics perspective provides a cross-level analysis amongst individuals, organizations and institutions by taking into consideration the fact that institutions are themselves human products, "or more precisely, an ongoing human production" (Berger & Luckmann, 1967, p. 52). Institutions, defined as "humanly devised constraints that shape human interaction" (North, 1990, p. 3), in this view, are generated, maintained, replaced or revised by human action. This process, however, occurs through the 'collective identity' of social groups, which is established through members' sharing of mutual and ongoing social communications, interactions and cooperation amongst each other (White, 1992). Thus, institutional logics perspective concentrates on the mutual relationship between individuals and institutions in providing explanations for institutional heterogeneity, complexity, stability and change. With its renewed focus on embedded agency (Seo & Creed, 2002) and collective identity (Polleta & Jasper, 2001), the focus of institutional theory and institutional analysis have taken a redirection toward its roots, in which Selznick (1949, 1957) stressed that organizations became value-infused, and thus acquired a distinct identity, and powerful leaders possessed the ability to define and defend specific institutional values (i.e., agency).

As it is clearly noticed in the way the two streams of theory proceeds, they are becoming closer to each other in terms of their arguments (i.e., rationalization of institutional rules through internal organizational dynamics such as organizational identity, power and interests; in other words, micro-foundations of institutional theory affecting macro-level institutional dynamics), and levels of analyses (i.e., focus initially being on the organizational value-infusion and then on the world system/society, subsequently on organizational field

and finally back on internal organizational dynamics eliciting collective responses to institutions, whereby influencing their underlying logics toward stability, revision, change or coexistence). These convergent developments, resulting in coming together of the old and new institutionalism, are recently easily recognized in the approaches of many analysts (Scott, 1994), some of whom are exerting considerable effort to bridge these two ostensibly distinct perspectives (Greenwood & Hinings, 1996; Oliver C. , 1992).

2.2. Paradoxes Identified in Institutional Theory and Institutional Analysis

Overall, institutional theory is generally viewed as a theory explaining similarity, stability and legitimacy of organizations and organizational arrangements, and it is mainly predicated on the premise that taken-for-granted rules, practices and applications organizations commonly adopt over time are the produced, revised and maintained by the institutional context (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Meyer, Scott, & Deal, 1983; Zucker, 1983). In this respect, institutional context provides scripts, prescriptions or "templates for organizing" (DiMaggio & Powell, 1991, p. 27) around which organizations converge (Greenwood & Hinings, 1996). Institutional context generates binding institutional templates for its inhabitants consisting of all relevant or interlocking organizations in the production of a product or service, such as suppliers, financiers, regulatory agencies, professional associations and leading organizations (Greenwood & Hinings, 1996; Scott & Meyer, 1991). Institutional contexts, or "societal sectors" (Scott & Meyer, 1991), are deemed to be tightly-coupled in that they "are perceived as having clearly legitimated organizational templates and highly articulated mechanisms (i.e., the state, professional associations, regulatory agencies, leading organizations) for transmitting those templates to organizations within the given sector" (Greenwood & Hinings, 1996, p. 1029).

According to early institutional scholars, institutional context is "characterized by the elaboration of rules and requirements to which individual organization must conform if they are to receive support and legitimacy" (Scott & Meyer, 1991, p. 123). In order to increase their survival prospects, organizations must accommodate institutional expectations, even if conformance may not increase chances of achieving enhanced technical efficiency or performance accomplishment (D'Aunno, Sutton, & Price, 1991; DiMaggio & Powell, 1991; Meyer & Rowan, 1977). The more organizations conform or become isomorphic to the

structuration of the fields, the more these fields impose constraints on individual or organizational agency, which in turn reduces variability in policies and structures of organizations in a given field (Hoffman & Ventresca, 2002). Organizational action, in this view, is regarded not as a result of carefully-crafted internal formulations, but rather as a choice among a limited menu of options made available by the actors of the organizational fields (Scott, 1991).

More recent contributors, specifically the proponents of the institutional logics perspective, however, posit that individual and organizational actors have some hand in shaping and changing institutions (Besharov & Smith, 2014; Oliver C., 1991; Seo & Creed, 2002; Smets et al., 2014; Thornton, 2004; Thornton & Ocasio, 2008; Thornton et al., 2012). While early institutionalists emphasize and advocate the prevalence of stability and inertia in organizational arrangements (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Tolbert, 1985), others maintain that overemphasis on inertia may be slightly misleading because "organizations constantly experience unfolding change" (Greenwood & Hinings, 1996, p. 1027). Thus, institutional theory in and of itself "presents a paradox" (DiMaggio & Powell, 1991, p. 1) and the contributing factors to this paradox require specific elaboration in the following subsections: 'legitimacy versus efficiency,' 'isomorphism versus divergent interests of various constituencies,' and 'structural embeddedness versus agency and interests.'

2.2.1. Legitimacy versus Efficiency

Organizations strive to become efficient in their operations for their economic interests and at the same time work toward gaining legitimacy in the eyes of their stakeholders for social acceptance. This dual focus at times presents a paradox for organizations to overcome. Organizations find themselves between a rock and a hard place when trying to accommodate both interests. Efficiency requirements drive organizations to arrange their operations around "the technical requirements of the task at hand" (Selznick, 1996, p. 2), while legitimacy pressures, at times, force organizations to move their attention away from focusing on input-process-output considerations. The questions organizations must find an answer to then become, should we be focusing on *what works* for us, or *what is expected* of us? In an effort to create a fine balance between the call of these, at times two competing demands,

organizations innovatively and at times manipulatively find ways toward appeasing the origins of those demands.

According to institutional theory literature, the mostly-pursued mechanism through which organizations strike this balance is by means of decoupling (Meyer & Rowan, 1977; Tilcsik, 2010; Westphal & Zajac, 1994), though other 'strategic' responses are also reported to be commonly utilized (see for instance Oliver C., 1991; Smets et al., 2014). Decoupling is referred to as a "process through which organizations separate their normative and prescriptive structures from their operational structures" (Pache & Santos, 2013, p. 974), enabling "organizations to maintain standardized, legitimating, formal structures while their activities vary in response to practical considerations" (Meyer & Rowan, 1977, p. 357). Organizations typically decouple their structures by allowing for some cosmetic changes on the surface systems, signaling external publics that the institutional practices are 'at work,' while, at the same time, protecting their core strategies, programs and procedures (Scott, 2001). Another response strategy, as defined by Pache and Santos (2013, p. 973) is selective coupling, which involves organizations' combining competing logics in a systematic fashion in order to manage "the incompatibility between logics and thus reduce the risks and costs of alternative practice-level strategies."

The main issue residing at the heart of the legitimacy-efficiency debate is whether the various strategies employed by the organizations are long-term sustainable. Some scholars are in agreement that decoupling strategies may not provide optimal solutions in the long run because the context in which these strategies are adopted dynamically change, rendering these strategies irrelevant and thus suboptimal over time, or intra-organizational coalitions may emerge supporting different logics, making it difficult to maintain a sustainable balance between the normative and operational structures (Pache & Santos, 2013; Seo & Creed, 2002). Unsustainable decoupling in this case may bring about the issue of dynamic coupling, which denotes fluidly enacting practices prescribed by opposing logics as intra- and extra-organizational contextual requirements combined dictate.

2.2.2. Isomorphism versus Divergent Interests of Various Constituencies

One of the presumptions of institutional theory is that organizations become more and more similar due to their technical, exchange (Meyer & Rowan, 1977) and societal

interdependencies. Isomorphism "forces one unit in a population to resemble other units that face the same set of environmental conditions" (DiMaggio & Powell, 1983, p. 149). "Independent of their productive efficiency, organizations which exist in highly elaborated institutional environments and succeed in becoming isomorphic with these environments gain the legitimacy and resources needed to survive" (Meyer & Rowan, 1977, p. 352), because essentially, "organizations compete not just for resources and customers, but for political power and institutional legitimacy, for social as well as economic fitness (DiMaggio & Powell, 1983, p. 150).

Standardization, routinization and taken-for-grantedness are in this case the core aspects of isomorphism. A hospital may not create its own accounting process, deviating from the guidelines set forth by the government to report accounting practices. Car manufacturers must abide by government rules in terms of minimum automobile security requirements in order to sell their cars. In most cases, organizations and or professionals can only operate in certain industries so long as they acquire necessary approvals from their professional associations. A hospital may launch a diagnostical unit if others have already set one up and the possession of it has proved to enhance their reputation. Organizations in this manner are "matched with – and almost absorbed by their institutional environments" (Meyer & Rowan, 1977, p. 352) by means of three different mechanisms: coercive, mimetic and normative processes (DiMaggio & Powell, 1983).

Not all practices and procedures adopted by the organizations, whether in pursuit of economic fitness, legitimacy or social acceptance, are embraced and fully supported by their constituencies, simply because different individuals or groups may have divergent interests and views in terms of how an organization should operate. Also, power asymmetries existing amongst the various constituencies dictate which institutional prescriptions should prevail, which puts the 'less powerful' at a disadvantage in terms of which institutional arrangements should be formed and reproduced (Seo & Creed, 2002). Also, standardization and routinization in highly institutionalized environments create a monotonous environment, in which innovation efforts are undermined. While a group of individuals in an organization may have a desire for a new technology to be developed, which will help produce better products and services, others may feel that the institutional barriers of the steps along the way may make it not feasible. Thus, frictions may come about amongst 'go with the flow'

and ‘change the flow’ proponents, which may form different opposing coalitions within organizations.

2.2.3. Structural Embeddedness versus Agency and Interests

Early institutional theorists firmly maintained that organizations are deeply embedded in highly institutionalized environments, which constrain their maneuver capabilities in terms of which strategies to choose or follow, which procedures or practices to adopt or whose interests to serve or satisfy (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Tolbert & Zucker, 1983). According to these theorists, organizational actors’ cognitive processes are also influenced by these institutional constraints, out of which their interests and identities are structured (Clemens & Cook, 1999; Friedland & Alford, 1991). Following the question raised by DiMaggio and Powell (1991, p. 29) “if institutions exert such a powerful influence over the ways in which people can formulate their desires and work to attain them, then how does institutional change occur?”, later contributors purported that organizations and/or actors have some hand in manipulating and/or restructuring institutional arrangements (Besharov & Smith, 2014; Oliver C., 1991; Seo & Creed, 2002; Smets et al., 2014; Thornton, 2004; Thornton & Ocasio, 2008; Thornton et al., 2012). Institutional embeddedness/agency interests debate has thus been a central issue of institutional theory (Heugens & Lander, 2009; Hirsch & Lounsbury, 1997a).

Institutions do exert a great deal of influence on the behavior of organizations in terms of providing stability and standardization, but they cannot completely restrict them to behave in certain pre-prescribed ways; they may, to an extent, impact the behavioral interactions amongst them. Dominant and powerful actors may themselves generate an area of discretion in shaping the institutional field in which they are embedded (Hoffman, 1999; Washington & Ventresca, 2004) through envisioning new procedures and practices and convince others about the applicability and utility of them (Besharov & Smith, 2014). Because in essence institutions are productions of powerful and dominant actors who can progressively create and recreate them (Currie, Lockett, Finn, Martin, & Waring, 2012; Fligstein, 2008; Lawrence, Suddaby, & Leca, 2011; Seo & Creed, 2002). In this respect, actors possess the capacity to act in ways beyond the prescriptions of taken-for granted rules (Garud & Karnoe, 2003; Giddens, 1984), and may view institutional structures as “enabling platforms that

organizations can use as jumping boards for autonomous, agentic behaviors" (Heugens & Lander, 2009, p. 63).

Thus, though effective to an extent, institutionalized rules, procedures and practices may not strictly dominate organizational behavior; they may even be, under appropriate conditions, bases for generation of new and/or improved ways for doing businesses, and actors in this manner, provided that they have the necessary power and motivation, can reproduce and transform those structures. In order for the actors to act as change agents (DiMaggio, 1988), however, they should hold the necessary power, be dominant in the field (Fligstein, 2008), and have the necessary motivation for a change (Seo & Creed, 2002) even though there may not be fertile grounds (rigidly, rather than flexibly, enforced institutional templates in the field), which may disable or limit their maneuver capabilities.

The paradoxes identified in the evolution of institutional analysis clearly identifies that an indepth view into lower level analyses is warranted to elicit the type of organizing principles or "frames of reference that condition actors' choices" (Thornton et al., 2012, p. 2) and also providing them with action-oriented "vocabularies of motive and a sense of self … [which] are available to individuals, groups, and organizations to further elaborate, manipulate and use to their own advantage" (Friedland & Alford, 1991; Thornton & Ocasio, 2008, p. 101), which will be discussed in the following section, 'institutional logics perspective.'

2.3. Institutional Logics Perspective

According to the previous theories of institutions, organizations are marched into accepting and being in line with the "ready to wear" (Creed, Scully, & Austin, 2002, p. 475) "symbolic systems … [or] supraorganizational logics" (Friedland & Alford, 1991) promulgated by the "centralized states, trade associations, unions and professional associations" which define the appropriate practices and procedures for organizations to adopt for the purposes of stabilization of organizational life (Meyer & Rowan, 1977, p. 351). Over time these *societal systems* or "macro cultural logics" (Hallett & Ventresca, 2006, p. 213) become taken-for-granted and incorporated into organization activity (DiMaggio & Powell, 1983) as "packaged codes" (Meyer & Rowan, 1977, p. 344). Under the effects of those inexorable forces, organizations are "driven to incorporate the practices and procedures

defined by prevailing rationalized concepts of organizational work and institutionalized in society" (Meyer & Rowan, 1977, p. 340) and become "more homogeneous … out of the structuration of the *organizational field* … by the state and the professions" (DiMaggio & Powell, 1991, p. 147). According to these early institutionalists, institutionalization "involves the processes by which social processes, obligations, or actualities come to take on a rulelike status in social thought and action" and by the statement, institutions are defined as "taken-for-granted classifications built into the society as reciprocated typifications or interpretations … which must be taken into account by actors" (Meyer & Rowan, 1977, p. 341). Others, however, view these explanations and definitions problematic, based on the notion that "institutions are not inert containers of meaning; rather they are 'inhabited' by people and their doings" (Hallett & Ventresca, 2006, p. 215). "Individuals are not free-floating atoms outside the social context" (Pedersen et al., 2013); they actively shape the institutions (i.e., rules, norms, values, routines, habits, traditions) while being constrained by them (Granovetter, 1985; Holm, 1995; Seo & Creed, 2002). If people are not "automaton-like processors of objective information [but are] interpreters of intrinsically ambiguous symbolic inputs," (Garud, Hardy, & Maguire, 2007, p. 961) then "What should we do about people?" was the question raised by authors viewing institutions actually being inhabited and not just passively received and acted upon by people (Hallett & Ventresca, 2006, p. 215). In this theoretical line of tradition, people are thought to be fundamental components of institutions, and thus a "peopled" approach was necessary to investigate "what institutions are at the ground level" (Hallett & Ventresca, 2006, p. 229).

It can be stated that institutional logics perspective emerged as a response to the gaps or paradoxes identified in institutional theory, in which many disconnects are identified between the institutions and the actual ground level processes, activities and work. Institutional logics perpective can thus be viewed as "providing a link between institutions and action" (Thornton & Ocasio, 2008, p. 100) by offering explanations regarding the interactions between individuals and the institutions and how and in what way they impact each other. By providing a cognitive framework guiding individual behavior, institutional logics thus help explain and justify why specific means are chosen to achieve certain ends; in other words, it enables individuals to rationalize their actions to themselves and others (Bacharach et al., 1996).

Complementary rather than contrary to the preceding theories of institutions, which privilege structuration or institutionalization by either the *societal system* or the *organization field* and largely ignoring the agency and creativity of humans, which, in their view, are implicitly assumed to be passive receivers and processors of objective information, institutional logics perspective provides a cross-level analysis amongst individuals, organizations and institutions by taking into consideration the fact that institutions are themselves human products, "or more precisely, an ongoing human production" (Berger & Luckmann, 1967, p. 52). In this view, "institutions are interpreted and modified as people coordinate the activities that propel institutions forward" and thus are "inhabited by people and their doings" (Hallett & Ventresca, 2006, p. 215). In this manner, while early institutionalists place a heavy emphasis on homogeneity, continuity and stasis, institutional logics perspective concentrates on the mutual relationship between individuals and institutions in providing explanations for institutional heterogeneity, complexity, stability and change (Thornton et al., 2012).

Institutional actors heavily draw upon a repertoire of institutions that are available to guide their actions and form their identities. Each institution can be said to have its own unique institutional logic (Friedland & Alford, 1991). Institutional logics are commonly described as "macro-level belief systems" (McPherson & Sauder, 2013, p. 167) or "taken-for-granted social prescriptions" (Battilana & Dorado, 2010, p. 1420) that "structure cognition and fundamentally shape decision making" (Marquis & Lounsbury, 2007, p. 799). Logics "furnish the guidelines for practical action" (Rao et al., 2003, p. 796) that "predominate in an organizational field" (Scott et al., 2000, p. 170). These belief systems greatly influence individuals' cognitive schemas related their way of doing businesses, and in a way, provide meaning to their activities. The main assumption of the institutional logics approach is that "the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics" (Thornton & Ocasio, 2008, p. 103). This embeddedness is reflected in a two-way ongoing mutual relationship between the logics individuals generate, and are also bound by (Besharov & Smith, 2014). Institutions, in this view, are produced and reproduced by human action, which are reflected in organizational activities, practices and procedures that in turn shape society's broader institutions (Smets et al., 2012). Thus, it is a very important "mediating" (Friedland & Alford,

1991, p. 242) mechanism explaining the relationship between human action and higher institutions established at the societal level.

Institutional logics scholars have identified various institutional orders and associated logics, to include: family, community, religion, state, market, profession, and corporation (Besharov & Smith, 2014; Friedland & Alford, 1991; Thornton, 2004; Thornton et al., 2012), each of which provides a specific cognitive schema and defines certain templates for organizational practices. Organizations also find themselves striving to accommodate divergent interests of their internal subgroups (Cyert & March, 1963). These various sources of institutional logics may generally constitute an organizational life full of conflict that "erupts from the clash of institutional logics" (DiMaggio, 1997, p. 277). Organizations often find themselves in the middle of these plural institutional logics (Greenwood et al., 2011), and in order to cope with those external and internal forces, may end up incorporating incompatible internal organizational arrangements that may not easily work together (Pache & Santos, 2013). Incorporating potentially antagonistic practices may, most of the time, be problematic in terms of protecting interests of both the internal and external referents (Pache & Santos, 2010).

2.3.1. Institutional Complexity in the Face of Multiple Institutional Logics

Organizations face institutional complexity whenever they confront incompatible prescriptions from multiple institutional logics (Greenwood et al., 2011), which are typically observed to exist in pluralistic institutional environments (Pache & Santos, 2010, 2013). Institutional complexity is defined as situations in which organizations and organizational actors experience "seemingly incompatible, socially-derived, expectations … arising from the multiplicity of logics" (Greenwood et al., 2011, p. 318-334). In the face of these complexities, "organizations in search of external support and stability incorporate all sorts of incompatible structural elements" (Meyer & Rowan, 1977, p. 356). Generally, the more the number of logics penetrating an organization are, the higher the complexity experienced by the individuals of organizations will be. Likewise, the higher the degree of inconsistencies amongst logics, the greater is the complexity organizational members will be exposed to and are forced to grapple with. Thus, "organizations operating in a more complex and conflicted environments will exhibit greater administrative complexity and reduced program

coherence" (Scott & Meyer, 1983, p. 129) requiring effective management. Whether the complexity stems from government mandate, prescriptions promulgated by professional organizations and/or actions of other organizations within the field, all of which may complicate the field because each of these forces may "make demands that are, at best, uncoordinated," (D'Aunno et al., 1991, p. 636) and thus are "often conflicting, vague and in flux" (Elsbach & Sutton, 1992, p. 700), organizations must be equipped to effectively manage and cope with institutional complexity. Dexterously confronting and managing inconsistent and at times contradictory institutional templates are important as how successfully the complexities of logics are managed by the organizations will have great implications on legitimacy and survival prospects of the organizations and "organization's access to critical resources" (Greenwood et al., 2011, p. 319). Recognizing the challenges multiple institutional templates may pose for organizations, researchers have recently "begun to explore in-depth the prevalence and implications of incorporating multiple institutional demands within organizations" (Besharov & Smith, 2014, p. 364).

Organizations, operating in environments characterized by varying degrees of decision making, are systems consisting of semiautonomous parts that vary in their responsiveness to each other and to their external referents based on how their members perceive and cognitively process the logics and their associated complexities they are expected to work around. The demands imposed by these various environmental forces are often incompatible, competing or contradictory (Greenwood, Diaz, Li, & Lorente, 2010; Pache & Santos, 2010; Scott, 1991), and thus, "they inevitably generate challenges and tensions for organizations exposed to them (Greenwood et al., 2011, p. 318). As they enact these varying institutional templates in their strategies, operations and activities, organizations are greatly "influenced by the potentially conflicting interactions between logics" (Greenwood et al., 2011, p. 322). By integrating logic plurality into organizational activities, organizations "map the complexity of environmental elements into their own structures" (Scott, 1987, p. 505), based on many factors, such as enforceability, attractiveness, applicability, and usefulness of these prescriptions, whereby "bringing the institutional conflict inside" (Pache & Santos, 2013, p. 973).

Research shows that the incorporation of plural institutional logics into organizational activities represent, for instance, contestation and conflict between or amongst logics

(Battilana & Dorado, 2010; Zilber, 2002), coexistence of logics (Dunn & Jones, 2010; Glynn & Lounsbury, 2005; Lounsbury, 2007; Reay & Hinings, 2009; Smets et al., 2014), and logic blending or hybridization of logics (Binder, 2007; Lounsbury & Crumley, 2007; Pache & Santos, 2013; Tracey, Phillips, & Jarvis, 2011; Voronov, Clercq, & Hinings, 2013). At the field level, these varying degrees of representations of logic plurality is believed to stem from (1) whether complexity is caused by two or more logics, (2) whether those logics are inherently incompatible, (3) whether institutional complexity is stable or in a continual flux, (4) whether the organizational field in which multiple logics are at play are characterized as being emerging or mature, (5) whether the position of organization - affected by the logic plurality - within the field is categorized as being periphery, interstices, central or boundary bridging, or (6) whether the field is fragmented, formalized or centralized (for a comprehensive review, see Greenwood et al., 2011).

The aforementioned studies, for the most part, however, investigate into and reflect structural and collective organizational responses to institutional complexities from an organizational field level outlook and do not explore how individuals within organizations make sense of, decode and tackle complexity, specifically when they work across institutional divides causing jurisdictional debates (Jarzabkowski, Matthiesen, & Van de Ven, 2009; Smets & Jarzabkowski, 2013). To investigate this phenomenon from a practice lens, a relatively more recent approach drills further down into the working dynamics of the organizations, and "focuses on the mundane practices – on what individuals actually *do* in their everyday work – that construct and resolve institutional complexity" (Smets & Jarzabkowski, 2013, p. 1280, emphasis in original). This work opens up an area of study delving into individual agency: action and interaction at the individual rather than collective or structural level (Bechky, 2011; Currie & Spyridonitis, 2015; Goodrick & Reay, 2011; Lawrence et al., 2011; McPherson & Sauder, 2013; Reay et al., 2016; Smets & Jarzabkowski, 2013; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012; Zietsma & Lawrence, 2010). In their endavors, scholars have attempted to explore how social actors at the ground level cope with multiplicity of logics and their associated complexities in two separate lines of companion research streams: institutional work (Bechky, 2011; Lawrence et al., 2011; Smets & Jarzabkowski, 2013; Zietsma & Lawrence, 2010) and practice lens approach (Currie & Spyridonitis, 2015; Goodrick & Reay, 2011; McPherson & Sauder, 2013; Reay et

al., 2016; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012). In these studies, however, it can clearly be discerned that the actors' enactment of agency is not solely triggered by actors' experience of complex institutional environments, but is due to their experiment of a specific situation with certain practical exigencies favoring adaptation of some practices over others (Smets & Jarzabkowski, 2013), or in some cases, to actors' motivation to pursue their interests (Currie & Spyridonitis, 2015; McPherson & Sauder, 2013). It is thus important to understand how actors at the micro level experience, make sense of and enact various institutional templates while performing their occupational tasks and activities (Kaghan & Lounsbury, 2011). This study therefore explores the micro-level implications of logics and their associated complexities experienced by physicians, as well as instantiations of logics as they relate to physicians' performing their daily routine based on their "lived experience[s]" (Lawrence et al., 2011, p. 52) by means of adopting a practice lens approach.

2.3.2. Institutional Complexities at Micro Level

Macro-level belief systems or logics are often embodied in organizational structures and practices (Greenwood et al., 2011; Thornton, 2004), by means of permeating through the organizational field level (i.e., meso-level) down to the intra-organizational level (i.e., micro-level) where they are actively translated into action by the ground-level social actors (Goodrick & Reay, 2011; McPherson & Sauder, 2013; Pache & Santos, 2010; Reay & Hinings, 2009). In this transformation process, "macro-orders are 'pulled down' and become imbricated in local or particular cases, situating macro effects inside organizations and individuals" (Powell & Colyvas, 2008, p. 279). In other words, the effects of macro-level belief systems are echoed at the practice level, just as they do at the meso-level, thereby bringing the tensions or contradictions of those logics down to the ground level where the actual daily activities of the organization are carried out (Pache & Santos, 2013). The ground level practices or activities are where the roots of the organizational activities reside, and therefore they may be viewed as the ground level representation of collective organization activity or vice versa (Powell & Colyvas, 2008). In this manner, logics structure or restructure individual and/or work practices (Goodrick & Reay, 2011), which may in turn influence collective organizational activity (Smets et al., 2012). Hence, in cases where

organizations are faced with logic plurality when attempting to satisfy multiple demands, so are their internal activities and practices at the ground level (McPherson & Sauder, 2013).

The complexities emanating from the existence of multiple templates and their associated expectations greatly influence the (re)construction of behaviors and processes of organizations and their inhabitants (Greenwood et al., 2011; Kraatz & Block, 2008; Lounsbury, 2007). The complexities resulting from the multiplicities of logics are pulled down and applied into, and thus are reflected in, every day level of practice (Powell & Colyvas, 2008). Though different logics may appear to prescribe certain templates, varied activities can be pursued under a common interpretation or account, or diverse practices may be enacted by organizational actors (Battilana, 2006; Garud & Karnoe, 2003) which may be geared toward gaining various different goals (McPherson & Sauder, 2013). Hence, on the one hand, complexities driven by multifarious institutional logics may constrain actors' actions, but on the other hand, they may also be objects of constant maintenance or modification through action (Barley & Tolbert, 1997; Hirsch & Lounsbury, 1997a). Institutional logics, in this respect, "shape rational, mindful behavior, and individual and organizational actors have some hand in shaping and changing institutional logics" (Thornton & Ocasio, 2008, s. 100; Scott, 2001). Critique, pragmatism, economic or political interest-seeking, rather than orthodox compliance, are the central logics of action and change (Leblebici, Salancik, Copay, & King, 1991; Seo & Creed, 2002).

The more complex the logics and their associated cognitive frames and normative prescriptions, the more it becomes cumbersome for actors to interpret those often conflicting frames and act upon them. Actors in these situations may be inundated by the efforts needed to interpret these expectations and may reflect different behaviors in satisfying various constituents' demands and their own interests in a variety of different ways (Fligstein, 1997; Jarzabkowski et al., 2009; McPherson & Sauder, 2013; Seo & Creed, 2002). This process entails selectively drawing on, interpreting and enacting a wide array of logics (Jones & Livne-Tarandach, 2008; McPherson & Sauder, 2013; Pache & Santos, 2013). In these challenging circumstances of reconciling various different prescriptions, however, actors inevitably may prioritize some interests at the expense of others (McPherson & Sauder, 2013). During these ongoing 'decision and subsequent action' points, "the agency used by

organizational and individual actors contributes to variation in how multiple logics become instantiated within organizations" (Besharov & Smith, 2014, p. 366).

Interpenetration of interinstitutional contradictions into the day-to-day practices subjects organizations and organizational actors to being "increasingly exposed to multiple, and yet interconnected, institutional arrangements and prescriptions" (Seo & Creed, 2002, p. 228). Sudden changes in government regulation may be a catalyst for interinstitutional incompatibilities (Marquis & Lounsbury, 2007; Raaijmakers et al., 2015; Reay & Hinings, 2005, 2009; Schneiberg & Bartley, 2001), and the locus of agency resides where these multiple, yet incompatible, institutions intersect (Clemens & Cook, 1999; Sewell, 1992). At the intersection of these institutional templates, conflicts arise in terms of which logics to adopt or which logics to shed in accomplishing daily tasks, and these conflicts become the heart of the source empowering certain interest groups, thereby creating "a capacity for action" (Kitchener, 2002, p. 410). Actors encountering these problematic situations, which, at times, require a great deal of imagination and judgement in choosing the appropriate course of action, may distance themselves from the expected or appropriate behaviors (i.e., the default logic), and exercise choice and pursue desirable institutional arrangements ultimately suiting their own interests (DiMaggio, 1988).

Embedded in pluralistic institutional environments as a unit of multiple institutional systems, organizations' internal functioning and dynamics indeed reflect the tensions or complexities of those larger belief systems or rules of the game (Kraatz & Block, 2008; Pache & Santos, 2013), and scholars have recently turned their attention to the implications of those broader institutional demands, and the heterogeneity of responses produced and mobilized at the intra-organizational level. The presence of heterogeneity of logics within organizations has been shown to exist in multiple different fields to include education (Thornton, 2004), communication (Ansari & Phillips, 2011), social enterprise (Dacin, Dacin, & Tracey, 2011; Pache & Santos, 2013), cultural industries (Glynn & Lounsbury, 2005), life sciences (Murray, 2010), professional services (Battilana & Dorado, 2010; Smets & Jarzabkowski, 2013; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012), cultural industries (Glynn & Lounsbury, 2005), manufacturing (Greenwood et al., 2010), justice system (McPherson & Sauder, 2013), and healthcare (Currie & Spyridonitis, 2015; Dunn &

Jones, 2010; Goodrick & Reay, 2011; Heimer, 1999; Kitchener, 2002; Özseven et al., 2014; Reay & Hinings, 2005, 2009; Reay et al., 2016; Scott et al., 2000).

Research carried out specifically in healthcare contexts to date has shown that healthcare organizations represent a common setting in which multiple logics and their associated inconsistent or contradictory templates such as family, law and medicine logics (Heimer, 1999), professional and managerial logics (Currie & Spyridonitis, 2015; Kitchener, 2002), market, state and professional logics (Scott et al., 2000), business-like and medical professionalism logics (Reay & Hinings, 2005, 2009), care and science logics (Dunn & Jones, 2010), professional, corporate, market and state logics (Goodrick & Reay, 2011; Reay et al., 2016), and business-like and public service logics (Özseven et al., 2014) are existent and enduring. It is not yet entirely known, however, how those various logics "are formed, reproduced, and modified through and interplay of action and structure" (Barley & Tolbert, 1997, p. 94) as well as the actual degree to which these broader demands are reflected or attended to at the ground level during everyday practice. Thus, more institutional logics research should "get closer to people and action" (Hallett & Ventresca, 2006, p. 222) as there is a "lack of attention to individual-level, practical responses to institutional complexity" (Smets & Jarzabkowski, 2013, p. 1283). The bi-directional relationship between logics and the actor instantiating them can only be informatively clarified through studying manifestations of those ground level practices in daily real-life work, which is what this study aims to accomplish. The following section "delves deeper into the dynamic patterns of complexity" (Greenwood et al., 2011, p. 334) arising from multiple institutional logics, and explores variations of ground level enactments or invocations of those logics as well as identifies various shortcomings of the research accomplished in healthcare to date with reference to micro-level institutional phenomena.

2.3.3. Micro-level Instantiations of Institutional Logics in Healthcare Field: Research Questions

As elaborated upon in the preceding section, healthcare facilities are prime examples of where institutional complexities are confronted by the social actors in their daily activities and practices (Greenwood et al., 2011), often following policy-driven radical revolutionary changes (Currie & Spyridonitis, 2015; Reay & Hinings, 2005, 2009; Reay et al., 2016).

Recent research performed in different healthcare contexts, post government-led policy-driven initiatives, shows that healthcare facilities are characterized by institutional complexity emanating from existence of multiple, yet contradictory, logics (Currie & Spyridonitis, 2015; Dunn & Jones, 2010; Goodrick & Reay, 2011; Kitchener, 2002; Reay & Hinings, 2005, 2009; Reay et al., 2016; Scott et al., 2000). In some of those studies performed at the micro-level, delving into how actors manage the complexities emanating from the plurality of logics and their associated variegated practices following sustained intrusion of the government into the healthcare system, the role of agency of actors was strongly emphasized (Currie & Spyridonitis, 2015; Reay et al., 2016). In one of the other studies - which involved solely archival data screening and analyses - exploring the evolution of the work of the pharmacists in a field with no exogenous shocks, however, the role of agency in institutional change was a secondary finding, but the researchers deemed it significant enough to state that "social actors attempt to use societal logics as a tool box to fit their interest" (Goodrick & Reay, 2011, p. 405). In the studies conducted in healthcare contexts, emphasizing strong agentic attributes of the actors, it was found that actors within organizations enact various levels of agency to interpret, negotiate and/or blend logics over time based on their structural position and political power (Currie & Spyridonitis, 2015) and identity (Reay et al., 2016). These studies highlight the structural constraints and/or advantages (i.e., power and politics relating to an actor's position) as well as actors' experiences in managing the complexities of logics; however, they do not explain how these actors view and interpret their social world during their daily work experiences as well as how they translate broader level cognitive frameworks into action as they perform their daily duties and responsibilities. This point is important in institutional logics perspective because in reality institutional logics and their associated practices are instantiated and materialized at the practice level (Barley, 2008; McPherson & Sauder, 2013; Powell & Colyvas, 2008; Sahlin & Wedlin, 2008; Smets et al., 2012). Additionally, though a few of the aforementioned studies attempt to explore the agentic nature of actors from a relational standpoint, none investigate the level of agency actors exercise in juxtaposing, negotiating, reconciling or creating logics while they perform their practical work, and thus the concept of "individual level agency" has largely been given short shrift in previous research (Smets & Jarzabkowski, 2013). As previous research attests to and calls for, it is also important to

elicit the implications of institutional complexity arising from multiplicities of logics on actors' activation of agency while performing their everyday practices (Battilana et al., 2009; Smets & Jarzabkowski, 2013), thus a more refined focus on "get[ting] closer to people and action" is certainly warranted (Hallett & Ventresca, 2006, p. 222).

The Turkish healthcare context is a perfect fit for the study of institutional logics from a practice level perspective, as it recently underwent a policy-driven change, which brought with it its associated contradictions and tensions for the field and its organizational level referents (Aksoy, 2007; Özseven et al., 2014). Therefore, from the institutional logics perspective, but from a micro-level lens, a comprehensive study of the implications of these broader level changes on the professionals who still need to get the job done is warranted. This study thus aims to explore what goes on "deep inside the organizations" (Whittington, 2006, p. 617) while physicians accomplish their daily work assignments. The reality is that the job is still required to be accomplished; regardless of however many institutional templates actors may be exposed to. In the case of our study, physicians, who are presumed to hold strong ties to their home group logics (i.e., professionalism) by means of their socialization, orientation and education (Currie & Spyridonitis, 2015; Reay & Hinings, 2005, 2009; Reay et al., 2016), are challenged with conforming to business principles (i.e., effectiveness, efficiency and customer service) while under the concomitant influences of public service considerations in accomplishing their daily tasks (Özseven et al., 2014). In this well-established and highly professionalized field, where there are strong institutional forces pushing toward conformity and stability, however, passive acquiescence by physicians, who adamantly protect their authority and autonomy (Friedson, 2001; Reay & Hinings, 2005; Reay et al., 2016; Thornton et al., 2012), may less likely to occur (Currie & Spyridonitis, 2015; Reay & Hinings, 2009; Ruef & Scott, 1998). Thus, the objective of the research undertaken here is to figure out how physicians tactfully manage these multiple prescriptions while still getting the job done.

In sum, the studies performed in various healthcare contexts to date reflect that their inhabitants exhibit different logical orientations over periods of time, specifically when there is sustained government intrusion into the field (Currie & Spyridonitis, 2015; Özseven et al., 2014; Reay et al., 2016; Scott et al., 2000). Recent studies have shown that the majority of those logical inclinations involve actors' exercising a great deal of agency while satisfying

multifarious institutional templates as well as their own (Currie & Spyridonitis, 2015; Reay & Hinings, 2009). Informed by the previous research findings in the area of study, this research sets out to investigate what actually goes on at the coalface of everyday life in the healthcare practice in terms of physicians' logical orientations or inclinations, and sets out to address the following research questions:

- Do physicians in the Turkish healthcare context exercise agency in reconciling multiple institutional prescriptions or prioritize some interests at the expense of the others?
- If so, what type of practice patterns may be associated with these logics or logic (re)combinations or interest-seeking endeavors?
- Which logic(s) could these practice patterns be representative of, when viewed collectively?
- Have any logic shift(s) or transformations in relation to physicians' interpretation and enactment of various institutional frame(s) materialized during their performance of daily routine tasks over a period of time? (i.e., before and after 2005, which is our historical marker for policy change initiatives).
- If physicians indeed reflect different logical orientations through processes of change, to what extent these logical orientations are reflected in physicians' cognitive schemas and associated practices?

CHAPTER III

HEALTHCARE FIELD IN TURKEY

The evolution of Turkish healthcare policies, strategies and applications has been examined under different time periods by various authors to date. For example, some studied the history of Turkish healthcare under the periods of 1920-1938, 1938-1960, 1960-1980 and after 1980 (Aksoy, 2007), some under 1920-1945, 1945-1960, 1960-1980 and 1980-2000 (Tekin, 2011), and some under the periods of before 2003 and after 2003 (Özseven et al., 2014). In order to consolidate those studies under a more general roof, and to provide historical clarity based on the major chronological events occurring after the proclamation of the Turkish Republic, this study reviews the evolution of Turkish healthcare under the periods of 1920-1960, 1960-1980, 1980-2002 and 2002 to present. The nature and characterization of events occuring under these periods qualify them to be labeled as: restructuration and organization period, 1920-1960; socialization and diffusion period, 1960-1980; liberalization transition period, 1980-2002; and radical liberalization period, 2002-present. Each of these periods will be thoroughly and diligently examined in the following subsections.

3.1. Restructration and Organization Period, 1920-1960

Although early modernization efforts of an unorganized and weak state of healthcare in primarily main settlements coincide with the later parts of the 19th century in Ottoman Empire history, it was with the establishment of the Ministry of Health (MoH) as a unique Ministry division on 2 May 1920, following the opening of the Turkish Grand National Assembly on 23 April 1920, that the Turkish government officially claimed responsibility for organization and provision of healthcare services for the entire nation. Since the establishment of the MoH, formulation of healthcare policies, their enforcement and implementation, and provision of healthcare within the boundaries of those principles have been within the primary responsibilities of the central government in Turkey. The below

excerpt from the first Constitution of Turkish Republic, which came into effect on 20 January 1921, delineates the government's undertaking this role along with others:

> "… in accordance with the laws to-be-enacted by the Turkish Grand National Assembly, the organization and administration of duties concerning foundations, schools, *healthcare*, economy, agriculture, public works and social aid duties are within the purview of the provincial assemblies" (Turkish Republic Constitution, 1921, art. 11, emphasis added).

Immediately after healthcare being cited first time in the first Constitution as one of the roles and responsibilities of government, the Turkish government has set to work by attempting to map the current stage of the Turkish healthcare by the cities and regions for its future healthcare organization efforts. The Turkish government was keenly aware of the fact that without comprehensively understanding the current stage of the healthcare of the nation, no plan could be devised and subsequently carried out to improve it. Thus, the years between 1920 and 1923 witnessed the newly established government's efforts to identify and solve the health problems emanating from the Turkish War of Independence and also to lay the foundations of the laws and regulations for the Turkish healthcare system (Akdağ, 2010; Sülkü, 2011). The Turkish government adopted different strategies for its preventative medicine and disease treatment services' organization structure in its efforts to fight the nation's health problems. During these years, the Turkish government supported regional healthcare service development efforts, such as establishment of regional or provincial hospitals through the local departments of the government for its disease treatment services, thus embracing a decentralized organizational structure (Akdur, 1998; Öztürk, 1999). In an effort to improve the healthcare services local government hospitals provide and also to encourage and guide the local municipalities and local government entities, the government built hospitals in some of the major cities such as Ankara, Sivas, Erzurum and Diyarbakır (Dirican, 1970). A special focus, however, was laid on fighting against contagious diseases by the government by means of establishing healthcare service units and dispensaries in the villages and provinces, which were completely under government supervision and control (Aydın, 2002).

Although healthcare and other fundamental rights are considered to be important and thus are heavily embraced by the first Constitution of Turkey, the second Constitution of Turkey,

which came into effect on 20 April 1924, did not include any direct references to basic rights and freedoms such as social security and healthcare-related topics or regulations (Akın, 2006), reflecting the fact that it did not attach much importance to them (Gözübüyük, 2013). In the parts of 1924 Constitution where it referred to them, it only cited those rights and freedoms by name and left their content specification and utilization to be determined by laws (Anayurt, 2003). The 1924 Constitution's only vaguely visiting these rights can be attributed to the fact that it was then assumed that these rights would have sufficiently been protected by means of legislations enacted by the nation's only and genuine representatives of the Turkish Grand National Assembly (Akın, 2006). With the 1924 Constitution, the Turkish government adopted a more liberal and individualist perspective, as opposed to the social perspective the 1921 Constitution embraced, carrying a belief system in which the individuals are supposed to take control of their own lives and thus should act accordingly to protect and promote them (Tanör, 1998).

In spite of the fact that 1924 Constitution *seemingly* did not place a great deal of importance on social rights, the special laws which were later enacted up until the establishment of the third Constitution of Turkey, conferred a wide range of social rights to individuals, thereby 'socially characterizing' the period spanning 1924 to 1960 (Akın, 2006; Tunaya, 1975). These years witnessed government's efforts to coordinate and organize the fragmented nature of preventative and treatment services throughout the nation. For instance, toward this aim, The MoH prepared and enacted 50 laws and statutes during the early parts of these years, 1923-1938 (Eren & Tanrıtanır, 1998; Metintaş & Elçioğlu, 2007). The most prominent and influential laws enacted by the government for the period from 1924 to 1960 are cited below for reference.

Table 1. *Healthcare-specific Laws Enacted Spanning 1924-1960*

Law No	**Enactment Date**	**Target Audience**	**Name of Law**	**Short Description of Law**
369	8 Nov 1923	Physicians	Turkish Republic Turkish Grand National Assembly Physicians'	• Law stipulates that all physicians graduating from a medical faculty will complete a two-year compulsory service in any region [mostly in rural areas] where there is a need.

			Compulsory Service Law	*The first law of the Turkish Republic mandating compulsory service for medical faculty graduates.*
767	17 Mar 1926	Physicians' and Pharmacists' Professions	Turkish Codex Law	• The law lays the foundations for regulation of Turkish Codex. • The law stipulates that a 'codex commission' of 15 people be established in order to publish the "Turkish Codex," which mainly delineates Turkish, French and Latin names and synonyms, composition, attributes, protection and the standards for the manufacturing of items utilized in medicine. *The first law issuing standards for disbursing medical items for Pharmacies. The first Turkish Codex was published in 1930.*
1219	14 Apr 1928	Profession of Physicians	Practice of Medicine and Related Arts Law	• The standards and qualifications for practicing medicine were defined for physicians, dentists, nurses, midwives and healthcare admin clerks. • Healthcare personnel's authorities and responsibilities were definitively stated. • Stipulates consent obtainment prior to any medical intervention. *Enactment of this law, for the first time, introduces practice of medicine by physicians as a unique profession and discipline.*
1593	6 May 1930	Healthcare System of the Nation	General Health and Hygiene Law	• Healthcare service policy rules were defined. • MoH's responsibilities regarding protection [with a specific focus on fighting against communicable diseases such as tuberculosis, trachoma and malaria] and promotion of nation's health were defined. • MoH's responsibilities regarding regulating and inspecting medical professionals' practices were defined. • MoH's responsibilities regarding establishing and administering healthcare inspection facilities were defined. • MoH's responsibilities regarding inspection of other professions whose practices affect health or healthcare services were defined.

				This law is the first most comprehensive law of the Turkish government covering <u>all</u> healthcare services throughout the nation.
2000	4 Jun 1932	Physicians	Revocation of Compulsory Service of Physicians Graduating From Medical Faculties as of 1932, and Compulsory Services Boarding School Medical Students Will be Subjected to, Law	• Law No 369 was revoked. • Two-year compulsory service requirement for physicians was rescinded. *With this law, medical school graduates were no longer obligated to serve their mandatory government service.*
2219	5 Jun 1933	Private Healthcare Sector	Private Hospitals Law	• Law stipulates the terms and conditions for establishment, utilization and closure of private hospitals. *First law to introduce private sector into healthcare, which the government historically had been directly and solely responsible for.*
3017	9 Jun 1936	Healthcare System	MoH and Social Assistance Organization and Public Servants Law	• Ministry was renamed as MoH and Social Assistance. • Healthcare organization's general framework was devised. *With enactment of this law, the general structure of the nation's healthcare organization, its hierarchical schema, apportionment of roles and responsibilities of authorities in this structural division and human resource management regulations (position grades, career progression principles etc.) were regulated.*
6023	31 Jan 1953	Profession of Physicians	Turkish Physicians Association Law	• Turkish Physicians Association is established to maintain the appropriate code of conduct amongst physicians, protect physicians' rights and benefits and also to promote and develop the profession for the well-being of individual and of the public. • Association is to maintain and promote profession's traditions fed by the philosophy in which servicing public health and patients

				altruistically and unselfishly are regarded as ideal values of the profession. • Association is to help reconcile the interests of its members with those of the government. • Association is to assist their members in finding job opportunities in order to improve their welfare level. *Turkish Physicians Association was established by law as the first professional association and trade union to represent the physicians, to protect their rights, to monitor conformity to the appropriate code of conduct, and to mediate the relationships between the government and the physicians.*
6134	10 Jul 1953	Government Hospitals	Turkish Grand National Assembly Transfer of Local Government Hospitals to Government Budget, and Alterations on articles (I) and (2) of Law No 4862, Law	• Hospitals belonging to local departments of the government, municipalities and foundations were consolidated under the roof of the MoH and Social Assistance. *With enactment of this law, healthcare services became the primary role and responsibility of the central government. Hospitals were started to be built in cities and provinces in an accelerated fashion. Thus, first level preventative healthcare services began to be ignored and more emphasis and attention were started to be given to second and third level treatment services.*
6197	24 Dec 1953	Profession of Pharmacists	Law on Pharmacies and Pharmacists	• The standards and qualifications for practicing as a pharmacist were defined. Law regulates the licensing of pharmacists and the actual practices of pharmacies. • Law stipulates under which conditions a pharmacy can be established and become operational. • With enactment of this law, only individuals graduating from a faculty of pharmacy from accredited Turkish Universities will be authorized to start a business as a pharmacist. *Enactment of this law, for the first time, introduces pharmacy as a unique profession and discipline.*

It is clearly observed from the legislations enacted between 1924 and 1960 that the government's vision was to establish the foundations of the healthcare system based on the pressing needs of the nation. With these legislations, the government took up the challenge and attempted to establish the foundations and the legal framework, and to regulate the standards and norms of the practices for the actors (i.e., government, private healthcare organizations, physicians, pharmacists, etc.) who were supposed to take part in ensuring success of the healthcare system of the nation. With the 1921 Constitution, the government, for the first time, declared responsibility for policymaking and delivery of healthcare services throughout the nation. The 1924 Constitution, however, was not in itself characterized to address social needs of the public, though the subsequent 'special' laws incorporated into it gave it a social character. Though the government ascribed great value to improvement of social welfare of its citizens during the period of 1920-1960, the one point that should not go unnoticed is that the government also allowed the private sector to trickle into the system - through enactment of the "private hospitals law" in 1933 - by casting their role as an alternative mechanism through which disease treatment services could be provided to the public. Since then, the presence of the private hospitals in the Turkish healthcare system has progressively increased, which likewise decelerated government's efforts to grow in this area. However, the existing hospitals for disease treatment services were far from meeting the ever increasing demands of the general public, which instigated the Ministry of Labor and other ministries and even some of the State Economic Enterprises to establish their own hospitals, which caused the Turkish healthcare structure to become highly-fragmented, multi-centered and uncoordinated in nature (Akdur, 2008).

By 1950s, the foundations of Turkish healthcare were more or less established. However, the healthcare services could still not be made available to the people living in rural areas and villages. At best, healthcare services were organized and thus were deliverable at provinces, but not in rural areas and villages. This was one of the aims that the Turkish MoH and Social Assistance strived to continuously achieve, from its inception, but was not able to achieve mainly due to (1) political instability and inconsistency, (2) financial problems, and (3) insufficient number of physicians and other healthcare personnel in Turkey, which, in the aggregate, resulted in the entire healthcare organization to be characterized as unfashionable, clumsy and inadequate (Tekin, 2011). Until 1950s, though the policies,

regulations and planning efforts of the government (such as in the cases of the "First Ten-Year Development Plan" and "National Health Program") aimed at properly organizing the delivery of healthcare throughout the nation, they were either too comprehensive to be implemented all at once or required large budgets, which the government was unable to support. Most of these plans were thus regarded as a flight of fantasy by government authorities. For instance, in 1946, the introduction of the First Ten-Year Development Plan, whose main aims were to modernize and expand the healthcare services in Turkey, was ridiculed by two of the deputies as;

> "In brief, there is a National Health Plan of this, in all aspects, ever-shaking and collapsing institution [MoH and Social Assistance] that even specialists from a rich country such as America regard as, at best, an imaginary, sweet dream" (Turkish Grand National Assembly Minutes of Proceedings, 1947, p. 719).
>
> "… as in every new thing, the things stated about this plan are the same … this [plan] was known before, it is not anything new, there is no such thing and it is non-implementable … same thoughts are shared and touched on by my friends, inside and outside, about the National Health Plan" (Turkish Grand National Assembly Minutes of Proceedings, 1947, p. 731).

Aside from the fact that the plans and programs could not be implemented mainly due to large budgets these programs required, another, maybe a more influential reason as to why they could not be implemented was that they were not sincerely embraced by the politicians because these plans and programs entailed government's auditing of medicine industry, government's manufacturing of some of the medications and immunizations for preventive medicine purposes and government's establishing installations for production of baby milk and formula, all of which, if implemented, would have interfered with the economic interests of the private sector investors (Özdemir, 2001; Tekin, 2011). In those years, it was clear that the private sector actors were very influential on shaping the policy making efforts of the Turkish Parliamentary System.

3.2. Socialization and Diffusion Period, 1960-1980

The third constitution of the Turkish Republic was approved on 9 July 1961 and enacted on 20 July 1961. It was quite different from the previous two constitutions in that it, for the

first time, explicitly housed laws elaborately identifying individual rights and freedoms. Specifically, clause number 10 identified that:

> "Everyone possesses untouchable, non-transferrable and indispensable basic rights and freedoms related to their personality. The government removes all political, economic and social obstacles, which conflict with individual peace, social justice and state of law principles, concerning limiting individual rights and responsibilities; establishes the conditions necessary for development of the individual's material and nonmaterial existence" (Turkish Republic Constitution, 1961, p. 4201).

Implicitly referred to in the above clause was the government's responsibility to ensure proper steps would be taken to develop a healthy and robust nation. This point was further elaborated in clause number 49 as:

> "The government is to ensure everyone lives in a healthy physical and spiritual life and receives healthcare. The government takes measures to meet the housing needs appropriate for the health conditions of the poor or the ones with low income" (Turkish Republic Constitution, 1961, p. 4204).

With a legislative reasoning as:

> "Even in the liberal government logic, the government's attending to health matters is generally accepted. However, in the present time's [social] welfare logic, maintenance of the health of individuals, whether through directly or through cooperation with the private sector and local departments of the government, is one of the primary responsibilities of the government" (Özer, 1984, p. 254).

With its strong emphasis on the social (welfare) 'state' logic, this was the first ever constitutional law that specified individuals' "health right" in the Turkish history (Tekin, 2011, p. 114). In line with the social government character of the 1961 Constitution, the MoH prepared a separate law, which mainly aimed toward taking care of the personnel and organization problems the Turkish healthcare system long suffered from, in order to bring the healthcare services to the rural areas through a cleverly designed series of planning stages, by means of which these services would be made available across the nation (Fişek,

1963, p. 3). This law was prepared for 'socialization' of healthcare, which, until then, was far from being satisfactory. The reasons for healthcare being unsatisfactory were explained by the MoH (Dr. Ragıp Üner) at the time as:

> "… our current health system has not been developed in a satisfactory manner and thus our expected healthcare delivery aims could not be achieved … first because our doctors working in public sector simultaneously own private practices and thus have the opportunity to make extra revenue … second, public health has not yet been recognized as a science in medicine … another reason is financial impossibilities … another reason is unequal distribution of our physicians … another reason is our physicians' eagerness toward being specialized into a specific branch in medicine, the fact of which works unfavorably against the specialty of preventive medicine… another reason is increase in the volume of patients for hospital physicians due to public medicine services being inadequate …" (Üner & Fişek, 1961, pp. 63-66).

Modeled heavily upon applications of socialized medicine in Russia and England (Üner & Fişek, 1961, p. 80) "The Law on Socialization of Healthcare" was prepared and approved on 5 January 1961 and enacted on 12 January 1961. With enactment of this law, (1) identification of provision of healthcare as a government responsibility, (2) diffusion of healthcare services across the nation, specifically to rural areas and villages, (3) delivery of preventive and treatment services in combination at public medical facilities, (4) centralized management of public healthcare services and (5) physicians' full-time employment at public medical facilities were stipulated (Fişek, 1983). The Law on Socialization of Healthcare and the others specified in the below table characterized the period spanning 1960 to early 1980s.

Table 2. *Healthcare-specific Laws Enacted Spanning 1960-1980*

Law No	**Enactment Date**	**Target Audience**	**Name of Law**	**Principles of the Law**
224	12 Jan 1961	Healthcare System of the Nation	The Law on Socialization of Healthcare Law	• "Socialization of health means that our citizens equitably benefit from all sorts of healthcare services based on the healthcare premiums they pay and on the budgets allocated by the public institutions, free of charge or partially

				participating in the cost of the care received" (Clause No: 2). • "…public sector healthcare personnel … may not operate independent businesses … MoH and Social Assistance … employs healthcare personnel by means of a contract" (Clause No 3 and 26). • "…the healthcare services provided by the public medical facilities … are centrally managed by the MoH and Social Assistance" (Clause No: 8). • "… community clinics are characterized as teams providing preventive and treatment services … persons requiring healthcare services, other than emergent cases, seek care at community clinics first" (Clause No 10 and 13). *The first purely-socially-characterized law of the Turkish Republic comprehensively outlining personnel and organization matters of the nation's healthcare.*
2162	9 Jul 1978	Physicians and Other Healthcare Personnel	Law on Healthcare Personnel's Full-Time Working Principles	• "…This law is enforced on … healthcare personnel and healthcare personnel assistants … employed at general and annexed budget institutions, local departments of the government and municipalities … personnel employed within the scope of this law may not practice their art and profession outside, may not be assigned salaried or contracted duties in formal or private institutions … this law repeals the clauses under Law No 224 relating to fiscal provisions regarding personnel" (Clause No 1, 7 and 13). *With enactment of this law healthcare personnel could no longer be employed through a contract and also they could not work both in public and private sector simultaneously.*
2368	31 Dec 1980	Physicians and Other Healthcare Personnel	Law on Healthcare Personnel's Compensation and Principles of Employment	• "… (healthcare) personnel, if they so desire … may practice freely [in private sector] … this law repeals Law No 2162" (Clause No 1, 3 and 6). *With enactment of this law, full-time working requirement in public medical facilities was*

				rescinded and physicians regained the right to privately practice their profession.
2514	25 Aug 1981	Physicians and Other Healthcare Personnel	Law on Some Healthcare Personnel's Government Service Obligation	• "…physicians are obligated to serve two years as a practitioner and two years as a specialist in places, to which MoH and Social Assistance is obligated to assign physicians" (Clause No 3). *This law reestablished physicians' compulsory government service which was rescinded through law no 2000 in 1932.*

The 1961 Constitution also included clauses regarding national development plans, via which its intentions would be planned and carried out:

> "… implementing economic, social and cultural development in democratic ways, and with this aim, increasing national savings, directing investments in line with societies' priorities and preparing development plans are obligations of the government … development is carried out through these plans" (Turkish Republic Constitution, 1961, Clause No 41 and 129).

In line with the stipulations cited above, a series of ten development plans spanning 1963 to 2018 were devised to date. The development plans coinciding with the period of 1960 to 1977 (first, second and third) all had similar clauses in terms of the planning and development of the health system of the nation:

> "… healthcare services pertaining to the public sector … will be centrally managed. Until this aim is achieved, necessary measures will be taken to closely cooperate."
>
> "… authority in terms of delivery of [healthcare] services will be diffused at the lowest levels."
>
> "… measures will be taken to ensure equal distribution of healthcare personnel amongst services and regions."
>
> "… measures will be taken amongst MoH and Social Assistance and other public agencies in terms of enhancement of environmental health conditions, public education in terms of health matters, population planning and nutrition."
>
> "… public institutions will continue to establish their own hospitals until central management can take place."

> "Measures will be taken to encourage the private sector to build hospitals."
>
> "Specific means by which hospitals can become facilities with revolving funds will be investigated."
>
> "Domestic pharmaceutical industry will be subsidized."
>
> "Investments laid toward healthcare will progressively increase."
>
> "Studies will primarily be initiated to establish a general health insurance, which will cover the entire nation" (Development plan: 1st Five Years (1963-1967), 1963; Development plan: 2nd Five Years (1968-1972), 1968; Development plan: 3rd Five Years (1973-1977), 1973; except private sector clause which was not cited in the Development plan: 3rd Five Years (1973-1977), 1973).

Though intended to improve the healthcare system of the nation with broad implementation plans devised in line with the socialization principles of the government, most of the highly challenging predictions of these plans were not able to be realized due to the over-ambitious reforms they entailed. The financial aids received from England and the U.S. (Turkish Grand National Assembly Minutes of Proceedings, 1961, p. 17) facilitated planning and implementation of the program, but they did not completely solve the problems associated with the implementation stages. Most of the over-ambitious predictions of the plans were not able to be realized due to (1) cost pressures, (2) infrastructure issues, (3) insufficiency of healthcare personnel, (4) bad environmental conditions, (5) tendency of physicians being specialized into a specific field versus working as a practitioner, all of which resulted in healthcare system of the nation to be only limitedly improved (Demirbilek, 1999). These issues impeded the development of the healthcare system in Turkey in an accelerated manner, characterizing the whole system as being clumsy in nature. Due to these problems, healthcare of the nation could not be socialized through all the provinces and villages. One thing that exceeded the development plans' expectations, however, was the bed capacities of the hospitals in the major cities, which resulted in concentration of a number of physicians at the hospitals in those cities. Concentration of physicians with specialties in larger cities exacerbated the unequal distribution of the physician workforce across the cities and regions, which further impeded the success of the socialization program (Turkish Republic Prime Ministry State Planning Organization, 1973).

3.3. Liberalization Transition Period, 1980-2002

With the enactment of 1982 Constitution on 7 November 1982, The Turkish government casted itself a new role in terms of its duties and responsibilities regarding healthcare strategies and implementation:

> "The government shall regulate central planning and functioning of the health services to ensure that everyone leads a healthy life physically and mentally, and provide cooperation by saving and increasing productivity in human and material resources."
>
> "The government shall fulfil this task by utilizing and overseeing the health and social assistance institutions, in both the public and private sectors" (Turkish Republic Constitution, 1982, Clause No: 56).

With a legislative reasoning as:

> "The government will establish health and social assistance institutions; it will support establishment of these institutions by the private sector."
>
> "The government will ensure that these institutions [public and private healthcare facilities] operate in sync with the primary aim being [set forth by the MoH and Social Assistance]: ["It is the obligation of the government to ensure that the citizens continue to lead a health life physically and mentally under protected environmental conditions"]" (Turkish Republic Constitution: Legislative Reasoning Incorporated, 2011, p. 114).

As of 1982, the government's outlook on delivery of healthcare significantly changed from viewing the *provision of healthcare* being a sole government responsibility to the *regulation and supervision of healthcare* being government responsibility. Supervision, versus provision, of healthcare meant that healthcare services would be conducted through business management principles entailing effective, efficient and equitable healthcare service delivery. Though preparation of it fell behind this liberalization period promoting business principles, the 4th Development Plan also partially enunciated these points:

> "The primary principle is to bring healthcare services to everywhere and everyone in an equitable, continuous and efficient manner, and thus to enhance the society's general health level."

> "To create efficiencies and gain the highest level of productivity out of the scarce resources … new regulations, considering demand and development, will be identified" (Turkish Republic Prime Ministry State Planning Organization, 1979, pp. 465-468).

The 5th and 6th Development Plans incorporated additional business principles related to the healthcare delivery roles of responsibilities of the government, outlined in the 1982 Constitution:

> "… efficiencies created will be enhanced in the socialization program, and the laws and regulations will be revised according to the conditions of the present time."
>
> "… preventive and basic healthcare services will be diffused throughout the nation in an adequate and effective manner."
>
> "… healthcare services will be improved to become effective, efficient, reliable, easily accessible, free from formalities and equally diffused throughout the nation."
>
> "… the current capacity of the inpatient facilities will be utilized more rationally, effectively and efficiently."
>
> "… in order to increase productivity related to healthcare service delivery, healthcare facilities will be considered from the perspective of business management principles."
>
> "… private healthcare institutions and hospitals will be incentivized" (Turkish Republic Prime Ministry State Planning Organization, 1985, pp. 150-152; Turkish Republic Prime Ministry State Planning Organization, 1990, pp. 356-357).

In addition to strongly embracing the healthcare-related clauses of the 5th and 6th Development Plans mentioned above, the 7th Development Plan also completed the missing pieces of the puzzle of healthcare management by business principles identified by the 1982 Constitution by incorporating the clauses below in the structure of its planning:

> "The MoH will be structured to provide preventive healthcare services, to ensure maintenance and protection of public health, to regulate and supervise the policies, standards and the norms of the healthcare field … and its direct role in provision of inpatient services will be progressively diminished."

"The authorities, duties and responsibilities of central administration will be diminished … the role of local departments of the government in reference to provision of (healthcare) service will be increased."

"For a more efficient and quality healthcare service delivery, hospitals will be made administratively and financially autonomous, their management structures will be strengthened through contemporary business administration logic, and within this scope, the necessary legal arrangements will be made" (Turkish Republic Prime Ministry State Planning Organization, 1996, pp. 46-48).

The laws enacted during 1980 and 2002 also highlighted the role of government as a regulator and supervisor, versus an actual service provider. With these legislations, the government's intent was to gradually move away from the position of a service provider to the supervisor of the healthcare facilities providing services and the regulator determining the rules and regulations by which these services were to be provided.

Table 3. *Healthcare-specific Laws Enacted Spanning 1980-2002*

Law No	**Enactment Date**	**Target Audience**	**Name of Law**	**Principles of the Law**
181	14 Dec 1983	Healthcare System of the Nation	Decree Law Concerning the Organization and Duties of the MoH	• One of the primary duties of the MoH and Social Assistance is "to maintain and protect individual and society's health in order to ensure everyone leads a healthy life physically, mentally and socially in a completely well condition, and to make, implement, or enforce implementation of, nation-wide plans and programs, establish the necessary organization or enforce establishment of organization [of a healthcare system] … to establish and operate the facilities needed to carry out these tasks" (Clause No 2a and 2k). *This decree law identified the MoH and Social Assistance as the body ruling and organizing the healthcare field to include establishing and running the necessary facilities to achieve its aims related to the nations' healthcare.*

3359	15 May 1987	Healthcare System of the Nation	Healthcare Services Basic Law	• "Healthcare facilities are planned and coordinated by MoH and Social Assistance … in way that they provide equitable, quality and efficient services; they are improved and financially supported" (Clause No 3a). • "… public healthcare facilities, with the proposal of the related Ministry and approval of MoH and Social Assistance, are converted to healthcare enterprises in the form of state owned enterprises … the healthcare services such as diagnosis, treatment and rehabilitation rendered by these enterprises are chargeable except when those services are preventive in nature" (Clause No 5 and 8). *This was the first-ever law enacted by the Turkish government pronouncing conversion of public healthcare facilities to 'enterprises.'*
3703	23 Mar 1991	Healthcare System of the Nation	Change on Decree Law Concerning the Organization and Duties of the MoH	• "… the expression cited in legislative regulations as 'MoH and Social Assistance' is changed to 'MoH' (Clause No 20). *With enactment of this law, the name of the Ministry was changed from "MoH and Social Assistance to "MoH."*
4046	27 Nov 1994	Healthcare System of the Nation	Law on Regulation of Privatization Applications and Changes on Some Laws and Decree Laws	• "… to achieve increased productivity and create efficiencies … inpatient facilities' transfer of operating rights or rent … cannot exceed 49 years" (Clause No 1-15). *This law enabled privatization of public inpatient facilities by means of transfer of their operating rights.*

In order to cope with the problems of the healthcare system of the nation, in line with the development plans and the laws and regulations cited above, a "National Health Policy" was also prepared in 1993 by the government to guide the healthcare policies and strategies of the nation through 2000s. The National Health Policy (NHP) was indeed later greatly embraced by the subsequent governments and it guided their health reform and/or transformation efforts. The principles of the NHP, which will be cited below, were almost identical to those of the programs announced past 2002 (Lamba, Altan, Aktel, & Kerman, 2014).

According to the NHP, the problems of the healthcare system were identified as:

> "The healthcare system has a management and organization system which is multi-headed, overly centralized and authority always centralized at the top levels. There is a conflict of authority, besides duplications, resulting from lack of coordination. The MoH is not influential over the other health institutions and is not able to completely exercise the authorities conferred upon itself by the laws and regulations. The MoH has been performing as a Ministry of Application, versus a structure devising macro plans and guiding the [health] sector, and the majority of the top managers' time is spent on personnel assignment duties. Professional healthcare managers are not encountered at any managerial position, ranging from top management positions to the positions at provincial areas, under the MoH. The central and provincial organizational structures of the MoH do not comply with modern management logics."

> "… the current picture of the healthcare of the nation reflects that preventive and promotional healthcare services are not adequately provided … the integration of provision of basic healthcare services could not be achieved … our citizens are not happy with the services they receive from healthcare facilities … socialization of healthcare efforts have not been able to result in the desired outcomes" (Turkish Republic Ministry of Health, 1993, pp. 48-49).

In the introduction part of the NHP, its end result was projected as "… to establish a society comprised of healthy individuals," but it was also stated that "… establishing a society with healthy individuals can be achieved not only through services provided by the healthcare sector, but also through policies developed supporting intersectoral relationships … this plan has been developed to reach those goals" (Turkish Republic Ministry of Health, 1993, p. 9). In order to achieve these aims, the plan involved the below sub-plans, programs and strategies to be adopted.

> "A decentralized health management system will have been established by 2000."

> "Management structure should be established in a way that it ensures development of healthcare services and achievement of health goals in the most effective and efficient manner."

“Decentralized management principles should be adopted in healthcare services’ organization and management structure.”

“The MoH should turn into an organization centrally developing policies for planning and supervising the [healthcare] sector.”

“Healthcare management should be performed by professional managers.”

“Vertical organization structures should be abandoned and integration logics should be adopted.”

“… general practitioner/family medicine system will be established in cities based on small population rules … family medicine specialists will be responsible for providing preventive and first level healthcare services … they will be paid by the general health insurance based on the number of registered people under their names.”

“[public] hospitals need to be managed according to contemporary management principles and they should be decentralized.”

“All types of management functions need to be performed solely by the hospital management.”

“A [public] hospital’s continuation of its functions needs to be based on efficiency principles.”

“Aside from very unique situations, inefficiently operated hospitals’ operations need to be stopped.”

“[public] hospital services need to be integrated with basic healthcare services.”

“… [public] hospitals will be decentralized and turned into enterprises which will make their own decisions in terms of [acquisition of] their resources and the utilization of their resources.”

“[Public] hospital employees will be paid based on their contributions [to the healthcare services delivered].”

“The studies relating to [public] hospitals’ decentralization and operation based on efficiency principles will be finished by 1993, and pilot studies will be initiated.”

“A General Health Insurance system will be established by 1999.”

"Provision and financing of healthcare services will be separated" (Turkish Republic Ministry of Health, 1993, pp. 47-59).

3.4. Radical Liberalization Period, 2002-Present

The healthcare policies and strategies the Turkish government has adopted following 2002 can be said to be a continuation of the inherited plans and programs initiated as of the enactment of the 1982 Constitution. Following 2002, almost all, and more, of the healthcare principles already set forth by the previous plans and programs were carried forward with the new plans and programs. Specifically, the HTP, introduced by the government in 2003, is the prime example of this trend. The contents of this program were developed based on the recommendations of the World Health Organization (WHO), International Monetary Fund (IMF), the World Trade Organization (WTO) and the Organization for Economic Co-operation and Development (OECD) and the financial credits received from the World Bank (WB), and espoused internally by the Turkish Industrialists' and Businessmen's Association (TIBA), Turkey's Independent Industrialists' and Businessmen's Association (TIIBA) and The Union of Chambers and Commodity Exchanges of Turkey (TUCCET) (Elbek & Adaş, 2009). "According to WHO, the health system of the country should be designed in a way to ensure the delivery of high quality health services for all people ... [healthcare services] should be effective, affordable and acceptable to the overall society … moving from these basic facts, HTP has been introduced in 2003" (Akdağ, 2010, p. 21) in Turkey. A review of the principles of the HTP reveals that they are essentially duplicates of the principles cited - and provided as guidance for Turkish authorities to follow - in the report the WB published, "Turkey - Reforming the Health Sector for Improved Access and Efficiency" (Pala, 2003).The HTP mainly includes principles concerning financing, organization and delivery of healthcare services in an effective, efficient and equitable manner and these principles are: human-centeredness, sustainability, continuous quality improvement, participation, reconciliation, volunteerism, separation of powers, decentralization, and competitiveness in service (Turkish Republic Ministry of Health, 2003). The main components via which these principles will be implemented are (Turkish Republic Ministry of Health, 2003, pp. 26-37):

"Ministry of Health as a planner and supervisor."

"A general health insurance consolidating everyone under one roof."

"Widespread, easy-access and a happy-face healthcare system."

"Strengthened basic healthcare and family medicine."

"Effective and staged referral chain."

"Administratively and financially autonomous healthcare enterprises."

"Highly motivated healthcare manpower equipped with information and skills."

"Education and science institutions to support the system."

"Quality and accreditation for qualified and effective healthcare services."

"Institutional structuration for a wise medication and supply management."

"[Establishment of] National pharmaceutical institution."

"[Establishment of] Medical equipment institution."

"[Establishment of] Healthcare information system."

A series of directives, laws and decree laws were later enacted in order to implement the initiatives required for the 'transformation' of the healthcare system. The most prominent directives, laws and decree laws of the period spanning 2002 to present are listed in the table below.

Table 4. *Healthcare-specific Laws Enacted Spanning 2002-Present*

Law No	**Enactment Date**	**Target Audience**	**Name of Law**	**Principles of the Law**
2003/5443	17 Apr 2003	Healthcare System	Directive on Inclusion of a Supplementary Clause in Government Employees' Treatment (Financial) Aid and Funeral Expenses Directive	• "… the entitled [government employees] can be, for the purposes of treatment, referred by the governmental healthcare facilities to private healthcare facilities (Clause No 2). *This law enabled referral of government employees to private healthcare facilities, which meant that government was willing to incorporate private healthcare into governmental healthcare (a domain once was strictly thought purely governmental).*

4924	24 Jul 2003	Healthcare Personnel	Law on Employment of Contract Personnel in Places Where There is Difficulty in Recruiting Personnel and on Implementation of Change on Some Laws and Decree Laws	• "… MoH can hire contractual personnel … contracted personnel may not perform any other salaried or contracted work in any other government or non-government entity and may not perform their profession or art freely" (Clause No 3 and 5). "…contracted personnel can be paid extra out of the revolving funds of their unit according the relevant rules and regulations" (Clause No 6). "… when deemed necessary, the healthcare services to be delivered by healthcare personnel and ancillary healthcare personnel may be outsourced, provided that these services are funded out of the revolving funds, according to the rules and regulations the MoH identifies" (Clause No 11). "… Law on Some Healthcare Personnel's Government Service Obligation is repealed." *This law enables the government to either recruit its healthcare personnel on a contractual basis or outsource the healthcare services. Payment of these services is to be funded out of the revolving funds.* *This law also discontinues the mandate for physicians' compulsory government service, which was established through law no 2514 in 1981.*
5258	9 Dec 2004	Physicians	Law on Family Medicine Pilot Application	"… the purpose of this law is to regulate the status, financial rights and basics for [healthcare] services for the family medicine which will be geared toward laying emphasis on preventive medicine, tracking of individual healthcare records and enabling access to these services equitably" (Clause No 1). *This law implements the "Family Medicine" initiative in Turkey.*
349	1 Feb 2005	Healthcare Personnel	Directive on Disbursement of	• "The aim of this directive is to … specify the bases, methods and ratios of supplementary

			Supplemental Payment out of Revolving Fund Revenues to Employees of MoH Assigned at Second and Third Step Healthcare Facilities	payment to the personnel employed under MoH … based on their title, duty, working conditions and period, contribution to services delivered, performance, government and non-government working status, working in sections such as medical examination, surgery, anesthesiology, incisive procedures" (Clause No 1). *This directive outlined the rules and methods for supplementary payment to the MoH personnel. This directive established the roots of the PBSPS.*
5371	5 Jul 2005	Healthcare Personnel	Law on Change on Healthcare Services Basic Law, Healthcare Personnel's Compensation and Principles of Employment Law, Public Servants Law, Practice of Medicine and Related Arts Law and Decree Law Concerning the Organization and Duties of the MoH	"… physicians and specialty physicians … are obligated to perform their compulsory government service as contracted healthcare personnel." *This law reinstated the compulsory government services for physicians.*

5396	14 Jul 2005	Healthcare System	Law on Inclusion of a Supplementary Clause in the Healthcare Services Basic Law	"… the [government] healthcare facilities whose necessity for establishment has been decided by the Higher Planning Committee may be outsourced to natural persons or legal entities in return for lease of those facilities for not more than forty nine years, and over a specific fee. (Supplementary Clause No 7). "… these real properties [government healthcare facilities] may be transferred to natural persons or legal entities" (Clause No 7). *This law opens healthcare, a field under government jurisdiction, to private sector in terms of its operation and ownership.*
5471	7 Mar 2006	Healthcare Personnel	Law on Disbursement of Revolving Funds to Rehabilitation Facilities and Healthcare Facilities Belonging to the MoH and Change on Law Concerning 2006 Central Management Budget	• "Out of the revolving fund revenues gained through contributions of personnel … payments may be made to … healthcare personnel … without respect to regular or over time work … the basis, procedures and ratios of these payments will be determined … by the MoH … based on personnel's title, duty, conditions and duration of work, contribution to service, performance and work status in terms of whether or not they are freelancing or performing patient visits, surgery, anesthesiology, invasive procedures or work in risky sections requiring special attention" (Clause No 1). • "… The total payments to be disbursed out of the revenues gained through contributions of personnel … may not be more than 50% of the current revolving fund revenues of secondary and tertiary healthcare facilities and 65% of the primary healthcare facilities" (Clause No 1). *With this law the MoH gained authority to determine the rules and procedures in terms of distribution of revolving funds healthcare facilities accumulate to their personnel.*

5502	20 May 2006	Healthcare System	Social Security Institution Law	"… Social Insurance Institution, Social Insurance Institution for Tradesmen and Craftsmen and Other Self-Employed, Retirement Fund Institution have been abolished and these entities have been transferred to Social Security Institution." *Enactment of this law united all public funds under the Social Security Institution, thereby creating a system in which all government-sponsored healthcare is financed through a single-payer (Social Security Institution).*
5510	16 Jun 2006	Healthcare System	Social Insurance and General Healthcare Insurance Law	"… the purpose of this law is to provide coverage to individuals in terms of social insurance and general health insurance … and regulate the bases and methods relating to the functioning of general health insurance (Clause No 1). "… contracted private healthcare facilities may bill the services they provide to the Presidency of Social Security Institution" (Clause No: 64d). "… the conditions in the exceptional cases under which individuals entitled to General Health Insurance may seek care at private healthcare institutions will be specified by the Presidency of Social Security Institution (Clause No 70). *This law established the long-desired General Health Insurance and also enabled referral of individuals (mainly civil servants) entitled to General Health Insurance to private healthcare facilities.*
663	2 Nov 2011	Healthcare System	Decree Law on Organization and Duties of MoH and its Subsidiaries	"… the MoH … is responsible for administration and policy making for the purposes of planning and diffusion of healthcare services across the nation … and with this aim, the MoH sets the strategies and goals and performs planning, regulation, coordination, guidance provision, monitorization, incentivization, leading,

				supervision and administers enforcement (Clause No 2). "… Turkish Public Hospitals Institution … performs performance assessment activities … ensures effective and efficient operation of second and third step healthcare facilities through Public Hospitals Associations (Clause No 29 and 30). "… hospitals are managed by the [professional] hospital administrators … and hospital staff [i.e.., professional hospital administrators, chief of medical staff, administrative personnel] are hired on a contractual basis… which will be annexed with performance criteria and goals in accordance with institutional goals and performance evaluation criteria (Clause No 30 and 32). *With this decree law, the MoH moved away from its vertically aligned central management structure and adapted a more lateral organizational structure with a functional organizational structure. The MoH also started to employ professional hospitals administrators in its healthcare facilities, which, until this decree law, had been managed by chief of medical staffs of the hospitals. This application, however, was rescinded as of 29 Jan 2015 through a formal memorandum published by the Legal Office of the Turkish Public Hospitals Institution and chief of medical staffs regained their authority to run the healthcare enterprises in addition to their primary duties of managing the medical operations.*
3131	31 Oct 2012	Healthcare System	Directive on Methods and Basis for Operation of Provincial Organizations of	"… Public Hospitals Associations are established in cities … for the purposes of effective and efficient utilization of resources" (Clause No 6). "… the Secretariat General supervises operation of healthcare facilities, monitors

	Turkish Public Institutions	their activities, performs evaluation and inspection, and ensures all preventive, diagnostical, treatment and rehabilitative services are rendered at these facilities" (Clause No 9). *With this directive, local government entities were established to autonomously manage the healthcare facilities and activities in every city in Turkey.*

The MoH enacted these legislations in order to ensure that (1) MoH was restructured as one that centrally made plans, generated policies and provided supervision for the healthcare system in Turkey, rather than one that actually executed implementation of those plans, programs and procedures in the actual healthcare service delivery activities, by means of which the sources responsible for provision of services (i.e., local departments of the government, private sector) and generating strategies (the MoH) were separated, (2) healthcare services management activities were decentralized by means of empowerment of local departments of the government, (3) government healthcare facilities were professionally managed through professional managers recruited mostly from the private sector, (4) healthcare services were made available to each and every individual in the nation through a 'general health insurance,' (5) healthcare services were organized, delivered and financed in an effective, efficient and equitable manner, (6) healthcare personnel were highly motivated to deliver best quality healthcare services through financial incentives driven by a uniquely-devised PBSPS, by which 'supervision-by-performance' versus 'supervision-by-hierarchy' principle was espoused (7) healthcare service quality was enhanced by means of injection of competition amongst government healthcare facilities (by stratifying them based on their attributes, which would encourage them to become better at services performed and thus become competitive with private sector) and (8) basic healthcare services (i.e., preventive services) were strengthened for a healthy and robust nation.

Taken together, as the preceding comprehensive review suggests, the Turkish healthcare system has had a long and challenging journey since the establishment of the Turkish MoH in 1920. As years passed, the goals, mission and applications of the MoH has also changed in line with the social, cultural, technological, financial, political and environmental changes

affecting the strategies, policies and provision of healthcare. In the 1920-1960 period, the MoH reflected dedicated orientations toward principles of state policy in terms of healthcare, and its mission was to fight the communicable diseases the wars in the earlier periods caused, and also to restructure and improve the healthcare system, which was in an extremely poor state, across the nation. The MoH took up the challenge, announcing that policy making and implementation of those policies regarding regulation, financing and provision of healthcare constituted its primary responsibilities, which would be fulfilled by its provincial government entities. Toward that aim, in the initial stages of the Republic of Turkey, various legislations were enacted in support of the healthcare-related priorities and interests of the society and of the fortification of the MoH's central management structure. The MoH, however, was able to partially achieve its goals and mission mainly due to lack of strong political will, political instabilities and financial difficulties experienced during the period of 1920-1960.

Following the year 1960, the government strengthened and solidified its role in terms of ensuring individuals' healthy state physically and spiritually by delineating healthcare as a non-transferrable and indispensable basic right for individuals in the 1961 Constitution, thereby, again, showing orientations toward principles of state policy in terms of healthcare even more formally and strongly. As of 1963, the MoH started advance planning its further healthcare strategies, for five-year intervals, and these plans were devised by the Turkish Republic Prime Ministry State Planning Organization. These plans first identified the problems of the current stage of healthcare of their time, and then identified strategies to resolve those problems. However, these five-year development plans could not be carried out in their entirety due to, again, lack of a determined political will and also financial insufficiencies experienced during the times in which they were to be implemented. They more or less followed the vicious cycle depicted in the Figure 2.

In the period spanning 1980-2002, the government started adopting strategies to gradually open the (until then) government-managed and -owned field of healthcare to private sector by means of commercialization of public healthcare. Specifically, in the later parts of 1970s and the beginning of 1980s, during which neoliberal views and policies gained accelerated momentum in the world, the Turkish MoH's perspective in terms of how Turkish healthcare

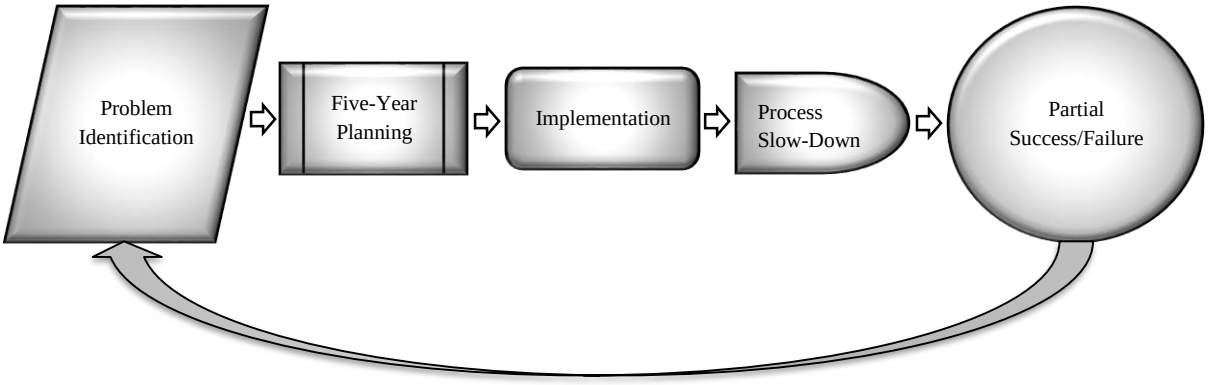


Figure 2. Five-Year Development Plan Realization Process

should be managed started to change progressively toward adoption of those neoliberal views (Elbek & Adaş, 2009; Karasu, 2011). In this new trend, financing and delivery of healthcare services were separated from each other, hospitals were to gain autonomy and would be managed by professional managers, but the ultimate goal was to ensure withdrawal of governments from the delivery of healthcare altogether (Ağartan, 2007). The 1982 Constitution included verbiage stating that the government's role in the financing, strategy development, implementation and provision of healthcare services changed from the government financing and providing healthcare services to the government regulating and supervising the healthcare services with a strong emphasis on integration of private sector into the field of public healthcare system. The Turkish government, which once undertook the responsibilities of ensuring healthy state of its citizens by providing healthcare across the nation with the 1961 Constitution, thereby reflecting strong emphasis on principles of state policies in terms of healthcare, withdrew itself from fulfilling those responsibilities by the 1982 Constitution and casted itself the role of regulation and planning of healthcare services for the nation instead, thereby slightly opening the field to market level forces, which essentially meant that the government was slowly beginning to emphasize business principles in terms of healthcare. The 'newly-adopted' neoliberal thought was comprehensively reflected in the five-year development plans issued past 1980s. However, though significant financial aid and/or strategic assistance and guidance were received from some universal actors promoting neoliberal policies regarding healthcare such as IMF, WHO, OECD and WB, the increased political instabilities experienced during this period

impeded the consistent implementation of the plans, programs and policies in the Turkish healthcare field.

The beginning of the single-party rule period of the Republic of Turkey in 2002 brought with it political stability, which facilitated policymaking and enforcement regarding healthcare reforms the previous governments failed to implement through completion. The political stability also increased the reliability level of Turkey in the eyes of the major universal actors such as IMF, WHO, OECD and WB, the fact of which in turn facilitated Turkish government's access to financial aids disbursed by those institutions. Thus, the years spanning 2002 to present witnessed that with the consistent political power the government possessed, as well as the financial aids received from the universal actors, the reform stages were implemented one after another without any hiccups, but under the name of a 'transformation' instead (Bulut, 2007). These years also witnessed a significant growth in the number of private healthcare facilities trickling into the system. Table 5 illuminates the growth trend of private hospitals in Turkish healthcare from 2000 to 2013.

Table 5. *The Growth of the Number of Government and Private Hospitals in Turkey (2000-2013)*

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Government Hospitals	917	926	837	852	890	853	820	900	897	886	896	893	928	960
Private Hospitals	266	273	277	280	285	301	341	375	411	461	501	517	555	557
Ratio of Private Hospitals	22%	23%	25%	25%	24%	26%	29%	29%	31%	34%	36%	37%	37%	37%

With the adoption of the HTP in 2003, and subsequently PBSPS in 2005, healthcare system was completely redesigned and it was converted from a government-managed field to a field dominated by business principles, whose characteristics in the Turkish healthcare context include, but are not limited to: employment of personnel under contracts with stipulations relating to certain performance criteria (versus employment under government employee status), outsourcing (ancillary services being outsourced to private sector), public-

private partnerships (in which government assumes responsibility only in clinical services and the construction of health facilities, delivery of ancillary services and non-clinical services, and operation of commercial spaces are transferred to private sector in return for lease of those buildings and services to government for a period of up to 49 years on a yearly payment), autonomization, corporatization and privatization of public hospitals (public hospitals being converted to business enterprises with annual budgets and performance goals), and finally, establishment of a "payment and rewarding system to encourage health workers to perform efficient and qualified healthcare services" (Turkish Republic Ministry of Health, 2008, p. 7).

In sum, various different orientations were reflected by the Turkish MoH during the challenging journey of healthcare policies and programs devised and implemented in Turkey. In the initial stages of the Republic of Turkey, the government, by the legislations enacted, communicated that ensuring maintenance and improvement nation's health was within the purview of the provincial government. In these years, individuals were regarded as "social citizens" (Kartal, 2009, p. 23) and priorities and interests of the entire society were guaranteed to be protected by the Republic of Turkey. Thus, the years spanning 1920-1980 were heavily characterized by state principles. Business principles were not at all characterizing the healthcare system in this period. In the period spanning 1980 to 2002, however, the government laid the groundwork for commercialization of public healthcare through the legislations enacted, but without proper implementation due to political instability and financial difficulties. In these years, healthcare system was under very little influence (only subtle shades) of business principles, but very strong influence of state principles remained effective. Following 2002, however, the one-party rule dominated the political arena and further legislations were steadfastly enacted toward commercialization and corporatization of the public healthcare system with prompt and decisive implementation stages. Specifically after implementation of the HTP followed by the PBSPS, from the perspective of the government, individuals began to be viewed as "consumers" (Kartal, 2009, p. 40) in their relationships with the government (just as market principles dictate), and thus the years spanning 2002 to present, when viewed from the government's perspective, were predominantly characterized by business principles (very strong influence) with relatively low influence by state principles.

These inferences are made based on the archival document screening accomplished on the laws, regulations, directives, memorandums devised and implemented by the Turkish Government since the establishment of the MoH. In terms of what is happening down at the ground level, in other words, whether the ground level implementers (in this study, physicians), who are the recipients of these cognitive frameworks, actually structure and enact their practices in line with the prescriptions of the government is still an unknown. In fact, what activated the researcher's curiosity in relation to generating explanations for 'what goes on deep inside organizations' in terms of the belief systems and their associated practices characterizing physicians' day-to-day work were the questions of whether they reflect isomorphic behaviors in line with the state policies, some of which required or involved revolutionary changes in the mindsets of the ground level actors, or whether they reflect different orientations to different belief systems or cognitive frameworks and enact practices in line with them, regardless of the templates the state attempted to infuse into the healthcare field with an ultimate aim to reconfigure how healthcare was to be delivered at the practice level (i.e., redesign of the content and organization of service delivery). What *does* really 'count' for the physicians in their thought processes resulting in action in their daily practices and whether what they believe that 'counts' has changed in any way, shape, or form during processes of institutional change were the main points evoking the researcher's curiosity. The researcher's curiosity stemmed from this cognitively induced deprivation that arose "from the perception of a gap in knowledge or understanding" (Loewenstein, 1994, p. 75). In the researcher's view, the world can only be grasped by understanding the *action* as portrayed by the actual implementers at the coalface, and not by the *dictates or expectations* of guidelines or frameworks by which the work is to be carried out.

CHAPTER IV

METHODOLOGY

The author attempted to craft a research design that best suited to most appropriately explore the research questions posed in this dissertation and to ultimately facilitate achievement of the goals of this study. The fact that the author of dissertation has been professionally involved and is well-versed in the Turkish healthcare system for the past twenty years has proved extremely beneficial not only in the development stages of the research design but in the entire research process as well. The author not only possessed an extensive prior insight in terms of the dynamics of the Turkish healthcare field, but also had prior expertise in professional medical coding (the author gained his certified professional coder diploma from the American Academy of Professional Coders, UT, USA, in 2004), which also facilitated accomplishment of data analysis stages. The author's involvement in and constant interactions with the ground level actors of the field allowed him to gain extensive insight into the institutional complexities experienced in the research setting and the dynamics of the healthcare system as a whole. In the following subsections, the research approach, data collection strategy and data analysis methods will be presented.

4.1. Research Approach

This research investigates the belief systems and their associated practices characterizing Turkish physicians' day-to-day routine work through processes of health reform initiatives. An in-depth review of the journey Turkish healthcare travelled from 1920 to present reflects, from the perspective of the Turkish government, the movement of the field from one phase to another with their associated institutional complexities. During this timeframe, the government espoused different institutional logics under the influence of broader dynamic global complexities, which in turn significantly affected how ground level actors should view the reflection of, and operate under, these institutional complexities in carrying out their daily activities. Institutional complexities create critical contexts (Pettigrew, 1990) warranting in-depth explorations to understand their varying dynamics, conceptual underpinnings and

reflections on the parties that are exposed to them. Hence, untangling and thereby making sense of the institutional complexities experienced by organizations and organizational actors requires a research approach, which should be exploratory in nature (Jarzabkowski et al., 2009).

With its superior exploratory and explanatory power, qualitative research has been identified to be highly instrumental for interpreting and understanding the complexities experienced by organizations and organizational actors in their natural contexts (Basit, 2003; Morgan & Smircich, 1980; Symon & Cassel, 1998) and thus have enjoyed a growing popularity throughout social sciences (Bryman & Burgess, 1994; Denzin, 1994; Marshall & Rossman, 1999). Qualitative research is "broadly 'interpretivist' in the sense that it is concerned with how the social world is interpreted, understood, experienced or produced … based on methods of data generation which are flexible and sensitive to the social context in which data are produced … based on methods of analysis and explanation building which involve understanding of complexity, detail and context" (Mason, 1996, s. 4). Its sensitivity toward the social context makes qualitative research "naturalistic to the extent that the research takes place in real-world settings and the researcher does not attempt to affect, control, or manipulate what is unfolding naturally" (Patton, 2015, p. 58). Thus, qualitative research is multimethod in its focus, involving an "interpretive, naturalistic approach to its subject matter … attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994, s. 2). Specifically, qualitative research designs concentrate on "the study of human behavior and social life in natural settings" (Punch, 2009, p. 170) and provide "deeper understanding of social phenomena and their dynamics" (Attride-Stirling, 2001, p. 385). Furthermore, qualitative research complements the measurement of 'why,' 'how,' 'how much,' and 'how many times' of human experience (Chism & Banta, 2007).

Qualitative research is especially powerful "as a source of grounded theory" (Patton, 2015, p. 18). Grounded theory, which falls within the tradition of qualitative research (Creswell, 2013), is inductively generated from fieldwork, that is, theory that emerges from the researcher's observations and interviews out in the real world" (Patton, 2015, p. 18). Recently becoming highly "popular as a form of qualitative research" (Allen, 2011; Dey, 2007, p. 167; Mills, Bonner, & Francis, 2006), grounded theory is defined as a "qualitative

research design in which the inquirer generates a general explanation (a theory) of a process, action, or interaction shaped by the views of a larger number of participants" (Creswell, 2013, p. 83). Grounded theory research employs an emergent design in which a comprehensive analysis is performed in a systematic fashion via a process of continuous interplay of data collection, analysis and purposeful selection of informants with rich information, which collectively contribute to advancement of development of theory (Strauss & Corbin, 1998).

The benefits of adoption of grounded theory are twofold. First, use of grounded theory is most beneficial specifically in cases where researcher aims to "understand the process by which actors construct meaning out of intersubjective experience" (Suddaby, 2006, p. 634) with the primary goal being generating "explanatory models of human behavior that are grounded in the data" (Morse & Field, 1995, s. 157). Development of explanatory models (substantive theory) which seeks to outline the relationships among concepts and set of concepts as they relate to human experiences and behavior is the centerpiece of grounded theory approach. Thus, the primary goal of grounded theory approach is to understand and offer a substantive theory with relation to the complex world of lived experiences from the point of view of who live it. Second, grounded theory approach is also warranted when the research undertaken focuses on relatively under-researched areas where no substantive theory has been generated explaining experiences and behavior of actors inhabiting those areas (Birks & Mills, 2011; Pidgeon, 1996). Indeed, "the strongest case for the use of grounded theory is in investigations of relatively unchartered waters" (Stern, 1980, s. 20). Taken together, grounded theory attempts to establish theoretical understandings or frameworks of relatively understudied phenomena, or to gain a fresh perspective in a familiar situation, and aims toward "discovering theories, concepts, hypotheses, and propositions directly from data rather than priori assumptions, other research, or existing theoretical frameworks" (Taylor & Bogdan, 1998, s. 137).

Adoption of grounded theory appear to be a suitable methodology as no substantive theory exists in either the Turkish healthcare context or other healthcare contexts specifically about the ground level practices of physicians from an institutional logics lens, although there are some studies explicating physicians' interactions with others in hospital settings or in healthcare fields from an institutional perspective (e.g., Kitchener, 2002; Özseven et al.,

2014; Reay & Hinings, 2005, 2009; Reay et al., 2016; Scott et al., 2000). What has been missing is participant voice accounts for an understanding of physicians' frame of reference for their medical practice from an institutional lens. In this respect, this study aims to establish a theoretical understanding by means of exploring the complexities of physicians' experiences in their daily work practices by giving voice to participant physicians, and thus to assist in bridging the gap between research and practice (Williams & Hill, 2001).

Accordingly, this exploratory study adopts a qualitative approach with a grounded theory design (Glaser & Strauss, 1967; Strauss & Corbin, 1994, 1998) to investigate the real-world perspectives and experiences of physicians through processes of change. In this study, grounded theory design was adopted not just because this approach is "the most influential paradigm" (Denzin, 1997, p. 18) and "most commonly used qualitative method … internationally" (Morse, et al., 2009) in the social sciences, but also because it responded to the needs of the research in terms of enabling understanding of the world of physicians, which is largely affected by a "generative flux of [institutional] forces and relations that work to produce particular realities" (Law, 2006, p. 7). Realities, however, exist in the form of shared symbolic meanings that can be fluid and changeable contingent upon changing environments, contexts and systems, in which they are generated (Aldiabat & Navanec, 2011; Charon, 2010). Under the influences of, and according to, the socially constructed realities, which may undergo revisions as the social systems affecting construction of those social phenomena change, day-to-day practices of physicians, which are believed to be customary and deeply established, may likewise differentiate. As Schwandt (1998, p. 222, emphasis added) points out, "particular actors, in particular places, at particular times, fashion meaning out of events and phenomena through prolonged, complex processes of social interaction involving history, language, and *action*." Hence, the two concepts important to grounded theory are the susceptibility of socially constructed realities to change due to environmental factors (i.e., change; volatility of conditions) and the actors' ability to exert control over their own destiny (i.e., determinism; actors' control over their own actions under volatile conditions). Accordingly, grounded theory "seeks not only to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions" (Strauss & Corbin, 1990, s. 5). In this manner, actors are viewed as having the means of controlling their destinies by their responses to changing

conditions. Which frame of references guide or shape physicians' day-to-day practices, and whether physicians actively control their destiny and amend their daily practices in any shape or form through processes of change (i.e., before and after implementation of HTP and PBSPS) are intriguing questions and are unanswered, and thus deserve in-depth explorations and descriptions. A "well-grounded theory should explain as well as describe" (Strauss & Corbin, 1990, s. 5) and this study aims to investigate these areas of interests thoroughly by means of consulting participant physicians' firsthand experiences and perspectives in order to provide explanations about the phenomena of interest as well as provide various forms of descriptive material for a visual representation of the meaning extracted from the data (Dey, 1993; Sandelowski, 2001).

Grounded theory, with its emphasis on social construction of reality with an interpretive perspective (Goulding, 1998), aims to "understand the action in a substantive area from the point of view of the actors involved" (Glaser, 1998, s. 115), via "explicating the process by which people come to describe, explain, or otherwise account for the world in which they live" (Gergen, 1985, s. 266). Understanding actors' action and explicating the process by which those actions are instantiated requires a focus on the ways in which actors make sense of the world through sharing their experiences via the medium of language. In this study, the researcher strived to understand and describe the world of physicians under study by means of relying on the knowledge from the "inside" (Charmaz, 1995, s. 30). The researcher thus actively sought to learn how physicians in their daily work lives constructed "their experience through their actions, intentions, beliefs and feelings" (Charmaz, 1995, s. 30) in their own accounts. Fundamental reasoning behind selection of grounded theory is thus to understand and provide explanations for how physicians create their socially-constructed worlds and act within them through processes of change by consulting their firsthand knowledge and experience. Grounded theory is particularly suitable for these studies in which there is a specific interest in practical activity, routine situations, participants' point of view and subjective experience (Denscombe, 2003). In what follows, the fundamental tenets of grounded theory, which are actively adopted and followed in pursuing this effort, will be discussed in detail.

Literature Review

One of the prolonged contentious debates in grounded theory research is when to review the related research in the area studied (Charmaz, 2006; Glaser, 1978; Strauss & Corbin, 1998). One view is that literature should be accessed only when the emergent theory is sufficiently developed so as to reduce the risk of bias (Glaser, 1978, 1992, 2001, 2005; Holton, 2007). Another view is that existing literature may be accessed and engaged "at all phases of research" (Strauss & Corbin, 1990, s. 56) to further foster the research process by helping the researcher to identify what is important to the developing theory (Hickey, 1997). Others advocate, based on the premise that neither data nor theories are discovered, but are constructed by the researcher following his or her interactions with the field and its participants (Charmaz, 2006; Mills et al., 2006), "recognizing prior knowledge and theoretical preconceptions and subjecting them to rigorous scrutiny" (Charmaz, 2008, s. 402). Some researchers further argue that research has to be grounded in both data and in literature (Goldkuhl & Cronholm, 2010; Lind & Goldkuhl, 2006).

Glaser (1978, 1992, 1998, 2001, 2005) adamantly argues that it is when most of the conceptual analysis of the data is complete and theoretical integration takes place that the researcher should start engaging in an exhaustive literature review. Glaser instructs, "When the theory seems sufficiently grounded and developed, then we review the literature in the field and relate the theory to it through integration of ideas" (Glaser, 1978, s. 31). At this stage of the research process, comprehensive literature review serves as just another source of data, which can "be woven into the theory … for constant comparison" (Glaser, 1998, s. 67). Holding off on a thorough engagement in literature is to ensure that the researcher is not contaminated by preconceived concepts and ideas already established in extant literature (Glaser, 1978, 1998, 2005).

According to later contributors to grounded theory, however, it would be unrealistic to suppose that the researcher sets out on a research study with no prior knowledge in the subject area of research (Bryant & Charmaz, 2007). They further argue that it is a common misconception that "grounded theory requires a researcher to enter the field without any knowledge of prior research" (Suddaby, 2006, s. 634) and that it is exceedingly difficult for grounded theory researchers to ignore the literature and be oblivious to any prior well-established conceptualizations in the area of research (Bulmer, 1979). As Goulding (2001, s.

23) states, “nobody starts doing research with a totally blank sheet … grounded theory is not atheoretical, but it does call for an open mind and a willingness to have faith in data.” It would be unreasonable to expect the grounded theory researcher to “unlearn” what has already been established in literature (Schreiber, 2001) and to pretend as if they were “theoretical virgins” (Clarke, 2005). Moreover, what seems to be an innovative breakthrough generated by the grounded theory research might simply be matter of researcher’s ignorance of the pre-established concepts in literature (Lempert, 2007). Thus, an early literature review familiarizes the researcher with the relevant literature, and provides an opportunity to understand how the phenomenon has been explored to date, thereby helping him or her to avoid conceptual or methodological pitfalls (Dunne, 2011; McGhee, Marland, & Atkinson, 2007).

In spite of the fact that there are different views on when to access literature among grounded theorists, the common denominator of all approaches is that the researcher should approach the literature with an ultimate aim to be informed and not to be guided by literature while performing grounded theory studies (Charmaz, 2006; Glaser, 1978; Strauss & Corbin, 1998). Performing a literature search, rather than a full literature review, before the researcher sets out on a grounded theory journey is indeed a prerequisite to grounded theory study (Glaser, 1992). Literature review in the form of a literature search is thus is warranted in order for the researcher to be familiar with and current in his or her knowledge of the literature (Lempert, 2007).

In this study, the researcher did not totally dismiss extant theoretical literature nor applied it mechanically into the research process. The theoretical contributions generated via this study were thoroughly grounded in data by grounded theory methods while being informed by existing literature. The researcher, in this manner, approached this grounded theory study with an open mind, but not an empty mind (Dey, 1993). The researcher did search the relevant literature surrounding the research interest briefly at the outset of the study and used these theoretical insights or “theoretical resources” (Watson, 1994, s. 215) in a sensible, creative and flexible way. The intent of this literature review was not to establish a pre-conceived conceptual framework, but to ensure that the researcher had a critical understanding of the extant literature, which provided points of departure for developing, rather than limiting ideas (Charmaz, 1995). The researcher refrained from an exhaustive

literature review until most of the analyses were complete and theoretical conceptualization and integration were in their final stages. It was at this last stage that the researcher performed an in-depth investigation into the relevant research for a successful and creative integration of the theoretical conceptualizations emerging from the grounded theory study with the conceptualizations of extant literature. At this stage, with the notion that "everything is data and contributes yet another perspective" (McCallin, 2003, s. 206) existing theoretical conceptualizations were used as another set of data for constant comparison with the emerging grounded theory (Glaser, 1998). Finally, the findings of this grounded theory study was compared and creatively integrated with their counterparts in the literature and theoretically conceptualized at a more abstract level (Glaser, 1992).

Purposeful and Theoretical Sampling

Purposeful sampling "applies specifically to qualitative research" (Patton, 2015, s. 265) and it involves deliberate selection of proficient, well-informed, or in other words "information-rich cases" (Patton, 1990, s. 169) with the phenomenon of interest (Creswell & Clark, 2011) so as to "learn a great deal about issues of central importance to the purpose of the inquiry" (Patton, 2015, s. 264). Selection of certain individuals or units is "based on a specific purpose rather than randomly" (Tashakkori & Teddlie, 2003, s. 713). In addition to knowledge, experience and expertise, other criteria for purposeful inclusion of individuals or units in the study are their availability, willingness to participate and the ability to communicate experiences and opinions in an articulate and thorough manner (Bernard, 2002; Spradley, 1979).

Theoretical sampling, one of the central tenets of grounded theory (Charmaz, 2008), may be viewed as "*a variation* within purposeful sampling" (Coyne, 1997, s. 629, emphasis in original). Theoretical sampling is "the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides which data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser, 1978, s. 36). It is a "purposeful selection of a sample according to the developing categories and emerging theory" (Coyne, 1997, s. 629). Researchers adopting grounded theory should let the perspectives of the individuals already involved in the study suggest the next step on what to look for and where to go to address them. In sum, theoretical sampling in grounded

theory is “the process whereby you decide what data to collect next and how to find it” (Holton, 2007, s. 278), but this process of data collection is “continually guided” (Glaser, 1992, p. 102) and “controlled by emerging theory” (Glaser, 1978, s. 36).

This study started out with purposeful selection of key informants in the initial interviews. The main driver of this sampling strategy was to incorporate in the study the individuals “who have had experiences [and insight] relating to the phenomenon to be researched” (Kruger, 1988, p. 150). The aim in the initial purposeful sampling was, from the perspective of physicians, to gain a baseline understanding and descriptive information in terms of “what is all involved here?” (Schatzman, 1991, s. 310). The interviewees were thus conducted with highly seasoned physicians with rich, intimate and extensive knowledge pertinent to the topics of research to address and elaborate upon the areas of interest. Efforts were geared toward gaining as much in-depth information as possible by means of delving into physicians’ experiences and opinions with regard to their belief systems and the associated practices in medicine. Purposeful sampling continued with ten participants, although emergent themes (i.e., regularly occurring patterns of behavior or certain phrases or words repeated by different informants) were followed up by the sixth interview. Purposeful sampling was followed by active sampling of new cases as the analysis proceeded (Pidgeon, 1996) in order to illuminate or saturate theoretical categories that emerged, or to discover more details or other properties about the emerging theory (Glaser & Strauss, 1967). At this theoretical sampling phase, selection of participants was sourced through snowball sampling procedures, which have been widely utilized in qualitative studies (Biernacki & Waldorf, 1981).

In the snowball technique, “The researcher identifies one or more individuals from the population of interest. After they have been interviewed, they are used to identify other members of the population, who are themselves used as participants, and so on. Snowball is useful when there is a difficulty in identifying members of the population” (Bryman, 2008; Mason, 1996; Robson, 2002, s. 265). Use of this technique was justified as the researcher at this stage was attempting to gain access to physicians at government medical treatment facilities, in which identifying participants who met the eligibility criteria (i.e., having been exposed to both before and after the healthcare transformation policy implementation) for the research would be challenging through the conventional methods like letter writing or

other communication methods. In addition, given the fact that there is a high level of networking in government treatment facilities, the researcher was best suited to reach potential participants with rich knowledge and experience through referral networks (Cooper & Schindler, 2003). Accordingly, subsequent recruitment of participants was exercised by means of referrals made by the initial contact - who had a great social network links within the government healthcare system - at one of the government medical facilities. The members of the referral chain generated through the initial contact had great accessibility to network links and knowledge about the information sought and they thus acted, in a way as "de facto research assistants" (Biernacki & Waldorf, 1981, p. 153). Through active utilization of those 'research assistants,' theoretical sampling strategy continued to fully explicate emergent themes until the categories of the emergent theory were saturated and no new data seemed to emerge (Charmaz, 2003). The main focus during the entire theoretical sampling phase was on sample adequacy (Bowen, 2008; Eisenhardt & Graebner, 2007) and the emphasis was thus continually placed on quality rather than quantity of data sources with the objective being reaching saturation with information on the topic versus maximization of the research sample (Padgett, 1998). In essence, theoretical sampling means sampling to the point of redundancy (Bowen, 2008; Charmaz, 2006; Strauss & Corbin, 1998), and the primary aim of the sampling strategy this study adopted was to achieve just that goal.

Interviewing, Field Observations and Documentary Qualitative Data

In qualitative research, the interview is one of the approaches for data collection, often combined with other data collection methods such as observation and document analysis (Eisenhardt & Graebner, 2007; Hall & Rist, 1999; Myers & Newman, 2007). Specifically, interviews and participant observations are the core methods of data collection in qualitative studies (Backman & Kyngas, 1999; Benoliel, 1996). Interviews are relatively unstructured at the initial stages of the studies, but become more focused as the study progresses. Researcher begins his or her research with pilot interviews to prepare and modify emerging interview questions, which are utilized in later stages of the interview process (Kim, 2011; Sampson, 2004). During these initial stages of unstructured and exploratory interviews, general themes and patterns begin to emerge. Informed by these insights, the researcher reaches additional informants to expand upon those insights or to gain different perspectives,

often via semi-structured interviews. In this way, the interviews would be "guided by theory development … the ongoing analysis will influence the questions that are asked, with the direction of the interview becoming driven by emergent theory" (Wimpenny & Gass, 2000, p. 1489).

Semi-structured interview is considered to be an important method for qualitative research (Flick, 2006). Semi-structured interviews utilize an interview guide – a script structuring the interview process (Brinkman & Kvale, 2015) – for the interviewer to successfully steer the conversation in a certain direction (Myers & Newman, 2007). In semi-structured interviews, in order to gain a rich understanding of the pre-identified topics, the task of the interviewer is to lead through the topics by flexibly utilizing the interview guide ensuring all questions are covered as successfully as possible (Myers & Newman, 2007).

In this study, the two main aims of the interview schedule and strategy were (1) to use a funnel-like approach whereby the focus of questions progressively moved from general to specific and (2) to avoid leading questions as much as possible in order to elicit rich and full description of the experiences and thoughts of the physicians. In this manner, at the initial stages of the research process, interviews were unstructured and exploratory and included general questions about the belief systems and experiences of physicians regarding their duties and responsibilities and regular work. Thus, in an effort to keep within the grounded theory approach, the initial questions were broad (i.e., open-ended) to allow for a variety of responses and to elucidate more detailed answers to ground the findings of the study in data rather than the researcher's own presuppositions (Kirchhoff & Lawrenz, 2011; McCallin, 2003). The initial questions to be addressed in this study were identified as:

1. How do you define your work as a medical professional?
2. What do you believe as important in the performance of your work?
3. Are there certain principles you abide by or draw from while performing your work?
4. Have you experienced any differences in terms of how you view your duties and responsibilities in any time in your career as a physician?
5. Do you believe the values, belief and rule systems of practicing medicine have in any way changed within the past 30 years?

Questions for which answers were sought later became more focused by delving into specific issues and concerns, by means of adopting a semi-structured interview approach. In following a semi-structured interview strategy, the aim was to "elicit data on perspectives of salience to respondents, rather than the researcher dictating the direction of the encounter" (Barbour, 2008, p. 119), allowing the researcher to explore the responses of the interviewees in an authentic manner (Smith & Eatough, 2007). Accordingly, a semi-structured interview protocol was developed focusing on areas of interest in order to elicit the cognitive structures and their associated practice characteristics guiding physicians' behaviors while they perform their routine work. The semi-interview content encompassed a set of questions with alternative subsequent items depending on the responses obtained, suggestions for prompts, and a proposed sequence for the questions, which was subject to change during the course of the interview (Robson, 2002). Interview questions were "directed to the participant's experiences, feelings, beliefs and convictions about the theme in question" (Welman & Kruger, 1999, p. 196). Data were obtained with the intent "to unfold meaning of people's experiences" and to elicit how participants "think and feel in the most direct ways" (Bentz & Shapiro, 1998, p. 96), ultimately allowing for the essence of the topic to emerge. Prompts were kept to a minimum to avoid leading the respondents, but were exercised to keep the interviews focused and relevant to the research topics. Researcher provided clarification only in cases when there was considerable digression in the course of the interviews or when the information participants provided was too ambiguous to be interpreted. A complete list of questions and their evolution from initial stages to the later stages of the study can be located in the Appendix.

Field observations, another core aspect of qualitative research, which can be documented in the form of field notes, are also important in order to triangulate interviews with these additional data. Field notes "are contemporaneous notes of observations or conversations taken during the conduct of qualitative research" (Thorpe & Holt, 2008, p. 97). Field notes are mental notes, jotted or scratch notes taken at the time of observation (participant or non-participant observation), discussions or highlights remembered, which are typically transcribed by hand for later development (Thorpe & Holt, 2008). The researcher conducted all interviews in physicians' workplace environments ranging from pre-op or post-up preparation areas (mainly for surgeons and anesthesiologists), practice offices, examination

rooms, procedure rooms, conference rooms and break rooms within the hospitals while they performed their daily activities (i.e., seeing patients, preparing patients for surgeries or procedures, conducting meetings). The fact that the researcher, during each and every visit of the participant physicians at their workplace environments, spent the entire day constantly observing their daily activities during provision of medical care allowed the researcher to make observations in terms of the nature and conditions of healthcare provided by the physicians participated in the study. The researcher systematically documented these observations in the course of writing theoretical memos. The main reason observations were also included in the study was to close the gap between what was said during the interviews, which may at times turn into "rehearsed events" (Crompton & Jones, 1988, s. 70) and what was actually done during a typical day in the daily activities of the physicians.

The notion that "all is data" (Glaser, 2001), is another fundamental aspect of grounded theory. According to Glaser (1967, 1998), whatever comes the researcher's way while studying a substantive area, such as archival documents, relevant literature etc. is considered data to constantly compare and to generate patterns and concepts. Accordingly, in this research, the principle of 'all is data' has been adhered to and the data collected from interviews, field notes, archival documents and existing relevant literature were circularly analyzed and compared to induce patterns and concepts.

Memo Writing

Memo writing is another core stage in the process of grounded theory generation (Glaser & Strauss, 1967). Memos are the fundamental processes of "researcher/data engagement that results in a grounded theory" (Lempert, 2007, s. 245). They "are theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding (Glaser, 1978, s. 83). These ideas serve as "written records of a researcher's thinking during the process of undertaking a grounded theory study" (Birks & Mills, 2011, s. 10). Thus, memos have been described as "… a storehouse of ideas" (Strauss & Corbin, 1998, s. 153) or "intellectual capital in the bank" (Clarke, 2005, s. 85).

Memo writing is essentially the "methodological link, the distillation process, through which the researcher transforms data into theory" (Lempert, 2007, s. 245). It is the researcher's continuous written dialogue in relation to emerging ideas or theoretical

conceptualizations, which stimulates generation of questions or insights to be addressed with the next participant. These ideas or insights are followed up with the subsequent participants to inquire about whether more data confirms the earlier developing ideas or they are refuted and thus should be discarded. Throughout this constant comparison process, the researcher uses memos to document these ideas or insights, continuously analyzes emerging concepts, develops relationships between categories or conceptualizations, and simultaneously raises codes to higher levels of abstraction (Charmaz, 2006). Thus, by writing memos throughout the research process, "the researcher explores, explicates, and theorizes these emergent patterns" (Lempert, 2007, s. 245).

Memoing was the most intellectually stimulating aspect of this study and aided greatly in "capturing ideas in process and progress" (Charmaz, 2008, s. 166). It was systematically used throughout the research process to record developing ideas, insights or tentative hunches and to reflect researcher's evaluations of them and thus played a pivotal role in the analytic process and the writing up of the study. Recording of memos and interweaving the conceptualizations arising from them in the coding processes and increasing the level of abstraction of these conceptualizations indeed forced the researcher to 'think about thinking.' Ultimately, throughout the research process, memoing kept the researcher on track as well as chronicle the ongoing conceptualization of the study. Two of the memos produced during the interview and data analyses processes are provided as examples below.

Memo 12.12.2015

Which core values or cognitive bases physicians' practices are feeding out of?

From the few interviews I have conducted thus far, it looks as if physicians are continuously referring to their various different orientations structuring their belief systems which then guide their behavior while performing their daily work. Physicians, in their accounts, state that which rule systems or orientations they may follow may differ by physician depending on how they perceive and internalize those values and cognitive structures. For instance, a physician stated, "I formed a unique philosophy for myself in my delivery of medical care." Another physician likewise stated "Physicians go to school for so many years and once they start practicing medicine, they develop a professional understanding 'a certain way of doing business' for themselves, and it may change from physician to physician."

This is intriguing, as one would think that since all physicians go through similar training and orientation at medical schools, they would probably have a relatively standard way of providing medical care. The assumption would be that this unique training and education deeply ingrained in them channel them into a specific way of thinking and performing. It looks as if this is not the case for physicians. Regardless of the standard training and education they go through, they, in a

way, are free to choose how they will apply those resources into their daily practices. This is very interesting and I believe it deserves more investigation in terms of which core values and cognitive processes guide physicians' practices in their daily routine. Now that data have emerged and opened this issue up, I should be more in tune with this topic in my following discussions. Thus, more sampling to uncover the dynamics underlying these phenomena is next.

Figure 3. Memo on Preliminary Understanding of Cognitive Bases for Physicians Practices

Memo 16.12.2015

The Core Values or Cognitive Bases Guiding Physicians' Practices

At this point, I have made a lot of headway in terms of distinguishing the mechanisms feeding physicians practices. From the data I have gathered thus far, it appears that physicians' core values or belief systems reflect themselves in their orientations toward how they should deliver medicine in four different and unique ways. For instance, a participant physician stated, "We heavily draw upon and abide by the principles of Hippocratic Oath and medical necessity while delivering healthcare." Another physician likewise stated, "Now, let's think about it. You are a physician and of course, you will abide by the principles of Hippocratic Oath. You cannot deviate from these principles." However, some commented in the opposite direction and stated, "In reality, it would be denying his or her profession for a physician to say that they do not abide by the principles of Hippocratic Oath and/or medical necessity while performing their profession, but I have to say that I do not agree that they actually do." Another physician, finding it difficult to reconcile the actual practices performed on the ground with the principles inculcated in them by their medical education, training and the principles of Hippocratic Oath, stated "To be honest with you, while performing delivery of healthcare in their daily routine, physicians set aside the principles of Hippocratic Oath and medical necessity and become slaves of their economic concerns." Some stated, "Hippocratic Oath and medical necessity are nostalgic concepts for physicians … all they think about is maximizing their revenue at the expense of butchering the principles of the Oath." Some of the physicians took a different stance and stated, "You have to follow the rules and the bureaucratic processes while delivering healthcare; you are essentially a government employee." Others presented a different viewpoint and stated, "In the old days, you had only a patient and a doctor in the delivery of healthcare, and that was it. Now, physicians must take into account and protect the benefit of the organization and the Ministry of Health, for which they essentially work, while determining which treatment method, supply and equipment they should use." Some elaborated on this aspect further and stated, "Whether you like it or not, physicians unavoidably are channeled into a mindset in which they abstain from ordering labs, tests or special studies unless they are absolutely, I mean *absolutely*, necessary. Because, these doctors' orders essentially increase the facility's expenditures and in turn affect the payment each and every physician receives from the facility's revolving funds."

The four unique and distinct belief systems physicians repeatedly refer to seem to be compatible with professionalism, principle of business (though not completely), principles of the state, and another one which seems to deviate from and be in conflict with all of the aforementioned three belief systems. Aside from these four different core values or underlying belief systems guiding their practices while providing medical care, physicians also discussed some fundamental integral

parts or attributes of their belief systems. In their accounts explaining their belief systems channeling their behaviors, they also constantly referred to what their actual focus would be during patient encounters, which seemed to vary in relation to their main orientation toward medical practice.

For instance, the physicians espousing and cherishing traditional core values of medicine stated "My job is to treat patients," while physicians whose main focus was maximization of their revenue stated "The benefit of the patient, protection of the health of the patient etc., are not in our radar; we treat so as to increase our revenue, and that is our only focus."

On the other hand, physicians with an orientation toward principles of the state, commented, "we are doing everything we can to ensure that we see as many patients as possible to ensure they have an easy and quick access to healthcare … patients are now able to choose which physicians they would like to be seen by … and their access to healthcare is significantly increased." Physicians with an orientation toward business principles (though not completely), state "Our focus now is to provide effective and efficient healthcare … we are doing our business according to efficiency principles … the concepts of efficiency, profitability and sustainability of the organization are constantly being mentioned in our meetings."

It was also intriguing that they also constantly visited how they in general viewed their status as well as their target audiences' status. Their view and categorization of themselves and their audiences seemed to also vary with respect to the belief system they espoused.

For instance, physicians with orientations toward conventional medicine constantly stated "We are healer-professionals and not anything else (referring to the fact that they are not businessmen, as required by the business principles) … and we treat patients. That is what we are educated and trained to do." Physicians with orientations toward business principles, however, stated, "You are providing a [healthcare] service to your customers and your organization, or you can actually say your *company* in this case, receives a payment in return for these services, and finally you as the physician will get your share out of the revenues made from the company's revolving funds. Thus, we call ourselves stakeholders or profit partners of our company." Physicians whose orientations were toward state principles pointed out, "We are public servants and that is what our status is; we are striving to do our job in accordance with the rules and regulations …. We view our patients as government healthcare beneficiaries." The 'renegade' physicians who deviate from or otherwise reject all these three unique orientations, and thereby attaching themselves to a separate but unique orientation, stated "We view the patients as a vehicle, a commodity, by means of which we will reach our aim, and that aim is to gain the most possible private revenue." Thus, these areas need to be further investigated in the following sampling of physicians. In addition, physicians' accounts of various ground level practices associated with these belief systems also require further investigation, which will be followed up in the subsequent sampling of participant physicians.

Figure 4. Memo on Cognitive Bases for Physicians Practices

Constant Comparison and Theoretical Saturation

Constant comparison method is another core feature of grounded theory methodology (Charmaz, 2006; Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1998). By means of an iterative process, constant comparison method confirms that theoretical concepts are identified across and amongst data sets, continuing collection of additional data to the point of theoretical saturation (Glaser, 1978, 1992; Strauss & Corbin, 1998). As new concepts or

constructs are noted, they are compared to other concepts with respect to communalities and differences, the process of which serves to uncover and explain patterns and variations. Constant comparison requires the researcher to constantly revise and evaluate emerging theoretical concepts on many different data sets via a continuous cycling, or "flip-flop process" (Pidgeon & Henwood, 1996, p. 88) between data collection and data analysis. In this process, the data to be collected next is determined by the conceptualizations that arise out of analysis of the previous data. This constant interplay between data and researcher's conceptualizations results in emergence of theory.

Constant comparison encompasses four stages (Glaser, 1965, pp. 439-443): *First stage*, which corresponds to the 'open coding' stage identified by Strauss and Corbin (1998), involves coding to establish categories and subcategories. In this stage, researcher performs incident-to-incident comparisons by means of comparing incidents (i.e., bits of data: words, phrases, themes or concepts) applicable to each category, the process of which involves coding each incident in as many categories as possible. This stage also entails generating theoretical properties of categories as the researcher finds similarities of incidents or group of incidents signifying certain theoretical dimensions of categories (i.e., subcategories). Once these categories and their subcategories are established, the researcher starts comparing incidents with the previously coded incidents within the already-established categories and subcategories to saturate these categories. When the researcher encounters different streams of thought, which are in conflict with earlier notions or thoughts, then the researcher starts recording memos on those emerging thoughts for further coding and constant comparison. *Second stage*, which corresponds to the 'axial coding' stage identified by Strauss and Corbin (1998), involves comparison of incidents with the theoretical dimension of the already-established categories. It also encompasses further integrating possible diverse subcategories (or categories) under more unified categories (i.e., linking of sub-categories to the core category). *Third stage*, which corresponds to the 'selective coding' stage identified by Strauss and Corbin (1998), involves progression of categorization to the highest level of abstraction by means of reduction of categories based on their underlying uniformities. Reduction of categories result in smaller set of saturated concepts, through paring off non-relevant categories and integrating categories into higher level abstractions in the form of overarching categories or themes, which are forced by constant comparison procedures. At

this point, researcher also consults relevant literature to ensure there is a close correspondence between extant theory and data and that the theory is applicable to a wide range of situations. This is the stage where the researcher's ultimate aim is to achieve parsimony in the number of conceptualizations and applicability of the scope of the theory. *Fourth stage* encompasses researcher's summarizing his or her theory by means of providing explanations for the findings reached in their study.

Saturation, in grounded theory, is used in a double sense: category saturation and theoretical saturation, both of which are interlaced and forced by constant comparison. Category saturation, which occurs in the earlier stages of the open coding process, refers to situations in which raw data are coded until no further codes are necessary to categorize the data (Strauss & Corbin, 1998). Theoretical saturation, on the other hand, is reaching "the point in category development at which no new properties, dimensions, or relationships emerges during analysis" (Strauss & Corbin, 1998, p. 143). It is the fundamental criterion utilized to judge when to cease theoretical sampling, at which time no further data collection is needed as it will not develop the theory any further (Glaser & Strauss, 1967). In other words, saturation is reached when no new or noteworthy conceptual properties, theoretical dimensions, insights or perspectives are seen within the data and that the category development is dense (Strauss & Corbin, 1998).

Consistent with the ground theory approach, the constant comparison method was employed to analyze the data. In accordance with the constant comparison method, numerous rounds of data were accomplished to ensure densification of categories. To achieve this goal, the initial participants, who offered valuable insights, were purposely re-interviewed multiple times in order to develop and further explore the emergent theory. Participants continued to be recruited into the study via theoretical sampling to ensure the validity of emergent theory and to prevent premature termination of data collection via further participant enlistments, which on an operational level meant asking participants to elaborate upon topics of relevance to a greater detail, sometimes working on in the face of repetition (Drisco, 1997). However, it was noticed that no new theoretical insights were emerging from the data and there did not appear to be anything relevant unaccounted for that would further the theoretical conceptualizations. At this point, the researcher actively and creatively engaged with pertinent literature to integrate the research findings with the emergent areas

of literature as well as with the body of literature, by means of comparing and integrating findings of the analyses, to further conceptualize those findings at a more abstract level. Although saturation is deemed to be relative and true saturation may never be attained as new information may continue to crop up during later parts of the analysis (Dey, 1999), those may be overlooked as they "will in all probability have little modifying effect on theory" (Glaser, 1965, p. 442; Glaser & Strauss, 1967). The researcher's efforts to seek new properties or dimensions through analyses reached a point of diminishing returns, at which point, additional data gathering was discontinued. At this point, the researcher was able to account for "as much variation in a pattern of behavior with as few concepts as possible thereby maximizing parsimony and scope" (Glaser, 1978, p. 93), via which theoretical completeness can be claimed.

Procedure

Data analyses were accomplished by hand, as the researcher had a strong preference for interacting with the data on a more personal level. This method of analysis was specifically opted for because the researcher also had a substantial experience in manual qualitative coding procedures and practices as a certified professional coder and a coding auditor. Although the volume of data subjected to coding procedures was at times overwhelming, continuous interaction of researcher and data proved beneficial in terms of noticing new insights and comparing them with earlier conceptualizations. Use of traditional method of analysis in research employing grounded theory approach is indeed suggested by grounded theory scholars (Glaser, 2003; Glaser & Holton, 2004; Holton, 2007). It is recommended on the premises that "the coding process in classic grounded theory is not a discrete phase but rather an intricate and integral activity woven into and throughout the research process" (Holton, 2007, p. 287). Glaser (1998, s. 185-186) suggests:

> "Technologies, especially computers, which produce inadvertently their own brand of ideational product by their constraints, are an easy cop out on the full power of memoing … the constant deburdening and delimiting of the grounded theory process on its route to a theory, is lost by the copious collections and process of computers and tape recorders. Thus,

taping and computerization offer safety net of technology, yielding a formulated product over a freer grounded theory analysis."

By the above statement, Glaser alerts against potential "technological traps" (1998, s. 185-186) of data analysis performed by utilization of sophisticated computer packages. Accordingly, by doing the data analyses (i.e., comparing, contrasting and repeatedly going over data) manually, the researcher was free from these technological traps, and adoption of this method adopted allowed him to be flexible and creative in all phases of data analysis processes.

4.1. Data Collection

Data collection and analyses were accomplished concomitantly, but for the purposes of providing clarity for this research study, data collection efforts are reported under this subsection. Data gathering was not a linear process and was driven by the inductive and interpretative method being employed. During all phases of data collection protocol, the researcher continually and carefully examined whether the analyses of newly collected data provided consistent or similar categories and/or themes or whether new patterns emerged. Data collection continued until diminishing returns from analysis of each new data collection (i.e., to the point where the overlaps and consistencies [i.e., saturation] in the participant accounts began to emerge as a more thematic and abstract story) were being achieved and that newly collected data confirmed findings from previous data (Charmaz, 2008; Glaser, 1992).

Following the necessary ethical approvals acquired from the Çukurova University Ethics Committee and Adana Branch of Public Hospitals' Administration of Turkey, the implementation of the research was officially authorized by the University and the MoH, and the researcher began to conduct the interviews and observations. In accordance with professional ethical guidelines, and given the professional status of the participants and the nature of the research, participants were verbally reminded that they were free to withdraw from the study at any point of time without necessarily giving a reason immediately before interviews. The voluntary nature of the interviews was stressed to all participants and no potential participant was coerced into participating in the study. All participants were fully informed as to the nature of the study (i.e., aim, objective and rationale) before being asked

to give their consent to participate. A brief introduction of the interview protocol and provision of reassurances that all information provided would be held in strictest confidence (i.e., participants' identities would be safeguarded throughout the research, and that identity of the respondent would not be linked to the information provided (Cormac, 1996; Oppenheim, 1992)) preceded each and every interview, and accordingly all interview notes were later anonymized (Morse, 1998).

The sequence of introduction for each interview followed warm-up, main body of interview, cool-off, and closure (Robson, 2002). A debrief followed each interview and feedback on the interview was elicited. A research assistant accompanied the researcher to take verbatim notes in all phases of this research. Following closure of interviews, almost all participants extended their appreciation for being interviewed on such an important topic and reported that they found interview questions very well designed and thus thought provoking. Some of the participants stated that the interview brought up issues they had not previously considered. Some reported that they had been so bogged down in their daily routine to reflect on their experiences and that it was so beneficial for them that they were able to converse about these issues with a researcher.

In line with the purposeful and theoretical sampling approach, which were already explained in detail in the preceding subsections, decisions about selecting and including empirical material were made in the process of collecting and interpreting data. Accordingly, sampling strategy involved purposeful sampling in the early stages and then a shift to theoretical sampling later in the study (Charmaz, 2006). Data collection was not planned in advance, but was directed by what emerged, in an iterative process of data collection and analysis (Glaser & Strauss, 1967). The physicians were included in the study based on their expected level of insights and contributions to elaboration and generation of theory. Data collection was thus done in a gradual and progressive manner. Data collection consisted of interviews and observations (from 2015 to 2016) and archival documents (from 1920 to present).

Initially, the researcher wished to understand the cognitive structures or the belief systems permeating the Turkish healthcare context all the way through the ground level practices to have a baseline understanding about the phenomenon under study. A combination of archival and interview data was collected. The aim of collection of archival and interview data was

to obtain a deep and broad understanding of evolution of the healthcare field, the institutional logics characterizing the perspective of the MoH and the practices enacted at the ground level, and thus to improve and strengthen credibility of the data (Miles & Huberman, 1994). Accordingly, the researcher first collected archival data regarding the legal environment in which healthcare was embedded. The researcher collected all available material regarding Turkish health system such as law texts (24), decree law texts (2), directives (3), Turkish Grand National Assembly Minutes of Proceedings (2), five-year development plans (10), memorandums (2) and a national policy document (1) for the duration spanning 1920 to present. Additionally, the researcher conducted interviews, lasting from 45 to 120 minutes with two policy leads from the upper echelons of the Turkish government.

Determination of the structure of the sample for the interviewees in a way that it socially represented various views on ground level cognitive frameworks and associated practices was a formidable task. To address this issue, the researcher had some starting points. The first one was that how physicians may interpret and enact their social world may be dependent upon their specialty in medicine. The second was that these interpretations and enactments may be influenced by physician's gender. The third one was that professional experience may also affect how they absorb and reflect those cognitive structures in their everyday practices, and finally the fourth being that those interpretations and enactments may be influenced by the cultural and political contexts (i.e., specific organization). In order to address these factors, the researcher ensured that physicians from various (almost all) specialties were included in the study. These specialties included orthopedic surgery (4), general surgery (3), cardio-vascular surgery (5), brain surgery (3), thoracic surgery (2), pediatric surgery (3), plastic surgery (2), ear, nose and throat surgery (3), obstetrics/gynecology (3), anesthesiology (3), urology (3), ophthalmology (2), endocrinology (2), pulmonology (3), nephrology (2), gastroenterology (3), neurology (2), dermatology (2), pediatrics (2), mental health (4), general practice (3), family medicine (3), and emergency medicine (2). Male and female physicians were integrated into the study as equally as possible (36% female and 64% male). Special care was taken to ensure a wealth of professional experience was represented in the sample, and toward this aim, only physicians with a certain level of experience was included in the research. Accordingly, the physicians participating in the study were professionally involved in provision of healthcare

for 21 to 44 years. In order to eliminate the issue of context-specificity, researcher purposefully selected participants from five different government hospitals. Interview schedules with the physicians employed by the government hospitals were accomplished as explained in the following stages.

The first stage in the interview schedules involved an exploratory phase in which the researcher conducted extensive interviews with ten well-experienced physicians who had been in practice for over thirty years through purposeful sampling strategy. These physicians were particularly selected by the researcher, using his own network links, for interviews due to their experience in the public healthcare system for at least thirty years. The length of interviews ranged from two hours to four hours, and these interviews were repeated three times with each interviewee. At the beginning, data were gathered by means of conversational interviews to enable participants to describe their experiences and observations in their own words and from their own perspective. Interviewees generally chose their own starting point; however, if a further prompt was requested, then elaboration on the possible influences of recent set of changes on delivery of healthcare, which began with the implementation of HTP and PBSPS, was suggested. This approach was chosen so that interviewees would have the maximum flexibility to (re)construct their experience of new policy implementation as well as reflect on events affecting practice of medicine in a way that made sense to them. Later interviews, however, increasingly and progressively focused on whether the physicians felt a difference in terms of the way in which they delivered healthcare before and after the implementation of HTP and PBSPS in their own regular course. Interviews were channeled into that direction via accounts provided by the participants as “we used to do things differently before we were asked to be a physician and a businessman at the same time,” “If you asked me how I am doing it now (referring to post policy implementation) I would have said it differently,” or “We have changed a lot. I mean the way we provide healthcare seems to be way more different than how we used to do it in the old days.” In general, during the interviews, depending on the courses of the interviews, various open-ended questions were addressed (by adding the clause, “could you please elaborate upon this subject?) including but are not limited to: “how do you define your work as a medical professional?”, “what do you believe as important in the performance of your work?”, “are there certain principles you abide by or draw from while performing your

work," "have you experienced any differences in terms of how you view your duties and responsibilities in any time in your career as a physician?" and "do you believe the values, belief and rule systems of practicing medicine have in any way changed within the past 30 years?" The goal of these interviews was to gain a comprehensive insight into the ground level incarnations of logics as well as whether the values, belief systems and/or work practices of the ground level actors had, in any way, been modified in line with the implementation of the HTP and PBSPS over time.

The second stage entailed conducting semi-structured interviews with fifty-four physicians currently employed at five different public hospitals. This stage also involved recruitment of participant physicians into the study through snowball sampling strategy along with a shift from purposive sampling to theoretical sampling. Physicians were from a wide variety of backgrounds and specialties to include, but are not limited to: orthopedic surgery, general surgery, cardio-vascular surgery, brain surgery, thoracic surgery, pediatric surgery, plastic surgery, ear, nose and throat surgery, obstetrics/gynecology, urology, ophthalmology, endocrinology, pulmonology, gastroenterology, neurology, dermatology, mental health, general practice, family medicine, and emergency medicine. All interviews were face to face and took place at the workplace location of the interviewees. These workplace environments ranged from pre-op or post-up preparation areas (mainly for surgeons and anesthesiologists), practice offices, examination rooms, procedure rooms, conference rooms and break rooms within the hospitals, which allowed the researcher to make observations in terms of the nature and conditions of healthcare provided by the physicians participated in the study. The researcher utilized an interview guide with an open-ended approach in an effort to (1) elicit answers fully from the perspective of the study participant, (2) progressively gain deeper understanding of the context and meaning of the responses provided through various forms of probing, and to (3) steer the conversation in those channels that lead to discovering the culture, norms, belief systems and experience of the respondents in their own words. The carefully crafted questions posed during the interviews allowed the researcher to glean the ways in which research participants viewed and interpreted their professional and social world. Interviews were geared toward identifying the general professional belief systems, behaviors and their associated practices physicians adopt during their daily work and whether

or not those belief systems and practices experienced any changes in relation to the period before and after the government-led health reform initiative.

During interviews, with the assistance of a research assistant, extensive and detailed notes were taken verbatim. The use of written comprehensive notes jotted down either during or subsequent to an interview has been considered to be superior to the exclusive use of audio-recordings that are subsequently verbatim transcribed (Fasick, 2001; Halcomb & Davidson, 2006; Wengraf, 2001), mainly due to the fact audio transcriptions may be open to potential human errors during the process of transcriptions (Easton, McComish, & Greenberg, 2000; MacLean, Meyer, & Estable, 2004), time consuming (Fasick, 2001; Wellard & McKenna, 2001), and costly (Wellard & McKenna, 2001). More importantly, recording devices often make people feel uncomfortable with being tape-recorded (Wilson, 2010) specifically when the topic of discussion is sensitive in nature. In these types of research, the nature of the topic "potentially poses a substantial threat to those who are or have been involved in it" (Lee, 1993, p. 4). In these research endeavors, recording devices may be viewed as an obtrusive intervention, and may "draw unnecessary attention to the observer and disrupt the natural flow of events and conversations in the setting" (Taylor, Bogdan, & DeVault, 2016, p. 82). They may have "fundamental effects in determining what actors think and feel about the researcher (mainly, it makes them terribly suspicious and on guard) and what they do in his presence" (Douglas, 1976, p. 53). It was the case for all participants of this research, and a good portion of them felt at times uncomfortable making statements about the practices they enact, a majority of which challenged the practices they were expected to follow. Most started the conversation by requesting assurance by means of statements or questions as, "My name is not going to be disclosed, right?", "No one will know that I said these things, right?", and "I am not going to be in trouble having this interview, right?" Some of the potential interviewees even rejected being interviewed (a total of three participants) stating that it was a "sensitive" topic as it involved government policy implementation and that they would rather not participate in the study for fear that they may "find themselves in trouble" (phone conversation with physician, Jan 2016). The fact that all interviewees were currently government employees made it tough for physicians to accept the interview, let alone being tape-recorded. Obviously, in these situations, tape-recording may make some respondents "extremely nervous about having an interview tape recorded" (Oliver P., 2010, p. 47) the

fact of which may alter what people may say about the topic under discussion, and researchers thus "should not record interviews if it makes informants ill at ease" (Taylor et al., 2016, p. 130). Rather than tape-recording, detailed note taking in some aspects is actually beneficial in that it reminds interviewees "that they are under constant surveillance and tips them off to areas in which the researcher is interested" (Taylor et al., 2016, p. 84). The researcher firmly assured all participants that their names would not be disclosed and that all interview notes would be anonymized. This assurance eased the acceptance and course of the interview and participants felt comfortable elaborating on the subject being discussed. Thus, the researcher opted for taking extensive detailed notes during interviews. Note taking versus tape-recording was also suggested during the exploratory interviews conducted with the two policy leads from the upper echelons of the Turkish government. In one of those interviews, the government representative stated, "I would not go with tape-recording, if you do that, people may feel uncomfortable and not say as much on tape, you may not get as much information from interviewees as you desire (interview with government representative, Aug 2015).

The hand-written notes were transcribed onto Word documents (Reay & Hinings, 2009) immediately following the interviews. These data were supplemented with unobtrusive observations, which were also hand-transcribed as field notes, which later were integrated into the theoretical memos documented. Collected interview notes and memos were reviewed after each interview and before the next interview to assist in building knowledge and understanding of the nature of logic representations at the ground level. Interviews and memos made after each interview were followed up in subsequent interviews, thus iterating perceptions to gain better understanding. Interviews ranged in length from one hour to two hours, but in a few rare cases, to five hours. The text material encompassing archival documents, interviews and memos reviewed amounted to a total of 6,416 pages.

4.1. Data Analysis

Before moving into the specifics about the data analysis procedures, it should be first explained that the actual data analysis process performed does not identically match the linear presentation of the data analysis processes reflected herein, as data analysis procedures performed in this research proceeded in iterative cycles, not in a sequential or linear order.

Thus, the data analysis stages explained in the following are not rigidly discreet, but significantly overlap. In other words, although presented in the following as a step-by-step procedure, the analysis involved an iterative and reflective process, and there have been a constant "flip-flop process" (Pidgeon & Henwood, 1996, p. 88) between the collection of data and simultaneous data analyses, and data and theoretical conceptualizations (Bulmer, 1979).

Data analysis, in Strauss & Corbin's (1998, p. 13) terms, is "the interplay between researchers and the data … [which requires] researchers to aptly name categories, ask stimulating questions, make comparisons, and extract an innovative, integrated, realistic scheme from masses of unorganized raw data." The aim is to consolidate various pieces of data under a composite pattern representing the essence of data, the practice of which is referred to as an act of "synthesizing" (Morse, 1994, p. 30) in a systematic fashion. Analysis, then, is segregation, grouping, regrouping and relinking data in order to consolidate meaning and explanation (Grbich, 2013), the tasks of which are best accomplished via a process called 'coding.'

Coding Procedures

In grounded theory, data analysis can be best conceptualized as accomplishment of a series of coding steps conducted on the data, which are the topic of analysis (Strauss & Corbin, 1998). A multi-stage coding system was used to assist in the analysis of data (Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998) (see Figure 5). Coding is generally defined as "the process of naming segments of data with a label that simultaneously categorizes, summarizes and accounts for each piece of data" (Charmaz, 2006, pp. 43-45). The first step in coding involves sweeping through the data and assignment of all meaningful quotations, the process of which has been variously referred to as initial coding (Charmaz, 2006) or open coding (Strauss & Corbin, 1998). Open coding is carried out depending upon the researcher' definition and preference of coding unit, which may include word-by-word, line-by-line, or incident by incident coding units (Charmaz, 2006; Saldana, 2009). Researcher may also use coding units as small as a single word or phrase or as long as several paragraphs or pages (Fassinger, 2005). In this stage, in addition to why, how, in which way, how much, when, in relation to and to whom (Strauss & Corbin, 1990), "what is this data a

study of," "what theoretical category does this specific datum indicate," "what is actually happening in the data" (Glaser, 1978, s. 57) and 'what is the basic social psychological process or social structural process that processes the problem to make life viable in the action scene' are the questions that are asked of the data. The open coding stage continues until the point of coding saturation, which is the stage in the coding process where no further codes are necessary to categorize the data (Glaser, 1965).

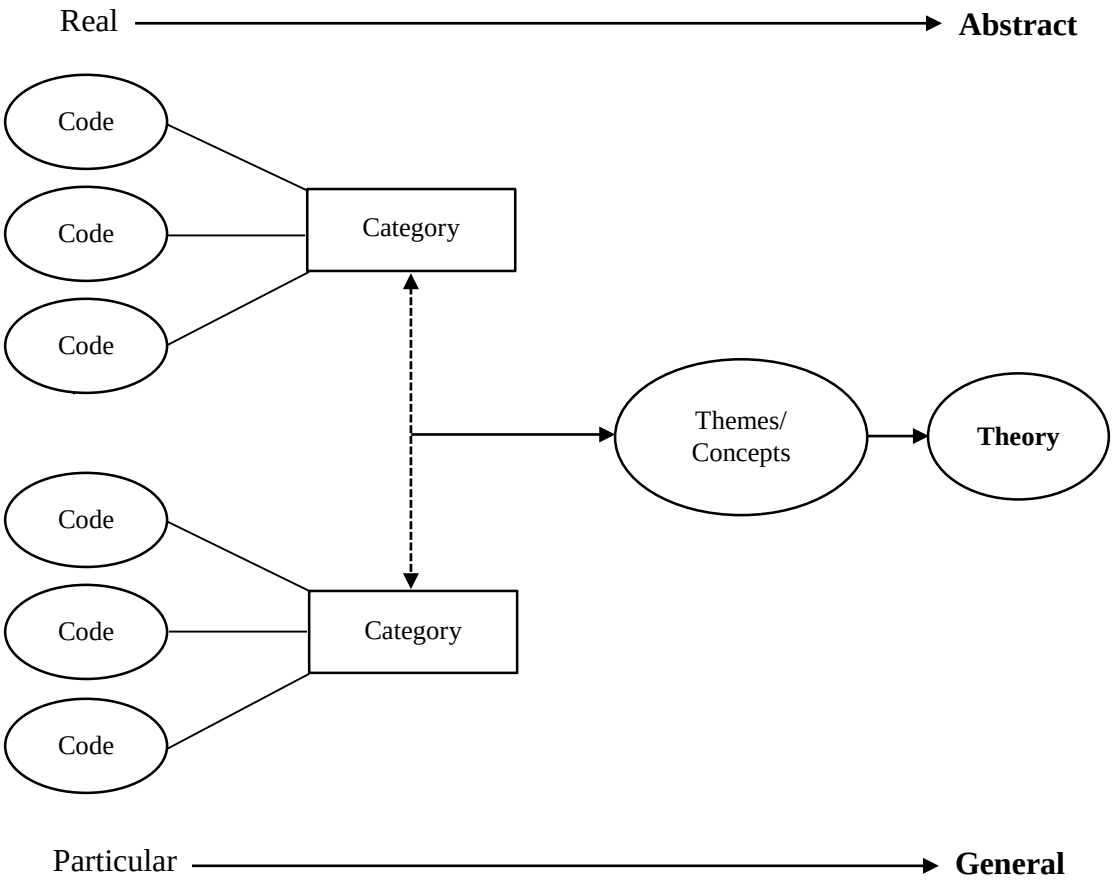


Figure 5. A Streamlined Codes-to-Theory Model for Qualitative Inquiry
Adapted from Saldana (2009, p. 12)

The second coding phase involves "using the most significant and/or frequent earlier codes to sift through large amount of data … goal is to determine the adequacy of those codes" (Charmaz, 2006, s. 57). In this stage, the primary aim is to find patterns and relationships in the data for further refinement and organization of the established open codes under more generic categories, the process of which has been defined as 'axial coding' by

Strauss and Corbin (1990) and ‘substantive coding’ by Glaser (1998). Substantive codes are “categories and properties of the theory which images the substantive area researched. They are used to build the conceptual theory” (Glaser, 1998, s. 136).

The third step consists of “the process by which all categories are unified around a ‘core’ category, and categories that need further explication are filled-in with descriptive detail” (Corbin & Strauss, 1990, p. 424; Strauss & Corbin, 1998), the process of which can be described as conceptualization or theme building (Saldana, 2009). This stage of the coding process has been identified as ‘selective coding’ by Corbin and Strauss (1990) and Strauss and Corbin (1998) and ‘theoretical coding’ by Glaser (1978, 1998). Theoretical codes “implicitly conceptualize how the substantive codes will relate to each other as interrelated, multivariate hypotheses in accounting for resolving the main concern. They are emergent and weave the fractured story into concepts back to an organized whole theory” (Glaser, 1998, s. 163). This is the stage where the core central or core category, “which consists of all the products of analysis condensed into a few words that seem to explain what this research is all about” (Strauss & Corbin, 1998, s. 146).

These coding stages ultimately facilitate convergence of various perspectives, whereby meanings “move from a lower level of abstraction to become major, overarching themes rooted in the concrete evidence provided by the data” (Bowen, 2005, p. 218). To achieve this aim, coding stages in this study involved continually modifying initial codes and categories, eliminating old ones and adding new ones to account for newly obtained evidence, ultimately arriving at overarching themes.

Data Analysis Procedures

Data analyses were conducted using constant comparative method (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Constant comparison is considered to be a core feature of grounded theory methodology (Bowen, 2008; Charmaz, 2006; Strauss & Corbin, 1998). Generally, constant comparison method encompasses continuously comparing and integrating statements (i.e., codes) relevant to each category or theme that emerge from the data, prompting the researcher either to note that additional information is discovered or to identify that the statements are beginning to repeat certain concepts and themes, signaling the fact that saturation has been reached (i.e., no new or relevant information emerging from

the analyzed statements would further develop a conceptual theme) and that the comprehending is complete (Morse, 1994). Several analyses were conducted both during the field study and following completion of all data collection phases, involving reviewing the interview transcriptions several times, coding statements diligently, choosing categories and composing matrices, establishing composite patterns (i.e., linking themes), and ultimately, generating theory grounded in the data and writing it up in a coherent fashion. Figures 6 through 9 denote an illustrated process of coding and analysis stages and collectively summarizes the participant physicians' accounts for four of the core themes emerged under one of the main attributes of participant's core values and cognitive structures guiding their behaviors: 'Mission Orientation.'

Rigorous data analyses reflected four different mission orientations of physicians: An orientation toward medicine, business principles, bureaucratic system and interest maximization. Figure 6 denotes the coding analysis process resulting in the emergence of the core theme 'Orientation toward medicine.' Under this overarching theme, two interrelated categories were saturated: 'Considering health and benefit of patient as first priority' and 'Exercising nondiscriminatory and ethical healthcare delivery.' The underlying codes yielding 'Considering health and benefit of patient as first priority' category were referring to practicing medicine with a focus on keeping healing of patients in the forefront of their work, such as 'Health of patients is our first priority,' 'Benefit of patients is at the forefront,' and 'Nature of the job is to heal patients.' These three codes were also generated through a number of rounds of coding analyses via which numerous interrelated codes were grouped under three codes. Some of the statements made by the physicians in relation to these three codes were as follows:

"Of course our first priority is to heal our patients."

"It would be in direct conflict with the nature of our job to ignore our main aim, and that is healing our patients."

"Patients' interests are and have been always our first priority."

"We do want to heal our patients; and that is what we are trained to do."

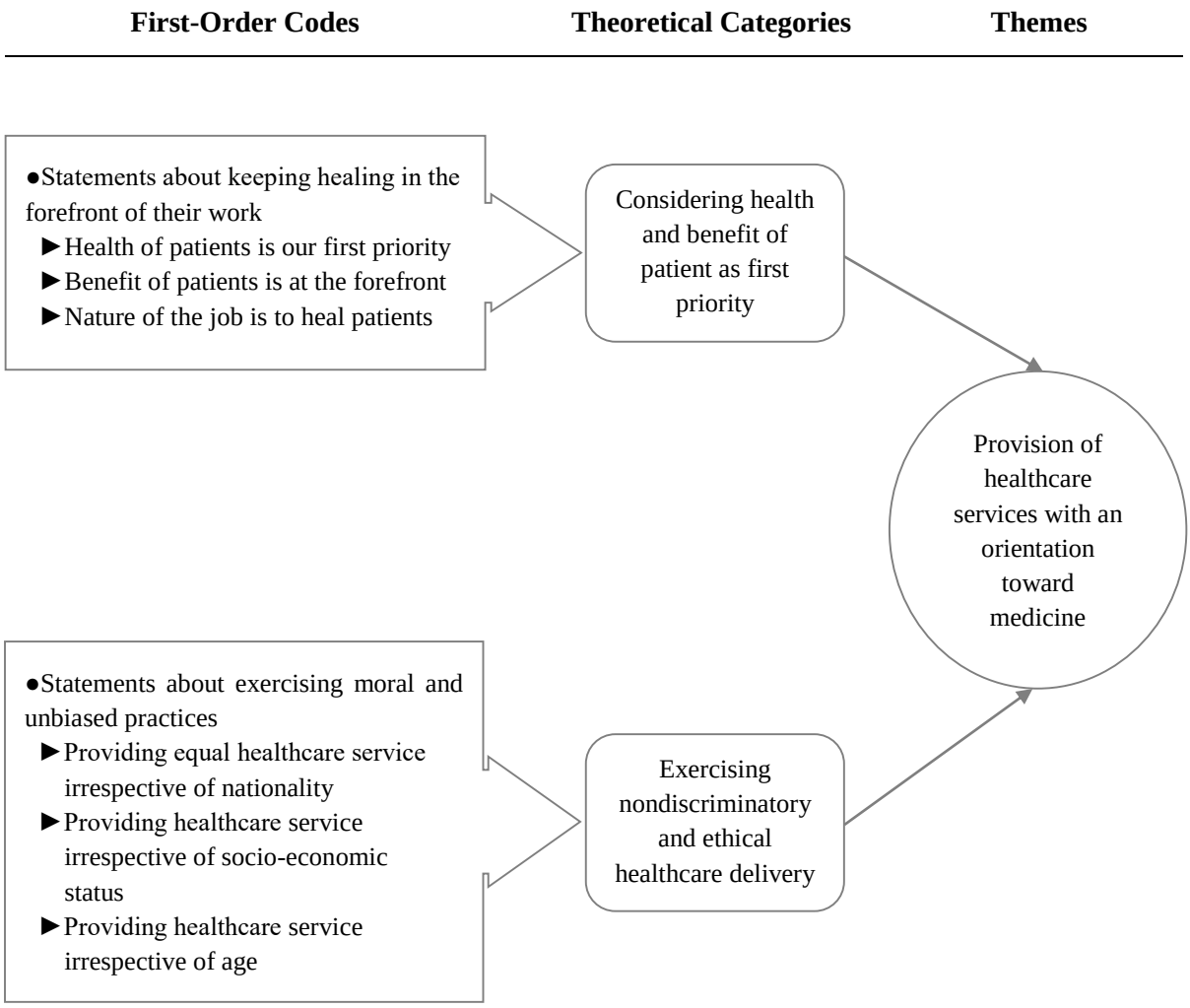


Figure 6. Illustration of Coding Process: Orientation Toward Medicine

The second category defined as ‘Exercising nondiscriminatory and ethical healthcare delivery’ subsumed the following saturated codes: ‘Providing equal healthcare service irrespective of nationality,’ ‘Providing healthcare service irrespective of socio-economic status’ and ‘Providing healthcare service irrespective of age.’ Statements made by the physicians in relation to these three codes, which were also saturated though rounds of data analyses, were as follows:

> “Now say that you have an emergent patient whose nationality is Syrian. You do not know this person at all and you have no idea why they are here. Nevertheless, you have to provide

this patient the same level of treatment as you would any other Turkish patient. Why? Because your professional conception says so."

"In some cases, we would have to treat some patients that are raggedly-dressed and filthy. If you saw those people on the street, you would probably avoid going near them for fear that you might contract a disease."

"Our only focus was on the patient back then. Think about it, patient comes and obviously he is very poor and uneducated. What are you going to do, not provide care? Of course not. Some of our patients were even illiterate. In those cases, we would write what they needed to do on a piece of paper and ask them to get help from their neighbors or relatives with reading and understanding them."

"I see my colleagues vigorously treating a 75-year old in oncology. The reason is we see that individual as a human; regardless of his or her age. In our view as a physician, everybody deserves to be treated."

Further cyclic data analyses emerged 'Orientation toward business principles' as another core theme, coding stages of which are illustrated in Figure 7. 'Practicing medicine with efficiency considerations,' 'Practicing medicine with profitability considerations' and 'Practicing medicine with competitiveness considerations' appeared to be the main categories on which 'Orientation toward business principles' theme anchored. The category defined as 'Practicing medicine with efficiency considerations,' was derived from the codes referring to practicing medicine with a focus on cost containment, such as 'Being careful about ordering tests,' 'Being careful about using supplies,' and 'Having to order/use cheap supplies.' Again, these codes were, after numerous rounds of analyses, reached as a finite set of codes which were discrete enough to avoid redundancy but were salient enough to be meaningful. The text segments related to these codes included:

"When the total monetary amount of the tests physician orders gets close to 27 TL, then the system starts alerting you that you have almost reached your limit for ordering tests, and we then think twice about ordering more."

"Supply procurement is now tracked and is being controlled. We are now more careful about what we use and how much we use."

> "This is a business. Efficiency is important. We are especially careful about the supplies coming from abroad as the less we use those supplies the less we will be a burden on the government budget."

> "In the past, we would place an order for that supply, and we would get 1,000 ordered from it. Later, we would only use 300 or max 500 of them. Those supplies had shelf lives and thus they would eventually expire and later be wasted. Now, things are different. We are now being careful in ordering and using supplies."

The category defined as 'Practicing medicine with profitability considerations' saturated around the codes referring to practicing medicine with a focus on maximizing organization's profitability, such as 'Being productive to generate more revenue for organization,' and 'Practicing medicine with a profitability focus.' The related text segments from the participant physicians' accounts included:

> "The business demands that we be productive and generate more and in turn get paid more, and we do just that."

> "The organization is sliding toward being a business enterprise. Profitability, efficiency, and competitiveness are now in everything we do."

> "In one of the meetings, the chief of medical staff stated, 'Doctor X, you earned this hospital 150,000 TL, and then turned to another physician and said 'You earned this hospital 300,000 TL. So, as you see, our focus is now on earning this hospital more money."

> "How much profit did this hospital make because of me is important, as that also affects how much I will be getting in return from the hospital."

> "Now, while we provide healthcare, we must take into consideration our organization's benefit and profitability."

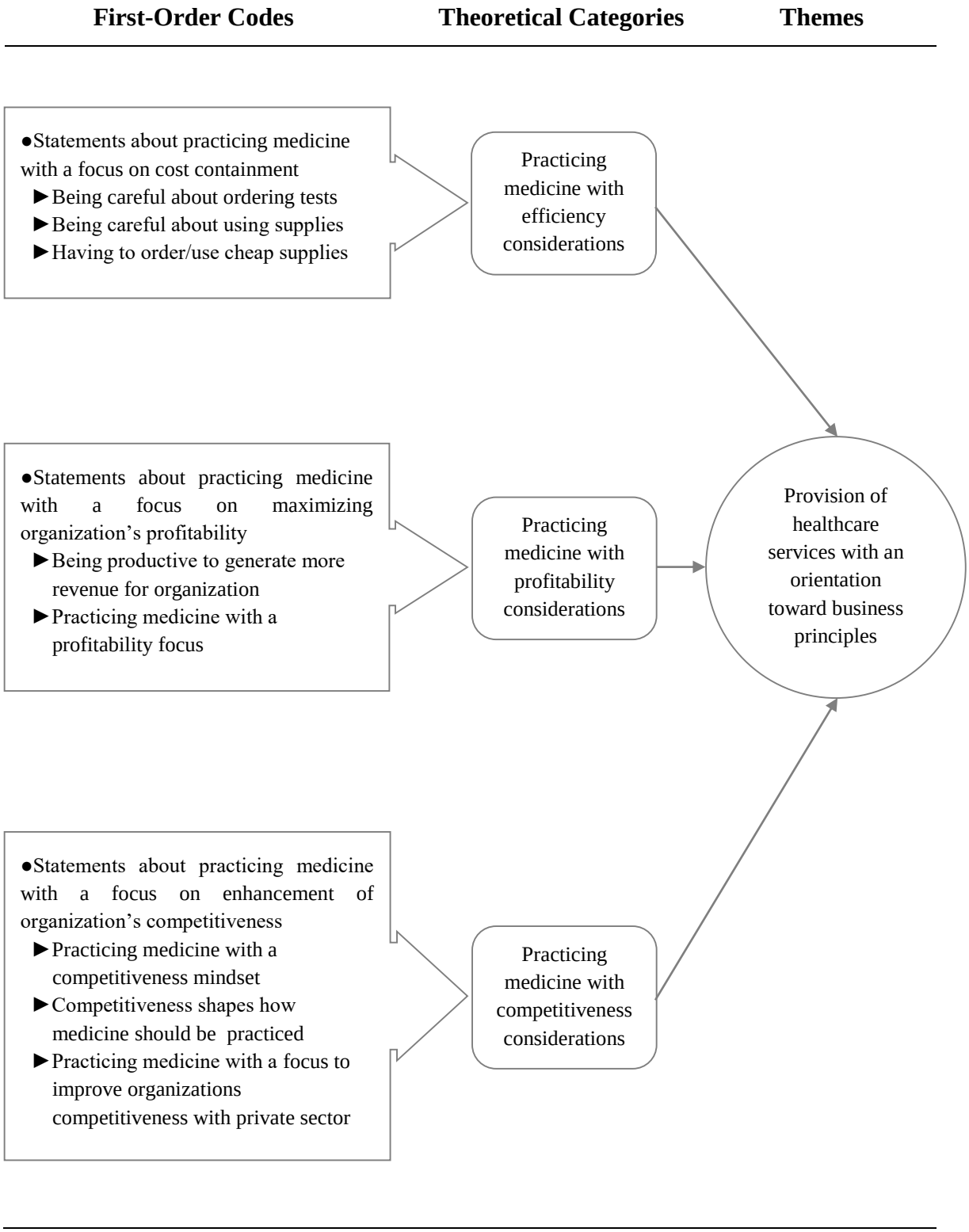


Figure 7. Illustration of Coding Process: Orientation Toward Business Principles

The last category saturated under the theme ‘Orientation toward business principles’ was ‘Practicing medicine with competitiveness considerations,’ which was derived from the codes encapsulating ideas referring to practicing medicine with a focus on enhancement of organization’s competitiveness, such as ‘Practicing medicine with a competitiveness mindset,’ ‘Competitiveness shapes how medicine should be practiced,’ and ‘Practicing medicine with a focus to improve organizations competitiveness with private sector.’ Text segments relating to these codes included:

> “Competitiveness is at the forefront of all we do now.”
>
> “Now, profitability, efficiency and competitiveness rules shape everything we do.”
>
> “This is ultimately a business enterprise now. Efficiency, competitiveness and profitability are at the forefront. With the provision of the necessary equipment and personnel, the best quality care is aimed and being delivered at this time.”
>
> “Public hospitals are significantly competitive now. It is because of all the technological equipment they have and the qualified physicians who operate them.”
>
> “We have been making a lot of headway in becoming a more competitive organization.”

Another core theme, which emerged from the data, was ‘Provision of healthcare services with an orientation toward bureaucratic rules and standards,’ the coding stages of which are illustrated in Figure 8. This core theme subsumed the following three categories: ‘Practicing medicine in accordance with laws and regulations,’ ‘Practicing medicine in accordance with bureaucratic system,’ and ‘Practicing medicine in accordance with standards and procedures.’ The category, ‘Practicing medicine in accordance with laws and regulations,’ was saturated around codes, which encapsulated ideas referring to practicing medicine while maintaining compliance with all associated laws and regulations, such as ‘Practicing medicine according to laws’ and ‘Practicing medicine according to regulations.’ The underlying text segments supporting these codes included:

> “I have been a physician since 1990. I have always worked according to the laws and regulations of the government.”

"We are employed by the government, and as a government employee, we do our business in line with the government rules and regulations."

"This is our job and we need to do it according to the regulations set forth by the government."

"You must abide by the laws. This is required of you if you work for the government."

The category identified as 'Practicing medicine in accordance with bureaucratic system' anchored on codes referring to practicing medicine while maintaining compliance with all associated bureaucratic rules such as 'Working in a hierarchical system,' 'Working in a highly specialized structure' and 'Operating in a high division of labor.' The statements in relation to these codes included:

"The work is being done in accordance with the requirements set forth by the bureaucratic system."

"We are abiding by the laws and the processes of the bureaucratic structure."

"Now, we have clinical chiefs. The work assistants perform are recorded under their name. Because the government gives them this power."

"The system works this way. We are working in a strict hierarchical system."

"… Everybody knew what their responsibilities were. Nurses would do nurse work and physicians would to physician work."

"… There was a superior-subordinate relationship; everybody focused on their own responsibility."

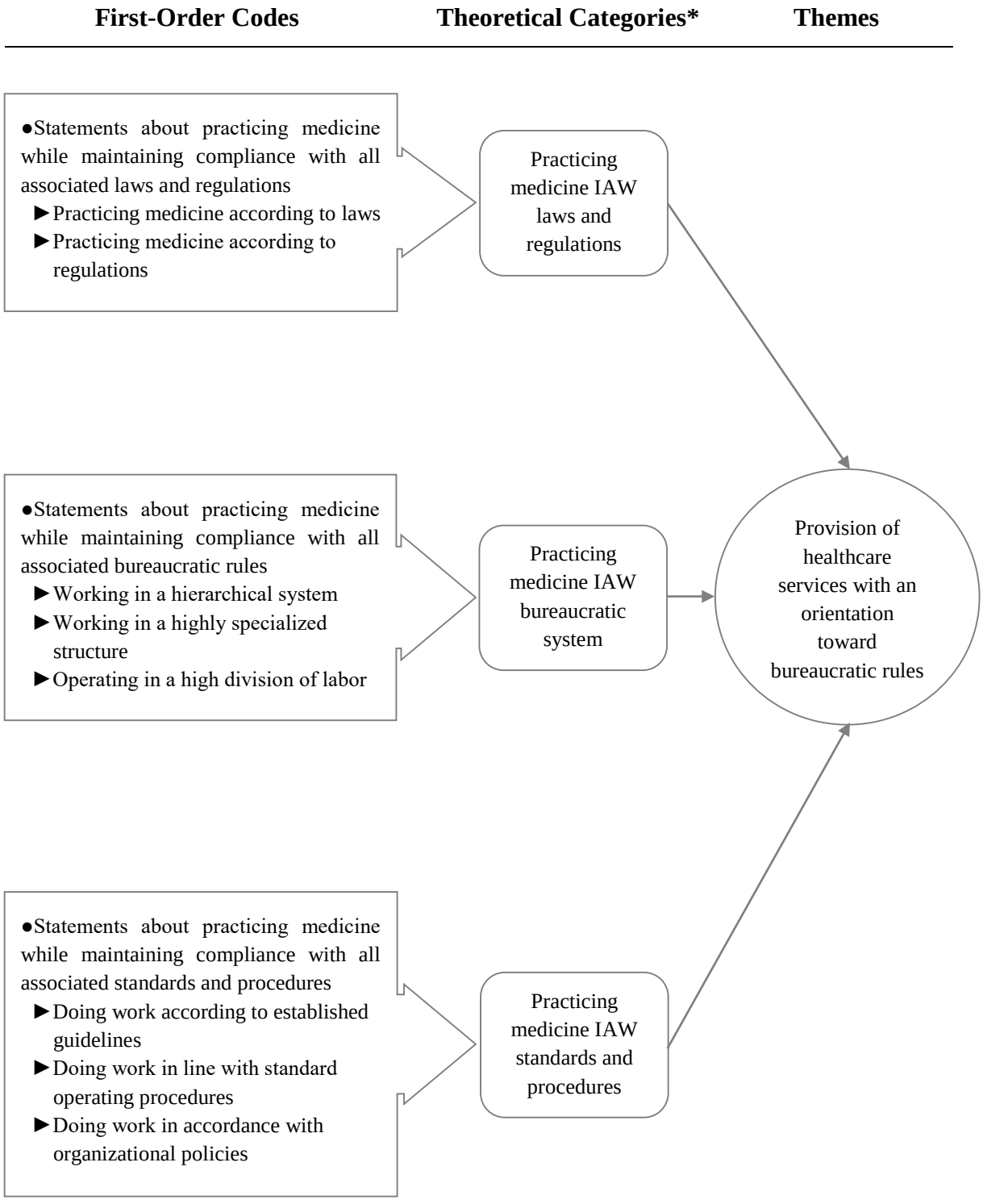


Figure 8. Illustration of Coding Process: Orientation Toward Bureaucratic System

*IAW: In accordance with

The last category emerged under the theme ‘Provision of healthcare services with an orientation toward bureaucratic rules and standards’ was ‘Practicing medicine in accordance with standards and procedures,’ which was saturated around the codes referring to practicing medicine while maintaining compliance with all associated standards and procedures’ such as ‘Doing work according to established guidelines,’ ‘Doing work in line with standard operating procedures,’ and ‘Doing work in accordance with organizational policies.’ Text segments relating to these codes included:

> “We follow rules and procedures; you need to, because that is the nature of government employment.”
>
> “Say the patient is running a fever. Physicians will request a consultation; because it is required by the procedures we must follow.”
>
> “Physicians will satisfy all required documentation as required by the established procedures in place.”
>
> “To be on the safe side, we ensure that all necessary standard documentation is completed in accordance with hospital policies and procedures.”
>
> “Standard documentation is completed by all physicians in this hospital.”
>
> “There are certain standards established by the government and we are doing our best to comply with them.”

The last core theme which emerged was ‘Provision of healthcare services with an orientation toward interest maximization,’ coding stages of which is illustrated in Figure 9. ‘Subjecting patients to extra charges,’ ‘Opting for treatment generating highest private revenue,’ ‘Ordering or performing unnecessary tests/procedures,’ and ‘Claiming reimbursement for unperformed tests/procedures’ emerged to be the categories on which the theme ‘Provision of healthcare services with an orientation toward interest maximization’ anchored.

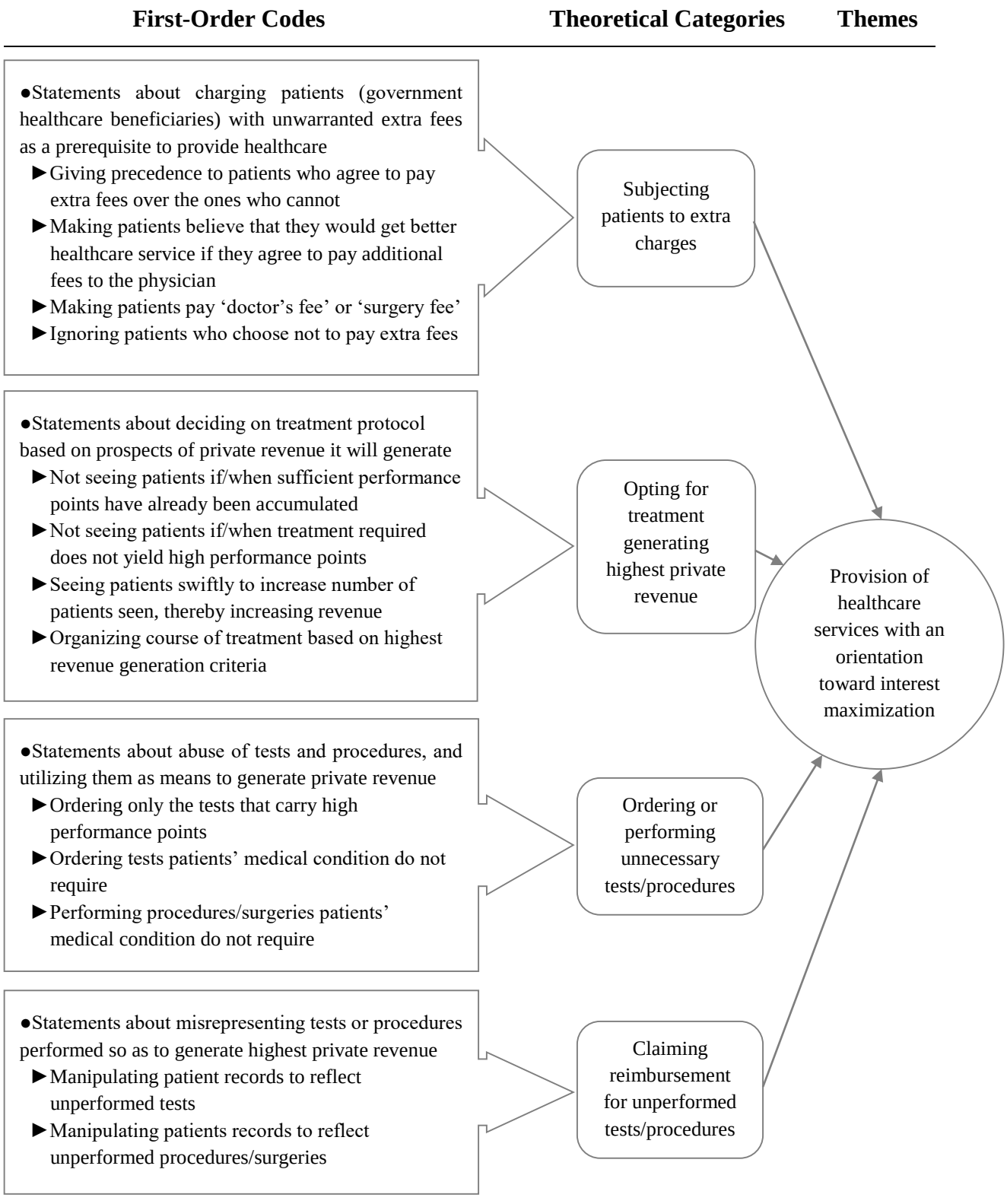


Figure 9. Illustration of Coding Process: Orientation Toward Interest Maximization

The category identified as ‘Subjecting patients to extra charges’ was derived from the codes referring to charging patients (government healthcare beneficiaries) with unwarranted extra fees as a prerequisite to provide healthcare, such as ‘Giving precedence to patients who agree to pay extra fees over the ones who cannot,’ ‘Making patients believe that they would get better healthcare service if they agree to pay additional fees to the physician,’ ‘Making patients pay a ‘doctor’s fee’ or ‘surgery fee’,’ and ‘Ignoring patients who choose not to pay extra fees.’ The text segments related to these codes included:

> “I have seen such cases … that patients who do not agree to visit the doctor’s office and pay the extra fee had to wait for months to get operated on. What will happen to those patients? What if their condition requires them to have a surgery immediately? What if those patients lose their lives while they are waiting? Then what is more important, healing the patients or satisfying the material needs of the physician? If the patient did not have the money to pay the physicians the extra fees, the physician would not provide him or her the medical care they needed and they would have to wait for months to receive the ideal healthcare they deserve. But, if they satisfied the physician financially, they would be prioritized over the ones who could not pay and would receive the medical care they needed immediately.”
>
> “I would tell the patient, if you want me to operate on you, then you will have to come to my private practice office to make a payment, and I will then perform your surgery.”
>
> “If the patients wanted to receive medical care, they then had to pay that additional fee to physicians. In here, the real aim was not to heal patients, but to use the status ascribed by the profession as means to generate private revenue.”
>
> “Even within the performance system, patients are still guided to private physician practice offices. Which ones? Of course, to the university professors’. I know it from my relatives who have had to visit university professors’ private practice offices and paid the doctor’s visit fee in order to be given precedence in treatment and admission to the hospital.”
>
> “The majority of physicians aimed to provide healthcare services only to those who could afford to pay additional fees … Some certain [healthcare] worries were being artificially created in people and those people were being financially exploited by those physicians. They [those physicians] were in many ways preventing patients from feeling that they were receiving the proper healthcare service they needed, while indeed they were, at the

government hospitals. Though those patients were actually receiving the appropriate medical care, they were, because of the misinformation they were receiving from those physicians, not able to perceive that the healthcare services they were receiving were adequate and aimed toward healing their illness."

"… Hospitals were venues those physicians would use to market their services and direct patients to their private practice offices only. As such, those patients coming to government hospitals were given a false impression by those physicians that the healthcare services they were receiving were not adequate, and thus would be made to feel unhappy about the services they were receiving. A misperception was being purposely being created in their minds that those patients were not being properly cared for or receiving incomplete or insufficient healthcare services at the government hospitals by those physicians because they had not visited those physicians' private practice offices."

"… Physicians must have been prepaid that surgery fee in order for them to operate on patients. If they were not paid those additional surgery fees in advance of the surgery, they would by no means perform those surgeries."

The category defined as 'Opting for treatment generating highest private revenue' was saturated around the codes referring to physicians' deciding on treatment protocol based on prospects of private revenue it will generate for them. The cyclic process of identification, comparison and collapsing the codes to produce a refined set of codes yielded the following saturated codes, which were collectively linked to this category: 'Not seeing patients if/when sufficient performance points have been accumulated,' 'Not seeing patients if/when treatment required does not yield high performance points,' 'Seeing patients swiftly to increase number of patients seen, thereby increasing revenue,' and 'Organizing course of treatment based on highest revenue generation criteria.' The text segments related to these codes included:

"We are providing healthcare, but how we will provide it is determined by the performance points it will generate for us."

"If physician's accumulated performance point is over the average, then s/he unavoidably starts procrastinating and not seeing patients. Why? Because there is no incentive."

"Now, the only thing physician is concerned about is his/her performance point which will determine how much additional revenue s/he will generate; that is it. You cannot show me one physician whose main concern is the benefit or health of the patient."

"When patient comes to you, since your only motivation is to increase your performance points, you channel the patient toward procedures which will bring you the highest revenue. But, maybe patient does not really need those procedures. This carries no importance for the physician. The only important thing is the private revenue physician will accumulate."

"… For instance, my concern is to see as many patients as quickly as possible in a day to the point I have accumulated enough performance points. You see, this performance system can drive physicians into unethical practices."

"When it is the 25th of the month, the surgeon has already accumulated enough performance points. From that point on, that surgeon won't do surgeries; s/he won't even accept emergent patients reporting to the emergency room."

"… Think about xxx specialists. Their only treatment method is ordering xxx tests. But, they cannot make much money out of those tests since their performance point is only xxx. What do they do? They perform acute xxx, because those tests carry greater performance points."

"… Say there is a procedure whose performance point is 500, but it is extremely difficult. In the amount of time it takes you to perform that procedure, you can perform 3 procedures, each with 400 points. My colleague tells me, 'Are you an idiot? Why are you still performing these (the ones with 500 points) procedures?' He is actually right. If you choose to perform the procedure with 500 points, you will need to do follow-ups with the patients over a period of years; but those other procedures are with low complication risks and require less post-op effort."

"Now, the physician normally should see 50 patients a day, but they end up seeing 80-100 patients a day in order to maximize their performance points. And this practice decreases the quality time the physician should spend with the patient."

The category identified as 'Ordering or performing unnecessary tests/procedures' was derived from the codes referring to physicians' abusing the medical tests and procedures by means of utilizing them as a private revenue generation mechanism, such as 'Ordering only the tests that carry high performance points,' 'Ordering tests patients' medical condition do

not require' and 'Performing procedures/surgeries patients' medical condition do not require.' Statements made by the physicians in relation to these codes included:

> "… For instance, xxx specialists order xxx tests in cases where those tests are not truly required; because those tests carry high performance points."
>
> "A patient comes; say with a xxx. I am automatically ordering xxx because I am subconsciously driven to order the tests with the highest performance points."
>
> "… XXX specialists for instance, examines the patient and immediately decides to perform an xxx anomaly test. Normally, xxx anomaly tests are done 10 in every 100 patients. But, it is performed on almost every single patient because it carries high performance points."
>
> "… Let me give you an example. One of my colleagues sees a patient with xxx pain. S/he immediately schedules a surgery and removes patient's xxx, xxx etc., which we surgeons call 'useless organs,' and tells the patient, 'Ok. I got all your problems fixed now.' You see everything is seen as money nowadays."
>
> "… There have been times in which some of my colleagues faced an internal ethical conflict, a dilemma. That is, performing a surgery when it is indeed not necessary, or a specialist not being happy about what he has been doing (misconduct), and feel regret. I have seen physicians who suffered from anxiety and depression resulting from this situation."
>
> "Can you think of a worse thing than operating on a patient needlessly? That is routinely being done nowadays."
>
> "… For instance, physicians are inclined to jump to the most complex surgery, which requires the greatest amount of supplies and performance points, even in cases where patients' true condition require a minor procedure."

The last category which was saturated under the core theme 'Provision of healthcare services with an orientation toward interest maximization' was 'Claiming reimbursement for unperformed tests/procedures,' which was supported by the codes referring to misrepresenting tests or procedures performed so as to generate highest private revenue. These codes were 'Manipulating patient records to reflect unperformed tests' and 'Manipulating patients records to reflect unperformed procedures/surgeries,' and they were derived from the text segments, some of which included:

"The main concern is to accumulate the highest possible private revenue. And you can only accomplish this goal via drawing on your knowledge and experience as a physician. Since you have the absolute authority, you find ways to saturate your performance points for the month. To do that, if/when needed, you will enter extra procedures into the system which you actually never performed."

"The main focus is on increasing performance points. If your points are low, then you start looking for ways to accumulate more. This can be done in various different ways. For example, while you enter the procedures you performed, you just add extra procedures."

"… For instance, say a physician performs a surgery. It is a minor surgery. While entering the procedure into the system, extra procedures are added by the physician. S/he actually never performed those. These things happen on a regular basis and there is no way to really control this."

"… Think, for instance, about xxx department. Physician writes his regular daily [follow-up] prescription, but enters it into system as if it were a new prescription."

"… Physician enters into the system a procedure for xxx removal. But from the size of the sample you send to xxx, it is obvious that you actually took a xxx, not a xxx as you claimed."

"… When physician believes s/he has not received the points s/he has deserved, s/he will slide into the other [dark] side. While entering procedures into the system, s/he will enter this or that procedure additionally to accumulate the performance points s/he believes s/he deserves."

"… Say that patient comes to xxx department with a xxx problem. Physician does not even examine the patient, but writes a prescription and gives it to the patient. When you later look at the breakdown of the services or procedures s/he entered into the system related to this encounter, you see that s/he actually entered an ultrasound into the system, which generated unearned performance points. But, you actually did not perform it?"

Data analyses were accomplished in five stages. In the first stage, archival documents generated by the MoH were screened to better inform the research in terms of the institutional logics dominating the healthcare field from 1920 to present. This investigation was performed to understand the evolution of the Turkish healthcare field from the institutional logics perspective and thus to enable the researcher to have a broad overview of the changing dynamics of the field.

In the second stage, pilot interviews were conducted with ten well-seasoned physicians. Main effort was to identify the (1) appropriateness of the research questions scheduled to be asked, (2) assess the quality of the data acquired based on the questions raised, (3) to gain a preliminary understanding, and (3) identification of the belief systems and the associated ground level logics enacted by the ground level actors at the intra-organizational level. Pilot interviews have been identified to be extremely useful in terms of determining the appropriateness of research questions, and whether or not any modifications are necessary for the following interviews to yield the richest data pertaining to the study (Kim, 2011; Sampson, 2004) as well as serving to identify gaps or potential wastage of unnecessary data collection (Sampson, 2004). The exploratory case interview data gathered from the ten well-experienced physicians indeed reflected several areas for improvement in the interview schedule as well as in the focus areas of the study. These interview data were later subjected to an in-depth data analysis. Following intensive data analyses and subsequent interviews confirming the outcomes of these analyses, a general frame of indicators related to belief systems and associated practices of the logics on the ground from the perspective of these seasoned physicians were identified and described. Efforts were geared toward gaining as much in-depth information as possible by means of delving into physicians' experiences and opinions with regard to their belief systems and the associated practices in medicine. Purposeful sampling continued with ten participants, although emergent themes (i.e., regularly occurring patterns of behavior or certain phrases or words repeated by different informants) were followed up by the sixth interview. Purposeful sampling was followed by active sampling of new cases as the analysis proceeded (Pidgeon, 1996) in order to illuminate or saturate theoretical categories that emerged, or to discover more details or other properties about the emerging theory (Glaser & Strauss, 1967).

In the third stage of the analyses, the data collected from the data set encompassing fifty-four physician interviews were subjected to a comprehensive analysis to develop codes, categories and themes. These in-depth analyses allowed the researcher to further saturate the characteristics of professional behavior, which then could be described as observable practices tied to characteristics of distinct logics manifested on the ground. These as well as preceding analyses collectively reflected that physicians in their day-to-day practices were under the quadruple influence of medical professionalism, business-like, state and rogue

logics. These observations indeed confirmed that logics exert substantial influence on which practices organizational actors should adopt (Goodrick & Reay, 2011; Jay, 2013; McPherson & Sauder, 2013; Murray, 2010; Pache & Santos, 2013; Reay et al., 2016; Smets et al., 2012; Thornton et al., 2012).

Fourth stage involved confirmation of the identified practice-level manifestation of logics and their characteristics. Informed by the fact that local new or key informants, referred to as "confidants," who are built into the study as sources of verification, can act as judges, evaluating the major findings of a study (Miles & Huberman, 1994, p. 275), the researcher met with four other physicians with over 30-year experience in the sector to review and discuss the observations and findings. The researcher also consulted leading institutional logics scholars in the Turkish academic community to seek their contribution as well as confirmation of the identified logic matrix through extended fruitful discussions. In this manner, the analyses pertaining to the identification and description of logics and their sub-elements were cross-validated via consultation of various actors (Pache & Santos, 2013). The physicians consulted were actively involved in Turkish healthcare for the periods pertaining to before and after policy-making and implementation phases of the reform initiatives in healthcare (i.e., before and after 2005 [henceforth referred to as Era 1 and Era 2], which is the historical marker for policy change initiatives). Similarly, institutional scholars consulted were deeply involved in, and were very knowledgeable about, the development and progress of the institutional logics literature. Data were collected from these key informants through confidential interviews and the main objective was to improve the credibility of findings and secure a breadth of information and insights from well-experienced physicians with high level of expertise and leading scholars in the field, who might have complementary, inconsistent or even contradictory perspectives (Hurley, 1999). Though not to the fullest extent, the analyses undertaken were also triangulated with research material describing various institutional contexts of the health sector (Kitchener, 2002; Özseven et al., 2014; Reay and Hinings, 2005, 2009; Reay et al., 2016; Scott et al., 2000). At this stage, the ground-level instantiations of logics and their associated practices pertaining to the healthcare organizations under study were successfully identified (see Table 1 under findings, chapter five).

In the fifth stage, main endeavor was to identify the observable practices in relationship to each of the unique characteristics of the four distinct logics in Era 1 and 2. To achieve this aim, a subsequent round of analyses was conducted on the data. These analyses allowed the researcher to gain a better understanding of the nature and existence of ground-level practices and their enactments or invocations on the ground. By means of these analyses, the researcher was able to measure the strength of each logic attribute by evaluating the extent to which the physicians' daily practices as indicated in their accounts were consistent with the practices implied by the identified practices pertaining to the sub-characteristics of the logics (Goodrick & Reay, 2011). These analyses enabled the researcher to compare the behavior prescribed by each logic with the actual behavior enacted or invoked (Pache & Santos, 2013) by the physicians on the ground. Then, the researcher, by means further analyses of the data, conducted counts of the occurrences of themes (Dey, 1993; Maxwell, 2010; Sandelowski, 2000, 2001; Sandelowski & Jones, 1996; Sandelowski, Voils, & Knafl, 2009) in terms of logic sub-characteristics enactments or invocations (Goodrick & Reay, 2011; McPherson & Sauder, 2013) for the two eras being studied. The researcher arrived at numerical evaluations in terms of the closeness of the day-to-day practices to the identified logic characteristic (Goodrick & Reay, 2011) by assigning a value of 1 in cases where a logic characteristic was invoked (McPherson & Sauder, 2013), following an in-depth analysis of the data through a series of coding steps ultimately arriving at an overarching theme (i.e., sub-characteristics of logics) (Saldana, 2009). Next, the researcher computed the strength of each logic characteristic, over a scale of 1 to 5 (Goodrick & Reay, 2011), where 1 indicates very low consistency and 5 indicates very high consistency, based on the aggregate total of the logic characteristics invocations grouped under each overarching logic (i.e., medical professionalism, business-like, state and rogue logics) for the two specified eras. The researcher also reflected full depiction of logic evaluations for the two eras by means of calculating the mean value for each logic attribute within a logic and for the four distinct logics for each period (Goodrick & Reay, 2011). During all phases of the data analyses, special attention was paid to ensure that data analyses were conducted iteratively amongst collected archival material, interview and observation data and relevant theory, by means of which most appropriate codes, categories and themes were developed within a constant comparative frame (Locke, 2001; Strauss & Corbin, 1998). All of these data analyses

procedures undertaken provided confidence that a rigorous qualitative research meeting qualifications of trustworthiness was conducted (Lincoln & Guba, 1985).

CHAPTER V

PRESENTATION OF EMPIRICAL FINDINGS

The main objectives of this study are to understand and identify (1) the nature and characteristics of "socially-constructed sets of material practices, assumptions, values and beliefs" (Thornton et al., 2012) (i.e., logics) in physicians' daily performance of work, (2) whether "new sets of material activities across actors" have emerged leading to "establishment of a new practice via institutionalization" (Lounsbury & Crumley, 2007, pp. 995-996), and (3) whether enactments of practice patterns or logics have witnessed any change over a period of institutional change processes (Thornton et al., 2005; Thornton et al., 2012). Following are the findings achieved during the rigorous data analyses performed throughout the study.

5.1. Nature and Characteristics of Logics Enacted at the Coalface

An in-depth multi-step grounded theory approach with an iterative fashion adopted in this study reveals that physicians have indeed been under the influence of logic plurality while performing their duties and responsibilities over time.

The results of the data analyses, which involved constant comparing and contrasting of data and theory (Ragin & Zaret, 1983) throughout the data collection and theory, suggest that physicians' belief systems and cognitive structures and their associated practice incarnations are anchored on four different core characteristics, which then are further organized around twelve different theoretical sub-characteristics. Data analyses reflected that the four fundamental characteristics decidedly anchoring on the belief systems and their associated practice enactments were **'Basis of goals and mission,' 'Identity categorization,' 'Service orientation,'** and **'Control of work processes.'** The twelve sub-categories organized around these four fundamental features were 'Mission orientation,' 'Goal focus,' 'Definition of target audience,' 'Definition of own status,' 'Service characteristics conception,' 'Quality conception,' 'Service organization,' 'Information provision role,' 'Professional role relationship,' 'Success criteria,' 'Quantitative service assessment' and 'Qualitative service

assessment.' In the following, these core characteristics and their sub-characteristics as well as the overarching theoretical themes grouped under them will be illustrated with applicable text segments in order for the reader to better understand the details about the process through which the establishment and organization of these attributes and themes were strictly grounded in data.

One of the four fundamental features, defined as 'Basis of goal and mission' was reached based on the recurring discussion of participants in relation to *the principles or core values according to which they perform their work as a physician*, which was further structured around the following theoretical sub-characteristics: 'Mission orientation' and 'Goal focus.' The coding stages ultimately yielding the four core theoretical themes; namely, 'Provision of healthcare services with an orientation toward medicine,' 'Provision of healthcare services with an orientation toward business principles,' 'Provision of healthcare services with an orientation toward governmental rules and standards' and 'Provision of healthcare services with an orientation toward interest maximization,' all of which were grouped under the theoretical sub-characteristic defined as 'Mission orientation,' were illustrated in detail with applicable text segments related to each theme in the preceding data analyses section, thus only some of the representative participant statements related to this theoretical sub-characteristic will be provided in the following.

Some of the recurring statements made by participant physicians in relation to 'Provision of healthcare services with an orientation toward medicine' theme included:

> "We do our work according to what we were taught at medical schools."
>
> "We are supposed to perform our work with a strong attachment to our professional norms and values and Hippocratic Oath."
>
> "We cannot deviate from our professional values which have been ingrained in us at medical school and further inculcated into us by our instructors. We definitely perform along the lines of those principles."
>
> "Physician's priority is to provide medical care in good conscience as well as perform in accordance with the principles of Hippocratic Oath."

Some of the recurring statements made by participant physicians concerning ‘Provision of healthcare services with an orientation toward business principles’ theme included:

> “We now perform our work based on business principles, because that is what our government wants us to do.”
>
> “We are now doing our job similar to how medical care is provided at private hospitals.”
>
> “You must do your job according to business principles now. Otherwise you cannot continue to exist in this pay-for-performance system.”
>
> “All of us are striving to be loyal to our Hippocratic Oath, but I believe it is only influential more at the cognitive level. To me, what is more important is to be able to provide the optimal as well as most cost-effective treatment. At this time, I can say that we are more in line with the business principles such as efficiency, profitability and competitiveness.”

Some of the recurring statements made by participant physicians supporting ‘Provision of healthcare services with an orientation toward governmental rules and standards’ theme included:

> “Of course, we need to abide by, and perform according to, governmental rules and procedures … ultimately, we are government employees.”
>
> “In a healthcare system completely designed by the government, I do not think you have a choice in whether you need to work in line with how government wants you work. We are being paid by the government and thus must comply with the laws and rules of the government.”
>
> “With all the malpractice lawsuits physicians have been subjected to, physicians have to protect themselves. Thus, we practice medicine ensuring we satisfy all governmental requirements, laws, regulations and rules.”
>
> “Physicians are performing their jobs within the parameters of the laws and rules.”

Some of the recurring statements made by participant physicians supporting ‘Provision of healthcare services with an orientation toward interest maximization’ theme included:

> "I developed a philosophy for my own ... and I am performing according to this philosophy … I have to think about my financial welfare as well."

> "When we think about majority of the physician practices, we see major deviations from Hippocratic Oath and our professional values and norms."

> "The only thing physician truly considers while practicing medicine is his or her financial gain. Can you blame them for it? You tell them that you will pay them based on the performance points they accumulate, and expect them to be ethical and conform to so-called Hippocratic Oath and professional norms. Those values are now sort of a matter of derision for us. The majority of physicians have totally ignored professional ethics."

> "There is no place for the Hippocratic Oath in this system. Physicians now are only concerned about filling their pockets. Benefit of the patient and professionalism are sort of nostalgic concepts for physicians now."

The core themes which emerged under the theoretical sub-characteristic defined as 'Goal focus' were 'Treatment, 'Effective and efficient treatment,' 'Treatment as a social right' and 'Treatment as means to maximize private revenue.' The ideas and statements in relation to these overarching themes will be provided in the following.

Some of the recurring statements in relation to the theme 'Treatment,' which encapsulates ideas and statements referring to physicians' main focus being *physicians' directing all their effort and energy toward healing and recovery of patients* while providing medical care, included:

> "Our focus as a physician is to heal our patients. This focus has never been ignored; it has always been at the forefront. It is in the fundamentals of practicing medicine."

> "… We were following the new developments in medicine back then. Our focus was very much on treatment only."

> "We cannot deviate from our focus on treatment. We are physicians; treatment of illnesses is what we have been trained and educated to do."

> "Why have we become a physician? In order to heal sick people."

Some of the recurring statements in relation to the theme ‘Effective and efficient treatment,’ which encapsulates ideas and statements referring to physicians’ main focus being *physicians’ directing all their effort and energy toward healing and recovery of patients in the most cost-efficient manner and by administering the best course of treatment yielding the most effective results at the first time* while providing medical services, included:

> “While providing care to our patients, our focus has now shifted to being efficient because that is what our government’s new policy is.”
>
> “We need to work efficiently to contribute to this enterprise’s profit prospects.”
>
> “I must protect the interests of this enterprise. We are all on the same boat. If this facility does not make profit, then my share that I will get from the revolving funds will also decrease accordingly. We thus need to contain costs as much as possible.”
>
> “Leadership always preaches us about being efficient in the services we provide; and we are, or at least have been trying to be, efficient in all we do.”

Some of the recurring statements in relation to the theme ‘Treatment as a social right,’ which encapsulates ideas and statements referring to physicians’ main focus being *physicians’ directing all their effort and energy toward providing medical care with an ultimate aim to improve the overall health of the society as well as contribute to increasing access to care for the individuals in the society*, included:

> “Physicians are now working harder and more … the fact of which enables more patients to have access to medical care. In the past, some patients would not have access to medical care because they were poor, but now patients’ have easy and increased access to medical care.”
>
> “In terms of the volume of healthcare services provided to the society, this [performance] system has been very beneficial. Patients are now easily accessing healthcare. Physicians are willing to see more patients now. Also, our citizens can now seek care at any hospital. In the past, a CT scan appointment would be scheduled for a few months out, but now you can have it scheduled for the following day.”
>
> “In this new [performance] system, patients have better access to care. Because, physicians are working harder and thus are seeing more patients.”

> "We are definitely motivated to see more patients now. We see more patients and that means more patients are being healed. Of course, this has some positive effects on the improvement of health of the overall society."
>
> "In the past, typically 80 patients would be in a queue to get seen by a physician, but they were not being provided the appropriate care they needed, because almost all physicians had their own private practice offices to which they would channel their patients in order to provide the care those patients needed. But now, no one has a private practice office. All physicians are doing their assigned shifts; they are reporting to work at 08:00 and leaving at 16:00. They are doing shift work, admitting their patients and attending to their patients. It might be partially due to the incentives offered by the pay-for-performance-system in which you must generate enough points to receive a good salary, but it ultimately produces better and increased healthcare for the society."
>
> "Some departments are providing excellent services. For instance, xxx department. We performed a study last year, and noticed that 118 patients out of 130 had a low socioeconomic status and thus low income. I will tell you this, xxx illness won't ask you whether you are rich or not; it will come and get you regardless of your financial status. I know the doctor responsible for the xxx department has no private practice office of his own. He cannot admit patients to generate performance points, because in order for him to do that all patients need to have xxx illness. Where would those people with low income go to get care had this medical facility not provided these services? These services were not being provided in the past; but now they are."

Some of the recurring statements in relation to the theme 'Treatment as means to maximize private revenue,' which encapsulates ideas and statements referring to physicians' main focus being *physicians' directing all their effort and energy toward generating and maximizing private revenue by means of utilizing their professional knowledge and status*, included:

> "Our only focus was not treatment. Back then, physicians would administer various different treatment methods for no reason. They would practice different examination methods and offer different surgical procedures so as to make patients attached to and dependent on them. That is how they would make money. Let me convey an anecdote related to this matter to

you. A patient previously monitored for about six hours with a diagnosis of acute xxx in a relatively smaller hospital in a rural area was transferred to a city hospital in an ambulance under the surveillance of the transferring doctor. The admitting surgeon on duty examined the patient and stated that the patient needed to be observed for about two hours before he could decide on the appropriate course of treatment for the patient. The transferring doctor stated that the patient was already observed for long hours before having been transferred here and that the patient could have been lost if not operated on immediately. Later on, after speaking with the relatives of the patient, the transferring physician realized that the admitting physician demanded a significant surgery fee from them, but since they were very poor, they could not offer him any money. That was the only reason why the admitting physician did not operate on the patient …. You think about how severe the consequences of these unethical inclinations may be."

"Our focus has always been to treat, provided that the physician is financially satisfied first. In the past, patients must have first agreed to pay those additional fees to be entitled to healthcare."

"The main aim is to maximize our private revenue as much as possible, and the physician will do whatever it takes to reach that aim."

"The main focus was to generate as much private revenue as possible. Physician would use the secrets of his profession to reach that goal. Physicians had an 'only I have the knowledge and thus the power' type mentality."

"Now say the patient comes to you and you have a number of treatment options. Which treatment option you will choose is strictly dependent upon your current status of your performance points and the revenue the treatment option will bring to you. What I mean is that patients' treatment, fast recovery or comfort does not by any means concern the physician. Performance point is the sole determiner here."

"… Say a patient with a xxx comes to you and says that s/he has been seen at xxx private hospital, and was asked to pay xxx TL for the surgery. You basically look at your performance points you have accumulated thus far and realize you have enough for that month to get you a good pay. And you think to yourself, why would I operate on this patient now? You send the patient home and tell him or her to come back next month, so you can collect enough performance points within the following month. Or, in the opposite case, you look at your

performance points and notice you have not accumulated enough, but the patient's condition does not really require a surgery at that time, but eventually will require it, you decide to do a surgery. Or patient reports to you and you evaluate surgical options and need to determine a surgery between two options; you choose the one with the highest performance points."

"I know a patient who has been operated on nine times. Patient has multiple xxxs in her xxx. Physician enters patient's xxx and removes only one of the xxxs, and then operates on the patients eight more times and removes only one xxx every time. Why? Because physician collects performance points for every single procedure s/he performs. What about the risks involved with performing so many procedures, which can actually be done only in only one procedure? Physician is no longer concerned with that aspect of the matter."

"Each and every physician is only concerned about their performance points. Do we need money for that month? If yes, then what do we do? We operate on whomever comes our way. It is like being a butcher. In this [performance] system, patients are really miserable. Physicians are cutting [operating on] almost every patient they see. You ask that patient, what illness did you have that required a surgery? S/he would say, I got an excellent examination or treatment, but in reality s/he really had had no serious health problem."

The other fundamental feature, defined as 'Identity categorization' was reached based on the recurring discussion of participants with reference to *who they were* and *how they viewed their target audience,* which was further organized around the following theoretical sub-characteristics: 'Definition of target audience' and 'Definition of own status.' The core themes, which decidedly anchored under 'Definition of target audience' sub-characteristic were 'Patient,' 'Consumer/customer,' 'Government healthcare beneficiary' and 'Commodity.' The representative text segments in relation to each of these themes will be presented in the following.

In reference to the theme 'Patient,' which encapsulates ideas and statements referring to physicians' view of their target audience being *persons, who are ill or injured, requiring healthcare services,* some of the recurring statements of participants included:

"We are dealing with patients and healing our patients is our first priority."

"We view them as patients. They are here seeking treatment."

"We viewed them as individuals needing our medical knowledge and expertise be healed."

"Of course they were being viewed as patients by physicians. They come to you with hopes that their illnesses will be cured."

In reference to the theme 'Government healthcare beneficiary,' which encapsulates ideas and statements referring to physicians' view of their target audience being *persons, who are carriers of governmental social security insurance*, some of the recurring statements of participants included:

"We were providing service to a population which was covered by social security insurance."

"We regard the population we serve as public healthcare beneficiaries."

"They are government healthcare beneficiaries."

"They are our citizens entitled to receive government healthcare services."

In reference to the theme 'Consumer/customer,' which encapsulates ideas and statements referring to physicians' view of their target audience being *persons whose healthcare needs need to be met in a satisfactory manner*, some of the recurring statements of participants included:

"We view them as consumers 100%."

"Patients are viewed as customers now and they are always right!"

"They are no longer patients. They are unequivocally customers in our view. This is in a way good actually. Because customers have some rights and demands, and you as a physician need to satisfy those needs. In the past, patients had to be satisfied with whatever service they were provided."

"We need to satisfy the population we provide healthcare services to. That is how you can win their patronage. So, the patients we serve are our customers whose needs we must satisfy."

"We view the population we serve as sort of a consumer."

"We absolutely view them as customers."

"They are a population group that won't repeat business with you or do not become your brand ambassadors if you do not satisfy their needs."

In reference to the theme ‘Commodity,’ which encapsulates ideas and statements referring to physicians’ view of their target audience being *persons over which physicians can generate private revenue*, some of the recurring statements of participants included:

> “Patients were being seen as a revenue generating mechanism.”
>
> “Physician would do whatever it took to win patients patronage. The main aim was to make as much money as possible from the patient. Thus, patients were being seen as a commodity.”
>
> “Patients are now viewed by us as commodities; we view the patient as a vehicle, a commodity, by means of which we will reach our aim, and that aim is to gain the most possible private revenue.”
>
> “The current situation is terrible for patients. Physicians could not care less even if the patient has been lost. They show no pity for patients. They state that infection has developed and that is why patient has been lost. All they care about is whether they have accumulated enough performance points from the patients. That is their true view of patients.”
>
> “Physicians see patients as coins tossed into the money box. Ka-ching, Ka-ching!”
>
> “Physician sees the patient at the outpatient clinic. Even if the patient’s condition is stable, and physician should see this patient again in two months, patient is instructed to come back for a follow-up in 15 days. Why? In order to collect more performance points out of the patient.”
>
> “Physician views patients as potential performance points now. Every time a patient enters the exam room, the meter starts clicking.”

The core themes which decidedly anchored under ‘Definition of own status’ sub-characteristic were ‘Healer-professional,’ ‘Stakeholder/profit partner,’ ‘Public servant’ and ‘Rogue intrapreneur.’ The representative text segments in relation to each of these themes will be elaborated upon in the following.

In reference to the theme ‘Healer-professional,’ which encapsulates ideas and statements referring to physicians’ view of themselves being *persons, who are, by demonstrating morality and virtue, effectively using their knowledge, education, expertise and skill to heal and/or cure the ill or injured*, some of the recurring statements of participants included:

> "Who are we? We are a professional group undergoing 6-7 years of primary medical faculty education and then another 4-5 years of education for further specialization in a certain branch."
>
> "We are physicians, we are educated and socialized in a certain way; we cannot think or act otherwise."
>
> "We are professional group striving to perform in accordance with the principles of Hippocratic Oath and medical necessity."
>
> "We are physicians whose aim and role should be to free our patients from any disease and ailment, keeping in mind our conventional professional norms and values."

In reference to the theme 'Stakeholder/profit partner,' which encapsulates ideas and statements referring to physicians' view of themselves being *persons who impact or are impacted by the operations and the prospects of a business*, some of the recurring statements of participants included:

> "We are considering ourselves as profit partners; how can we think otherwise? The more this enterprise makes profit, the more my share is out of that profit."
>
> "If in this new [pay-for-performance] system, a pie is being created based on the cumulative performance points generated by physicians, and each physician will then receive their share of that pie in proportion to the points they generated, how else could we identify ourselves other than profit partners? Of course, we view ourselves as a stakeholder of this business. The more this business makes, the more profit share we get from it proportionally."
>
> "They are paying us based on our contribution to the overall revenue this facility generates. This hospital generates revenues. An invoice is cut and provided to the Social Security Institution. After all the overhead is paid off and the government gets its share, each physician will get his or her share from what is left based on their accumulated performance points. So, a pie is being created, each clinic gets its small slice out of this pie, and all physicians who are members of this clinic get their share out of this pie in proportion to their accumulated performance points."
>
> "We consider ourselves as profit partners or stakeholders. There is this thing called revolving funds. The money which will be distributed to us is determined based on some computations.

> There are some coefficients involved in those computations. There is this coefficient that concerns us and it ranges from xxx to xxx. If our share is distributed over the percentage of xxx, then the money I will get will go down to xxx, but if it is distributed over the percentage of xxx, then it will go up as much as xxx … Do you now understand the degree of our partnership in relation to the funds of this business?

In reference to the theme 'Public servant,' which encapsulates ideas and statements referring to physicians' view of themselves being *persons, who are employed by the government and labor for the public good,* some of the recurring statements of participants included:

> "We are government employees. We are striving to perform our job properly and according to the governmental rules."
>
> "We are employed by the government. We are a professional group working under the government umbrella and serving the public."
>
> "Ultimately, we are working for the government and thus are government employees."
>
> "As physicians, we are working as public servants and are viewed by the society as employees of the government."

In reference to the theme 'Rogue intrapreneur,' which encapsulates ideas and statements referring to physicians' view of themselves being *persons, who have the resource and capabilities of the organization they are employed by available to them at their disposal, pursuing their own private interests while utilizing those resources and capabilities, which should actually be mobilized for furthering the interests of the organization,* some of the recurring statements of participants included:

> "I really do not know what our status is as physicians at this time. I cannot say we are performing as physicians because this piecework-rate-pay system ruined medicine and physicians' ethical considerations while practicing medicine; I want to say that we are profit partners because of this performance system, but cannot see physicians as profit partners as we are only sharing the profits of this enterprise, and not feeling any obligation to share the risks involved with the operations of the enterprise, and thus we do not feel the responsibility of a regular stakeholder or profit partner. We are not government employees either because

government employees are obligated to protect public interest. All we are concerned about is protecting our own interests."

"Now, while at the government hospital, physicians' business cards were located on the table and the nurse or other healthcare personnel knew to hand it out to each and every patient that entered the doctor's office to get seen. The physician would use the secrets of his profession and expertise to direct as many patients as possible to his private practice office."

"I have seen some of my colleagues actually demanding a surgery fee even in their doctor's office at the hospital and actually receiving it from the patient. You are on your duty as a government employee at the hospital. How can you do that? I call them 'fearless' physicians, because it really takes some courage to do that."

"… Government hospitals were venues those physicians would use to market their services and direct patients to their private practice offices only."

"… Let me give you an example. A patient is diagnosed with xxx. It is not infected yet and can be treated with medication. But, the surgeon decides to do a surgery and removes the xxx. They [surgeons] are now thinking to themselves and saying 'I wish this patient would have a xxx in his or her xxx so I can remove it and fill my performance quota.' It is unfortunate, but these things regularly occur nowadays."

"… Now, this issue has reached a different stage. In the past xxx, xxx and xxx surgeries would be performed needlessly and physicians would make money out of the patients. We have gone past those stages, now physicians are even performing xxx surgeries. There is this discretionary space concept in medicine and in some cases there are not established certain courses of treatment. What I mean by that is, the physician can perform either xxx or xxx. Since xxx has more performance points, physician opts to do that surgery. Of course, in this case the facility and ultimately MoH is being financially damaged, and patients may end up suffering medically."

"… We had a new xxx specialist who had just been assigned to our hospital. It had been only 20 days since his commencement of work. A patient, who was apparently very poor, came to the xxx department. He lost one of his xxx while operating on a machine. One of the xxx's could be easily sutured and the other could not be. The xxx specialist spoke with the patient for about ten minutes and then convinced the patient to have the surgery in a private hospital … We learned that the patient had to pay xxx for that surgery at a private hospital, and it was

done by the same xxx specialist who could have easily done the same exact surgery at our [government] hospital."

The other fundamental feature, defined as 'Service orientation' was reached based on the recurring discussion of participants with reference to *how they structured the content and organization of their work as a physician,* which was further organized around the following theoretical sub-characteristics: 'Service characteristics conception,' 'Quality conception,' 'Service organization,' 'Information provision role' and 'Professional role relationship.' The core themes which decidedly anchored under 'Service characteristics conception' sub-characteristic were 'Medicine-based service,' 'Market-oriented service,' 'Public service' and 'Private revenue generation-oriented service.' The representative text segments in relation to each of these themes will be elaborated on in the following.

In reference to the theme 'Medicine-based service,' which encapsulates ideas and statements referring to physicians' view of the nature of the services they provide being a *healthcare service that is medically determined (i.e., in accordance with the requirements of the acceptable healthcare standards; delivered in order to fulfill the patient care and treatment requirements),* some of the recurring statements of participants included:

"The service we provide is essentially a healthcare service; a very sensitive service, and it should be viewed as that, not a business."

"Our job is to provide healthcare service."

"Our only aim is always to heal patients according to what we have been taught."

"… When you view it that way, you realize that we view the services we provide as a medical service, nothing else."

"We provide healthcare services and we do it according to the principles of Hippocratic Oath and medical necessity."

In reference to the theme 'Market-oriented service,' which encapsulates ideas and statements referring to physicians' view of the nature of the services they provide being *an individualistic service (i.e., individual-based and consumer-driven) that is determined by the business and/or market principles (creating, managing and sustaining the demand and supply for services delivered),* some of the recurring statements of participants included:

"The service we now provide is seen as one that should be effective and efficient; these are the business principles being integrated into healthcare service delivery by the government nowadays."

"Do you know what our chief of medical staff says? They [management] want to close down one of our departments. They [management] are saying that xxx department is making more money than xxx department, and thus they are going to cut down on our outpatient clinic and surgery days and allocate those days to xxx department. Actually, we have a bigger patient volume and circulation, but they are making more money than we are, because they almost have no outlays. We are seeing more patients and serving our society and our society truly needs this department to continue to exist, but since we have more outlays, our department is not making a lot of money and thus is being viewed as costlier to the enterprise; they [management] are therefore considering closing it down. If/when they close down our department, we won't be able to provide care to those with traumatic injuries and they will have to wait for 10 days, versus the current practice in which we can schedule them for the following day … The thing that drives this whole issue this route is that it is being viewed as a market service."

"… Now, this [healthcare] service has become very individualistic. It is no longer viewed as a public service as it used to be."

"It [healthcare] is completely an individualized market service now. There are enormous profits in this business; similar to the profits realized in the private sector."

"The main focus is on the individuals [patients]; their immediate needs require satisfaction. The system channels us into that direction."

In reference to the theme 'Public service,' which encapsulates ideas and statements referring to physicians' view of the nature of the services they provide being *healthcare services provided by the government to its beneficiaries who are entitled to public healthcare,* some of the recurring statements of participants included:

"We are essentially providing a service to our citizens with an ultimate aim to improve public health."

"At first sight, it looks like you are only treating the individual. But in the whole scheme of things, you are actually providing a service to the public. Why? Because that person is gained

back to the society as being a healthy individual and that way you have actually protected and improved public health."

"In my view, it [healthcare] is a citizen-based public service."

"I personally believe that the services we provide should be deemed as public service. I know that there are others [physicians] who think differently. They [physicians] want to help this facility make more profit. I do not view it that way."

"Since we provide this [healthcare] service to government healthcare beneficiaries, I believe it can be categorized as public service."

In reference to the theme 'Private revenue generation oriented service,' which encapsulates ideas and statements referring to physicians' view of the nature of the services they provide being *services that are utilized as means to generate private revenue*, some of the recurring statements of participants included:

"For physicians, the only and most important thing is how much what he or she will be doing will bring him in terms of private revenue. So, the physicians view the service he or she provides as a means to maximize private revenue only."

"… I never think of the healthcare services I provide ultimately improving the health of the public. Just like I stated before, since our only motivation is to maximize our private revenue, I do not believe we can speak of a societal matter here."

"… Now, healthcare services have become a private revenue generation mechanism."

"… When you consider the main aim being making money out of it, and not curing, then you see that it is a service practiced just for that purpose."

"I cannot say that the services we provide are deemed as public service because you provide public service under the roof of a government hospital. Physicians would refer them to their private practice office to make money out of the patients."

The core themes which anchored under 'Quality conception' sub-characteristic were 'Physician's prerogative to define,' 'Service is defined quality to the extent it is commensurate with generally-accepted quality standards,' 'Service is determined appropriate to the extent it is commensurate with bureaucratic or legislative requirements'

and ‘No quality conception. Service is defined quality to the extent it provides highest private revenue for physicians.’ The representative text segments in relation to each of these themes will be elaborated upon in the following.

In reference to the theme ‘Physician’s prerogative to define,’ which encapsulates ideas and statements referring to physicians’ view of the concept of quality being *in the domain of and controlled by physicians*, some of the recurring statements of participants included:

> “Quality of the healthcare services delivered was 100% under the control of the physician; there is no need to even make any further comments on this topic.”
>
> “Quality was in the domain of physicians.”
>
> “Quality was a concept being shaped under the strict authority and control of the physician.”
>
> “What is important for us is the healing of patient. We have spent our whole lives in learning and practicing this profession. Administrators are of course thinking differently. What is important for us is not those so-called quality standards, or in other words the make-up, but to restore the health of the patient. Quality healthcare service is one that enables the fastest and comfortable healthcare recovery and the physician is and should be the sole authority determining the properties of those services.”

In reference to the theme ‘Service is defined quality to the extent it is commensurate with generally-accepted quality standards,’ which encapsulates ideas and statements referring to physicians’ view of the concept of quality being *a market-oriented set of standards and measures to increase the likelihood of desired health outcomes*, some of the recurring statements of participants included:

> “There are some quality criteria set forth by the management and we, as physicians, have been striving to comply with those criteria … Everything we do now is associated with a specific set of guidelines or instructions, which we are supposed to follow.”
>
> “Physician strive comply with all the standards and procedures set forth by the facility. Those standards truly enhance the quality of care.”
>
> “The MoH has adopted some quality standards recently and I truly believe they are very beneficial for quality of care. The higher the standard of the care and the more technological the care you deliver, the more you can speak of increased levels of quality. I am a strong

believer of the fact that quality service is not solely a service satisfying the healthcare need, but the service satisfying the healthcare need in the best way possible and as technologically as possible. In the healthcare services provided that way, for instance in surgeries, patients are mobilized more quickly and with less complications."

In reference to the theme 'Service is determined appropriate to the extent it is commensurate with bureaucratic or legislative requirements' which encapsulates ideas and statements referring to physicians' view of the concept of quality being *a government-oriented set of standards and measures to regulate healthcare delivery and service management*, some of the recurring statements of participants included:

"We are completing all the necessary bureaucratic paperwork as required by the government in order to be compliant with the service quality criteria … Those documents are later randomly audited by the government officials for appropriateness of services provided."

"You must abide by all the governmental regulations and directives pertaining to the delivery of healthcare services. In the end, you are a government employee."

"There was not so much of a quality concept back then. But, all healthcare-related services had to be in line with the government rules and directives. If everything is in line with the preset standards, then I guess you would call it a quality service."

In reference to the theme 'No quality conception. Service is defined quality to the extent it provides highest private revenue for physicians,' which encapsulates ideas and statements referring to physicians' view of the concept of quality healthcare services being *services that enable the provider to realize the maximum private revenue possible*, some of the recurring statements of participants included:

"Quality? Who cares? You cannot show me a physician who is truly concerned about the quality of care. For physicians, quality service is the most private revenue earning service ... If you think about the sole performance point generation focus of physicians, you will notice how quality of care becomes meaningless for them."

"… To sum up, the more you financially satisfy your physician, the better quality the healthcare service you get."

> "You cannot show me one single physician who cares about service quality in this facility. Our focus is not on quality, but to increase our performance points as much as possible. They are emphasizing quality of care, but what incentives are you providing for physicians? Please, no one should find what I am saying strange. If you tell me, I will pay you for what you produce, then I will only produce. But how do I produce? By exploiting the system for my own private purposes. Now, you think about it. Under these conditions, do you believe providing quality care, one that is aligned with medical standards and principles, is important for physicians? Do you believe it is a possibility? Do you believe a physician in this case cares about quality? Of course not."

> "Quality is no one's concern actually. Everyone is just concerned about his or her own salvation. Physician's only objective is to generate the maximum possible performance points with the least risk. Management is only concerned about ending the day with the least possible cost. Whose concern is quality care at this time? No one's."

The core themes, which anchored under 'Service organization' sub-characteristic, were 'Physician-centered,' 'Consumer-centered,' 'Bureaucratic-rules centered' and 'Private revenue maximization-centered.' The representative text segments in relation to each of these themes will be elaborated upon in the following.

In reference to the theme 'Physician-centered,' which encapsulates ideas and statements referring to physicians' view of organization of healthcare being *in the domain of and controlled by physicians,* some of the recurring statements of participants included:

> "Physicians had complete authority over the organization of work."

> "Physicians would closely monitor patients' medical care and guide the entire process. All other professional staff would follow physicians' orders … No one could deviate from those orders."

> "Physician would direct the entire process of the course of the treatment. It was completely under the control of the physician."

> "Only the physician was behind the wheel. S/he would attend to the patient. S/he would guide the entire process and would pay particular attention to ensure the patients would be free of any infection or complication post-surgery."

In reference to the theme ‘Consumer-centered,’ which encapsulates ideas and statements referring to physicians’ view of organization of healthcare being *driven by the notion of consumer-centeredness and customer satisfaction*, some of the recurring statements of participants included:

> “In this performance-based system, physicians no longer have control over their work. The entire healthcare system has gone under the control of the consumers.”
>
> “In the past, whatever the doctor said would get done. Now the only important thing is patient satisfaction. Our only aim now is to make our consumers happy.”
>
> “We are customer-satisfaction oriented. If the patient requests a test, we usually order it. Because we want to ensure the patient leaves here happy.”
>
> “In the past, whatever the physician said would be the rule. Now, the most important thing is patient satisfaction … there has truly been a radical change in the dynamics of delivery of healthcare.”

In reference to the theme ‘Bureaucratic-rules centered,’ which encapsulates ideas and statements referring to physicians’ view of organization of healthcare being *driven by bureaucratic rules, standards and procedures*, some of the recurring statements of participants included:

> “We must organize the services we provide around the rules and procedures; you cannot do otherwise; you are essentially a government employee.”
>
> “We used to organize the healthcare services in accordance with the laws and bureaucratic procedures. You had to do it that way, because it was a requirement of being a government employee.”
>
> “Now, there are malpractice laws in place and the lawsuits are costly to the government as well as to the physicians. Thus, physicians must perform responsibly and in accordance with the applicable laws.”
>
> “As a physician, you must comply with the rules and regulations because of the fact that you are a government employee. This applies to everything we do.”

In reference to the theme ‘Private revenue maximization-centered,’ which encapsulates ideas and statements referring to physicians’ view of organization of healthcare being *driven by physicians’ private revenue maximization motives*, some of the recurring statements of participants included:

> “The only and most important thing for physicians while coordinating care and selection of a particular course of treatment is the private revenue it will bring to the physician.”
>
> “Professional norms, values or Hippocratic Oath have become meaningless for physicians. Say that a procedure does not carry any performance points. You won’t find a physician performing that procedure anymore. Say that a procedure has been bundled in another larger procedure. You won’t find a physician diagnosing a patient with that illness anymore.”
>
> “… In actuality, the determiner of the organization of healthcare is the private revenue physician will generate out of the services s/he will provide. Patients’ restoring his or her health is no longer physicians’ concern.”
>
> “The status of my performance points in relation to my quota is of utmost importance for me while organizing medical care for a patient.”
>
> “Performance point is the sole determiner in the organization of healthcare nowadays. The procedures that carry no performance points are not being performed anymore, even though it may be to the detriment of the patient medically.”

The core themes, which anchored under ‘Information provision role’ sub-characteristic, were ‘Instruction provider,’ ‘Information provider,’ ‘Documentation provider’ and ‘No information provision/false information provision geared toward maximization of private revenue gain.’ The representative text segments in relation to each of these themes will be elaborated upon in the following.

In reference to the theme ‘Instruction provider,’ which encapsulates ideas and statements referring to physicians’ view of their information dissemination role being *‘persons in command,’ giving authoritative orders based on the physicians’ judgement about what is in the patients’ best interest*, some of the recurring statements of participants included:

> “Whatever the physician said was the rule. We would give the patient his or her prescription and tell them to use as prescribed.”

> "We would tell the patient 'I will cut [operate on you] you tomorrow, and the patient could never ask why they were being operated on or whether there were any complications involved in the procedure. It was as if patients were speaking to someone with divine authority."
>
> "Physicians would only give orders and patients would fulfill those orders."
>
> "Physician would not even listen to the patient, and patients would know not to ask anything … Physician would direct the patient that s/he would be administered a catheter with a urinary drainage bag for a week, and the patient could not even ask why s/he would need it or whether s/he needed to be careful about certain things while the drainage system was attached to them … they would only follow the orders."

In reference to the theme 'Information provider,' which encapsulates ideas and statements referring to physicians' view of their information dissemination role being *a partner to the patient providing information with a cooperative and consensual approach toward a better informed decision-making for the common goals of disease treatment, disease prevention and health promotion*, some of the recurring statements of participants included:

> "This system is more geared toward information provision, but the paperwork it generates causes a heavy workload for us. For instance, in the past, we would only abbreviate S.C. for subcutaneous, but they want us to write it out completely now. Everything must be as explanatory as possible in this new system."
>
> "We have increasingly been providing more information to patients about their treatment. You have to get a consent from the patient before you can do anything on that patient. It was not this way in the past; physician would do whatever s/he would deem appropriate. We now have some set quality standards providing clear instructions in terms of daily ordering of patient medication, explicitly stating in which timeframes medications need to be administered etc. … Physicians who do not follow these instructions are being warned."
>
> "We now provide information to patients about their illnesses and treatment protocols."
>
> "We provide clear explanations on how they should use the medication prescribed to them. We give information about what to do if/when adverse effects are experienced. We have brochures prepared for these purposes and they are being handed out to patients."

In reference to the theme ‘Documentation provider,’ which encapsulates ideas and statements referring to physicians’ view of their information dissemination role being *a government servant fulfilling the paperwork requirements of the bureaucratic system*, some of the recurring statements of participants included:

> “We now have to obtain an informed consent from each and every patient. I cannot operate on a patient without those signed consent forms anymore. There was no such thing in the past. We would only get a document signed by the patient stating that they would assume all the risks involved in the procedure and that was it. Now, for every single procedure, we must get a two-page document read and signed by the patient. You can consider those as documentation handed to you at the banks when you apply for a credit card. Do you read them before signing? No. Same thing happens here. They just sign the paperwork to get past this bureaucratic hurdle.”

> “Physicians get the standard documentation filled out by the patient only … We have financial worries as well as governmental constraints. You have sixty patients waiting outside. You must see them all in a day.”

> “Physicians are no longer authoritarians as they used to be. There is no such strict authority anymore. We are now having to get a lot of documents signed by the patients.”

> “We would only get some standard documentation filled out by the patients. They would not even know what they were signing. They would just sign them without even looking at them and they would not ask a single question.”

In reference to the theme ‘No information provision/false information provision geared toward maximization of private revenue gain,’ which encapsulates ideas and statements referring to physicians’ view of their information dissemination role being *self-serving persons either performing no communication, due their fervent obsession with their own financial interests, or misguiding patients via providing erroneous information, aiming toward maximization of their private revenue gain*, some of the recurring statements of participants included:

> “We are not giving orders as we used to or providing information. Because physicians are not concerned with patients’ illnesses or with providing them the medical care they need. Do you

believe we have time for providing information to patients? Patients do not even know what type of surgery they will be going under or who will operate on them. Now, when you go to a bank, do you know which customer representative will be dealing with you? A Private Customer Representative. It is the same with us. A specialist. Who that specialist is does not carry any importance for anyone anymore."

"Physician's only concern is to maximize his or her performance points. Communicating with patient, or providing information about the treatment procedures or protocol are not a concern for physicians anymore."

"We are not providing information; we are actually doing nothing. We do not want to. Physicians do not like doing their jobs … with all the patients we have to see, what directive or information provision are we talking about? These are utopian concepts nowadays. All we want is to make as much money as possible."

"We do not in any way provide any information to patients. We give their prescription and send them off their way. If it were in our hands to decide, we would not even see patients. But, we have to, because we need to generate performance points."

"… In some specialties, there are not enough patients to fill your performance quota. In those circumstances, physicians want to perform some procedures on patients although they may or may not be indicated. Physicians eventually somehow convince the patients that they need those procedures utilizing their expertise and secret knowledge."

"… Patients coming to government hospitals were given a false impression by those physicians that the healthcare services they were receiving were not adequate, and thus would be made to feel unhappy about the services they were receiving. A misperception was being purposely being created in their minds that those patients were not being properly cared for or receiving incomplete or insufficient healthcare services at the government hospitals by those physicians because they had not visited those physicians' private practice offices."

"… They [patients] do not even know which operation they will be undergoing or why they are being operated on. Physician deemed it necessary; that is why … are all surgeries being performed truly necessary? I do not believe majority of them are."

The core themes which anchored under 'Professional role relationship' sub-characteristic were 'Professional information exchange- and cooperation-based practice,' 'Individual and

autonomous practice,' 'Hierarchical- and division of labor-based practice' and 'Interest groups-based practice/practices characterized by economic-based animosity/corruption.' The representative text segments in relation to each of these themes will be elaborated upon in the following.

In reference to the theme 'Professional information exchange- and cooperation-based practice,' which encapsulates ideas and statements referring to physicians' view of their professional role relationship with colleagues and other healthcare personnel being *organizing the content and delivery of healthcare in a team approach*, some of the recurring statements of participants included:

"We are working as a team. We are requesting consultations and deciding collectively."

"At least two physicians jointly attend xxx surgeries. It is that way in xxx department. Physicians are constantly exchanging information about treatment procedures."

"Unlike how it is now, there was indeed teamwork in the past. Physicians would consult with their colleagues in different specialties for the best treatment method. It was done so as not to miss anything before the treatment option was chosen."

"In the past, there existed teamwork amongst physicians. We cannot disregard this fact."

"There is a great deal of cooperation and collaboration amongst physicians. Specifically, it is a lot more on non-routine patients."

"… In one occasion, our clinical chief took some of the patient files to Ankara where he discussed them with his professor. There had been cases in which we consulted our professors to get their opinion before we decided on surgery."

In reference to the theme 'Individual and autonomous practice,' which encapsulates ideas and statements referring to physicians' view of their professional role relationship with colleagues and other healthcare personnel being *organizing the content and delivery of healthcare with a competitive individualistic approach (in which physicians would perform medicine independently due to the individualistic compensation plan [PBSPS] in place)*, some of the recurring statements of participants included:

"Physicians are now working individually."

> "There is no team work amongst physicians anymore. It occurred only in the past. Physicians are now working individually and autonomously because of this performance system."
>
> "Physicians are only concerned about their own specialty; the whole thing has now become individualistic."
>
> "Now this performance system provokes physicians to work individually to generate maximum amount of performance points. Thus, if the physician knows more or has more experience about a specific treatment or procedure, that physician strives to keep it all to himself or herself to prevent others to learn what s/he knows. The logic behind it is that others should not be privy to that information, so s/he is the only one who can administer those procedures."

In reference to the theme 'Hierarchical- and division of labor-based practice,' which encapsulates ideas and statements referring to physicians' view of their professional role relationship with colleagues and other healthcare personnel being *organizing the content and delivery of healthcare in a tenure-, role- and responsibility-based approach,* some of the recurring statements of participants included:

> "… Back then, there was a subordinate-superior relationship in the healthcare delivery. Everything was being done in a more organized way."
>
> "… Everyone knew their roles and responsibilities. Nurses would only do nurses' work and other healthcare personnel would do whatever was required of them at the time of delivery of healthcare."
>
> "Now, we have clinical chiefs. The work their assistants perform are recorded under their name. Because the government gives them this power."
>
> "… You had to show utmost respect to your instructor."

In reference to the theme 'Interest groups-based practice/practices characterized by economic-based animosity/corruption,' which encapsulates ideas and statements referring to physicians' view of their professional role relationship with colleagues and other healthcare personnel being *organizing the content and delivery of healthcare in an unvirtuous circle of referral or cartel-like collusive physician arrangements approach as well as being*

characterized by strong mistrust and hostility, some of the recurring statements of participants included:

> "Physicians are now working in groups with the main aim being maximizing the group members' private revenue."
>
> "Physicians are operating without knowing what other physicians are doing. Everybody is after maximizing their performance points. For this reason, a lot of unfriendly arguments have frequently been occurring amongst physicians."
>
> "We hear that physicians are grouping together and sharing patients amongst each other only in those groups and not allowing others to join unless it contributes to more performance point generation for the members in those groups."
>
> "… An enormous competition has grown amongst physicians. The reason is the motive to generate more revenue. Physicians are no longer in contact with each other."
>
> "Physicians are grouping together. They are forming two- to three-physician groups. The members of these groups are protecting each other's interests by sending patients to each other, thereby generating performance points. For instance, I am the only physician actually attending a surgery, but am including one of my group member's name as one of the attending surgeons on the operation notes, just so my group member will generate performance points as well. My other group members are doing the same thing for me. We are doing this for each other all the time."

The last fundamental feature, defined as 'Control of work processes' was reached based on the recurring discussion of participant physicians with reference to their perception of *how the work they perform and/or produce was assessed,* which was further organized around the following theoretical sub-characteristics: 'Success criteria,' 'Quantitative service assessment' and 'Qualitative service assessment.' The core themes which distinctly anchored under 'Success criteria,' sub-characteristic were 'Physician's prerogative to define,' 'Performance point,' 'Performing in accordance with laws, rules, procedures, duties and responsibilities' and 'Highest private revenue generation.' The representative text segments in relation to each of these themes will be elaborated on in the following.

In reference to the theme 'Physician's prerogative to define,' which encapsulates ideas and statements referring to physicians' view of the success criteria for their performance

being *in the domain of and controlled by physicians*, some of the recurring statements of participants included:

> "Physician's success was a prerogative of physicians. Physicians go to school for so many years. After so many years of schooling and practice, they develop a unique sense of professional understanding."
>
> "Physicians do not like interference into their professional domain. Whether s/he is successful is none of anybody's business, except the physician's."
>
> "Physician does not want or like how he is practicing medicine questioned. This is his private domain and s/he has received a comprehensive education and training in it. His or her success concerns only the physician and it is strictly in his or her domain of responsibility."
>
> "In terms of success, I was evaluating myself; it was like a self-control mechanism. For instance, if the patient I treated was healed, then I would consider myself successful."
>
> "There did not exist a mechanism to measure physician's success. Physician was, just like in the other matters, on his own."

In reference to the theme 'Performance point,' which encapsulates ideas and statements referring to physicians' view of the success criteria for their performance being *highest possible performance point generation*, some of the recurring statements of participants included:

> "Our only success criteria is unequivocally the performance points we generate. If your performance points are high in number, you are a good and successful physician in the eyes of the management."
>
> "A good physician is not an ethical one at this time; the most valuable physician is the one who uninterruptedly sees the highest number of patients and performs the highest number of surgeries. How will this enterprise be successful? By means of individual physicians,' or in other words successful physicians' producing more."
>
> "If your outpatient clinic patient visit numbers are low, or if we talk about surgeries, your number of surgeries are low, whatever else you do is useless. In the opposite case, management says, 'good job, you work hard.'"

> "If you collected a high number of performance points, you are a good and hardworking physician in the eyes of the management."
>
> "Performance point is the most important issue now. Your success is certainly measured by your performance points. If you produced a lot, then you are a star."

In reference to the theme 'Performing in accordance with laws, rules, procedures, duties and responsibilities' which encapsulates ideas and statements referring to physicians' view of the success criteria for their performance being *performing duties and responsibilities in relation to healthcare services in a proper manner (as instructed by the applicable laws, regulations and guidelines),* some of the recurring statements of participants included:

> "If you were coming to work in time and doing your shift properly, then you were a successful physician."
>
> "The more you followed the rules and procedures of the facility and the government related to your work, the more successful you were."
>
> "If you did your duties and responsibilities as expected, then you were successful."
>
> "… Basically, if there were no patient complaints related to the care you provided, which the chief of medical staff would have to deal with, then you would be viewed as successful by the management. So, if the work you produced did not result in any patient complaints, then you were good-to-go."
>
> "The most important thing was whether you performed your duties and responsibilities in accordance with rules and regulations. In addition, if the surgeries you performed had no post-op complications and the patients were happy, then you would be regarded as a successful physician. The MoH and the management would be measuring your success this way."

In reference to the theme 'Highest private revenue generation.' which encapsulates ideas and statements referring to physicians' view of the success criteria being *maximum amount of private revenue creation using their potent and secret wisdom*, some of the recurring statements of participants included:

> "Physicians' success was measured by their material possessions. It was a way of displaying their social class. The more expensive physicians' cars, houses and summer villas were the

more successful were the physicians. So, the success of the physicians were a matter of how much money they made out of their patients."

"The criteria for our success was the money we would make doing this job. Physicians were already receiving a salary from the government, but were demanding additional fees from the patients on top of it. Physicians' cognitive sense of success and satisfaction increased as s/he made more money this way."

"Physician's success was measured based on how much money s/he made out of the doctor's visits and surgeries s/he performed."

"Physician's main aim is to exploit the system. The most important thing is the material gain the physician will generate. Physicians talk to each other and discuss their collected performance points to see who has been more successful."

"For the physician, success is being measured by the money s/her earns, not whether s/he is conforming to the principles of Hippocratic Oath while performing his or her work. The more the performance points, the more the private revenue, and thus success."

"Whichever physician makes more money and whichever physician buys the most luxurious car is the successful physician. This performance system really degenerated the physicians badly."

The core themes, which distinctly anchored under 'Quantitative service assessment' sub-characteristic were 'Professionally autonomous,' 'Performed regularly by management and inspection committees,' 'Performed occasionally by state officials', and 'Rogue autonomous.' The representative text segments in relation to each of these themes will be presented in the following.

In reference to the theme 'Professionally autonomous,' which encapsulates ideas and statements referring to physicians' view of assessment of the quantity of healthcare services being *in the domain of and controlled by physicians*, some of the recurring statements of participants included:

"No one would question the quantity of healthcare services delivered. No one would ask how many patients I saw or how many procedures I performed, or why I saw the number of patients

I saw, or whether I should have seen more or less patients. If the physician saw those patients, it was out of the physician's own initiative to see them."

"Physician would do as much work as s/he deemed necessary. No one could question the physician based on the work s/he produced."

"Could you have dared to tell the physician to produce a certain amount of work back then? Physician was the boss in those times."

"Questioning physicians' work in the past? Like how much work s/he generated? It would have been perceived as having infringed upon his private domain."

"Some physicians would come to work at 11:00 a.m. and leave at 14:00 p.m. They would see 10-15 patients and then leave for their private practice offices to see their pay patients. They would themselves decide how many patients they needed to see in a day."

In reference to the theme 'Performed regularly by management and inspection committees,' which encapsulates ideas and statements referring to physicians' view of assessment of quantity of healthcare services being *performed by the hospital management and formal inspection committees, established to evaluate the degree of productivity as well as achievement of performance targets*, some of the recurring statements of participants included:

"The work you produce is under constant control now. During our periodically-held provider staff meetings, which are chaired by the chief of medical staff, the work that has been produced by physicians are being discussed and various clinics' productivity ratios are being compared."

"… Statistics in terms of who produced how much is being tracked monthly."

"Management reviews numbers monthly. They pull the statistics and say, your specialty performed thirty major surgeries, five minor surgeries and two local procedures. Then turns to another specialties' numbers and say, look, this other clinic performed a hundred type 'A' surgeries, and I see that your clinic has not performed any of those. Then say that they will have to decrease the surgery slots for those which have not been able to reach their performance targets."

> "Now the situation is a lot different compared to our old days. Management is now constantly monitoring the status of our performance points. The ones that are not meeting their targets are warned via different ways."
>
> "Management's eyes are always on us. How many type 'A' or 'B' surgeries have been performed are tracked closely. They are constantly keeping and monitoring these statistics. Physician is no longer the king s/he used to be. They are like a worker in a company. Their performance is constantly being monitored by management."
>
> "Measurement is being done by the management. Every month, they are putting the statistics on the table. In the past, there was no such thing as monitoring how much a physician produced. You now feel that you are under constant surveillance."

In reference to the theme 'Performed occasionally by state officials,' which encapsulates ideas and statements referring to physicians' view of assessment of quantity of healthcare services quality being *performed by government authorities sporadically as well as on an as needed basis,* some of the recurring statements of participants included:

> "Back then, management was of course keeping track of the work produced, but it did not really mean much in terms of increasing production ratios. Because there was no incentive."
>
> "Statistics were being maintained for the purposes of the MoH. At times, we would have meetings to discuss, and being a former chief of medical staff back in the day, I would say that we might decide on increasing the number of patient encounters by, say 3% to 5%. But, since the hospital pretty much had a set budget and that it would not generate any additional revenue for physicians, we would decide not to even bother."
>
> "… As far as I know, management would report the number of patient encounters and surgeries up to the MoH. I am not sure if those numbers carried any importance though."
>
> "There is definitely a huge emphasis on the healthcare delivery statistics now. Way back when this performance-based system did not exist, management I believe would still track the patient encounter statistics, though I am not sure if it benefited anyone in any shape or form."

In reference to the theme 'Rogue autonomous,' which encapsulates ideas and statements referring to physicians' view of assessment of quantity of healthcare services being *non-existent, the fact of which creates a discretionary space for physicians, who then manipulate*

and exploit this gray area for financial gain at the expense of the welfare or their patients, some of the recurring statements of participants included:

"… Since the quantity of the work physicians generated was not a real concern for anyone, physicians would see as many patient as they deemed fit, and they would then leave the hospital early to see those patients they already directed to their private practice offices as pay patients."

"… If physicians saw their patients, it was because they took the initiative to see them. No one would question why they did or did not see patients or perform surgeries. Since they were pretty much on their own, they would try their best to channel as many patients as possible to their private practice office."

"Physicians would see as many patients they wanted to see and leave. Some physicians would come to work at eleven o'clock and leave at two o'clock in the afternoon. They would go to their private practice offices to see their pay patients, who were actually government healthcare beneficiaries that those physicians had told to come to their private practice offices."

"… Physicians would make patients wait at the emergency rooms and patients would suffer. Physicians would not examine patients. Physicians would hand out their business cards to patients and ask them to come to their private practice office to get seen. It had completely turned into a business for them. We would order consultations, but could not find a doctor to perform the consultation. Because physicians would spend majority of their time at the break rooms watching horse racing or stock exchange market. Why? Because they had either bet on a horse racing or selling or buying stocks and wanted to check the status of those …. They would report to work at ten o'clock in the morning and could not care less about seeing patients, who had been in the line since five o'clock in the morning, until they left early in the afternoon. And no one could ask them why. I am speaking based on the observations I have made since 1991. Back then, all physicians had private practice offices. When we examined the patients as assistant physicians at the time, we would state that admission was necessary and refer them to our more senior physicians' private practice offices. Patients had to visit the doctor's private practice office. Otherwise, they would not be admitted; they would be abandoned to their fate … I unfortunately witnessed some situations in which some poor

villagers had to sell their cows, which were their only income generation mechanism, to get operated on."

"… The surgeries which carry high performance points but low risks are preferred by physicians now. High-risk surgeries are no longer being performed. Besides, physicians are practicing medicine for the sake of their purse only. For instance, in some circumstances, the performance points related to the work performed within the last two-three days of a year may be rolled over into, and thus are reflected in, the following year. In those cases, since those physicians who will be receiving revolving fund payments over the hospital average will have no worries in terms of collection of performance points, and they thus decide to see no patients. So, in those cases, never mind the principles of Hippocratic Oath or professional norms or values, they can be easily disregarded. Those physicians take administrative leave for those couple of days [the last two-three days of the year], and do not even bother coming to work."

"… I tell my colleagues, 'I have collected enough performance points to reach my target and am done with my surgeries. I am leaving for three-five days … we take care of each other this way … we have to do it; otherwise our performance points will be cut if we end up using leave beyond ten days, per the government directive issued in 2003."

"… The primary focus is performance points. If I see thirty-six patients in a day, in other words, spend fifteen minutes with each patient, then I can only collect one thousand performance points. If I see seventy patients, however, I will have collected three thousand performance points. Then, why would I spend fifteen minutes with each patient? I will spend one third of the time; five minutes will be more than enough for a patient. I will see one hundred patients and increase my performance points."

"… You cannot make physicians see patients when they realize that the value that is created via seeing those patients is lower than a certain level."

"Physicians are autonomous in how much work they want to generate. Autonomous in the sense that they use their professional discretionary space to determine how much work they should generate, but they do it based on how much private revenue that work will gain them. For instance, once we have reached our performance point target, we start to not see patients; honestly, we tend to slack off."

The core themes which distinctly anchored under ‘Qualitative service assessment’ sub-characteristic were ‘Professionally autonomous,’ ‘Performed regularly by management and inspection committees,’ ‘Performed occasionally by state officials’, and ‘Rogue autonomous.’ The representative text segments in relation to each of these themes will be elaborated upon in the following.

In reference to the theme ‘Professionally autonomous,’ which encapsulates ideas and statements referring to physicians’ view of assessment of healthcare service quality being *in the domain of and controlled by physicians,* some of the recurring statements of participants included:

> “No one would question service quality. No one would ask me whether I provided a good or quality service or not. Whatever I did was strictly out of my own initiative. Physician would say that s/he deemed this course of treatment appropriate and that was the end of it.”
>
> “Physicians autonomously decide what needs to be done and how it needs to be done. The content and quality of the service can only be determined and shaped by the physicians. Even another physician from another specialty cannot understand why’s and how’s of a service a physician performs anyway.”
>
> “The concept of quality was a professional prerogative of physicians to define back then.”
>
> “Physician was autonomous in terms of quantity and quality of the care. Because the competition arising from today’s performance-based system did not exist back then. Physician had the complete authority to decide what s/he would do and in what way s/he needed to do it.”
>
> “Physicians were on their own in terms of the quality of care. No one could dare to interfere with their decisions on that. The concept of quality was however physicians defined it.”

In reference to the theme ‘Performed regularly by management and inspection committees,’ which encapsulates ideas and statements referring to physicians’ view of assessment of healthcare service quality being *performed by the hospital management and formal inspection committees established to ensure services conform to market-oriented (i.e., commonly-accepted) standards of medical care,* some of the recurring statements of participants included:

"They [inspection committees] do perform those quality checks to ensure that the quality criteria set forth by the MoH is being conformed to."

"… For instance, they [inspection committees] check to see whether the space in patient rooms and examinations rooms is compatible with the standards in terms of square meters, whether certain arrangements have been made to ensure patient privacy is protected, whether certain security measures have been implemented, whether a certain number of beds are available, whether the oxygen tubes valves have been checked and when the last check was performed on them, etc."

"Inspection committees are performing some assessments. In government hospitals, there are performance inspection committees comprised of twelve physicians, each with a different specialty. This committee inspects whether the medical services delivered in government hospitals conform to ethical norms and guidelines of medicine."

"There are inspection committees acting as mechanisms for evaluating physicians' performances in terms of appropriateness, timeliness, ethics, etc."

"They [inspection committees] are periodically evaluating the work that is being performed. In addition, they inspect the work performed very hard and diligently specifically subsequent to a patient complaint."

In reference to the theme 'Performed occasionally by state officials,' which encapsulates ideas and statements referring to physicians' view of assessment of healthcare service quality being *performed by government authorities sporadically as well as on an as needed basis*, some of the recurring statements of participants included:

"It [healthcare service quality assessment] was being done by the government authorities irregularly. Specifically, they would inspect our work mostly when there was a patient complaint."

"They [government authorities] would, from time to time, conduct unannounced visits and inspections with no prior notification. These inspections would be performed to check whether or not government standards were being met in terms of delivery of care."

> "Inspections would be done very rarely, and I cannot even consider them true inspections. They [government authorities] would come and evaluate the adherence of the medical practices as well as hospital procedures to the guidelines of the MoH."
>
> "The only time they [government authorities] would come to conduct any sort of a true inspection would be when there was a patient complaint regarding a post-surgical complication. They [government authorities] would really crack down hard on the specifics of the entire case when that happened."

In reference to the theme 'Rogue autonomous,' which encapsulates ideas and statements referring to physicians' view of assessment of healthcare service quality being *non-existent, the fact of which creates a discretionary space for physicians, who then manipulate and exploit this gray area for financial gain at the expense of the welfare or their patients*, some of the recurring statements of participants included:

> "Can you be professionally autonomous in terms of quality of care in a healthcare system like this? Physician does not have a clear conscience in terms of his or her conception of practice of medicine. Service quality is not something physicians are concerned about anymore. There are performance collection worries constantly pulling physicians' conscience toward the dark side, and thus they do not have time to even think about quality. While deciding on the proper treatment method, physicians are now stuck between their purse and their guilty conscience and they do not, under this predicament, show any concern for service quality. In this case, do physicians enact some unethical behaviors? Of course, they do. This is an inevitable result. If you force them into it, they will give you what you ask for."
>
> "The inspection committees are only looking at whether physicians have entered unwarranted procedures into the system. No one is looking at the quality of the services. In a relationship like the one mentioned here, you [inspection committees] are regarding physicians as potential thieves and physicians are regarding you [inspection committees] as a structure exploiting their labor. Can physicians maintain ethics in a system like this? No, they cannot. Can physicians focus on quality of care? No. In this situation, the only aim of the physician is to save his own ship. Can you still talk about service quality in this situation? Not really."
>
> "Inspection committees cannot evaluate whether we performed our jobs well, and they actually are not anyway. And by the way, we are not doing a good job either. I know some

physicians who stare at their patients in such a bad way…. How many patients can a physician see day? Two hundred and fifty? Can s/he? Theoretically not likely. Now, for instance, xxx encounters. How much time does one take for a physician to perform? At least thirty minutes. A physician works for eight hours a day. Can s/he provide more than sixteen encounters a day? No. Out of a twenty work-day in a month, a physician can provide up to three hundred and twenty xxx encounters. One physician entered into the system stating s/he performed five hundred of them. That is exactly what these inspection committees are focusing on. Whether or not physicians have entered unwarranted procedures into the system. Once they notice these thefts, they basically remove them out of the system … You will find very few physicians practicing medicine with a clear conscience. Under these circumstances, can you expect these physicians to provide proper healthcare service to patients? Which quality are you talking about?"

"There is this concept defined as hospital average in terms of performance points. You need to meet or exceed that average. If you cannot, your revolving fund payments will be low, and you will be warned in a few months by the management. You then try to find ways to reach that target. It is exactly in those situations where deviations from the professional norms and values are seen. Physician swerves into wrong paths in order to reach that target. And they do it as inconspicuously as possible."

"Inspection committees are only looking at whether the services entered into the system are padded. There is not a real evaluation for quality. That is not a real concern for anyone, really. They cannot truly assess my work in terms of service quality anyway. Besides, you cannot show me a physician who is genuinely concerned about service quality. The only thing physician is thinking about and is motived to do is to maximize his or her performance points."

"To me, service quality is no one's real concern. There are those inspection committees because they know that physicians' real focus is on making more money, not on service quality. And to be honest, physicians are a bit inclined toward fraud. It is a control mechanism to punish those deviant behaviors with payment cuts. So, under these circumstances, service quality becomes a concept which is empty inside."

"Centralized patient appointment scheduling system provides appointments only in ten-minute intervals and you can see up to thirty-seven patients that way. When you see only

> those many patients though, your end-of-month accumulated performance points will be low. In this situation, physician sees more than thirty-seven patients, and this number goes up to seventy or eighty. So, since your motivation is to see more patients and collect more performance points that way, you spend less time with patients and in that case the quality of care you deliver diminishes greatly."

Clustering the themes, which were comprehensively elaborated upon and illustrated with applicable text segments above, and thereby ensuring that they accurately characterize the institutional logics instantiated at the practice level, required a long, tedious and continuous investigation into the literature as well as meetings and exchanging of ideas between the researcher and academia. Toward this aim, researcher's maintaining a constant dialogue amongst the data, literature and academia proved extremely beneficial. Data were continuously compared with the findings of the literature throughout the research process, which meant triangulating the accumulated data with research material describing the institutional logics permeating the contexts of the healthcare sector (Kitchener, 2002; Özseven et al., 2014; Reay and Hinings, 2005, 2009; Reay et al., 2016; Scott et al., 2000). This triangulation was not performed to inquire about, or seek, whether full support could be gathered from the imprinting literature; it was done to compare findings of this research with the findings of the earlier research in the area of healthcare. In addition to the relentless efforts exerted toward triangulation, the researcher also cross-validated the data and preliminary findings with numerous field level experts and highly-tenured participant physicians throughout the research process. As a result, a total of thirty-six themes (twelve respective themes under each logic) were clustered under medical professionalism, business-like and state logics.

The remaining twelve themes, however, were not able to be clustered under any of the aforementioned logics because of their unique characteristics. The researcher, throughout the research process, discussed these emerging 'nonconforming' outlier themes with his dissertation supervisor as well as academics whose research focus was on institutional logics. Numerous vigorous discussions held in an effort to most appropriately identify and map these discordant themes resulted in a consensus that they were roguish in nature, involving abnormal and deviant organizational phenomena, which impinge upon organizational action, thereby being representatives of patterns of rogue practices, and thus could be organized

under the logic identified as 'rogue.' Further literature review indicated that those patterns of behaviors were indeed encountered and documented in various different organizational domains and practices, discovered as a "serendipitous by-product of other more straightforward activities … [which] can be revealed to be far more obvious and accessible than was anticipated." (Linstead, Maréchal, & Griffin, 2014, p. 178). In this body of literature, it was emphasized that these organizational phenomena, which are observed in professions, institutions, workplaces, public spaces and everyday life, occurring in the dark side, have long been neglected and should be brought back into the focus of organizational theory (e.g., Linstead et al., 2014; Vaughan, 1999). In this tradition, the dark side has been recognized as "not only dark *out*-side, but is to be found within organizational boundaries, practices and logics … and it can be … addressed in existing organizational theory" (Linstead et al., 2014, pp. 166-178, emphasis in original; see also Land, Loren & Metelmann, 2014; Vaughan, 1999). With the identification of the fourth logic being rogue, all forty-eight themes were successfully mapped to their respective institutional logics. Table 6 summarizes the logics and their associated characteristics mobilized by physicians in their ground level practices where "institutional myths are coupled to actual work" (Hallett, 2010, p. 56) (research question # 1).

Individuals actors draw from and are nested within (Besharov & Smith, 2014), and act in accordance with, broader-level societal logics to the extent their social, professional and economic needs are satisfied. Viewed this way, medical professionalism logic derives from the societal level professional logic. In the medical professionalism logic, the content and organization of work is determined and controlled only by the profession (Friedson, 2001). When guided strictly by medical professionalism logic, physicians would practice medicine autonomously or in partnership with other physicians with relevant expertise and experience. Physicians would practice medicine solely relying on abstract knowledge, abiding by a moral code of ethical conduct, the principles of Hippocratic Oath. Patients and the rest of the healthcare team (i.e., nurses, technicians and other professionals) are expected to follow physicians' orders and medical direction without question. Physicians guided by medical professionalism logic would maintain complete and uninterrupted authority, autonomy and control to provide medical care in a way that only *they* deem most appropriate.

Table 6. *Institutional Logics and Their Associated Characteristics at Practice Level in Turkish Healthcare*

Nature of Demands	Aggregate Theoretical Characteristics	Theoretical Subcharacteristics	Medical Professionalism Logic	Business-like Logic	State Logic	Rogue Logic
Belief Systems (which core values and/or cognitive structures guide behavior [i.e., practices])	*Basis of Goals and Mission*	*Mission Orientation*	Provision of healthcare services with an orientation toward medicine	Provision of healthcare services with an orientation toward business principles	Provision of healthcare services with an orientation toward governmental rules and standards	Provision of medicine with an orientation toward interest maximization
		Goal Focus	Treatment	Effective and efficient treatment	Treatment as a social right	Treatment as means to maximize private revenue
	Identity Categorization	*Definition of Target Audience*	Patient	Consumer/customer	Government healthcare beneficiary	Commodity
		Definition of Own Status	Healer-professional	Stakeholder/Profit partner	Public servant	Rogue Intrapreneur
Ground LevelPractices (as means to pursue core values)	*Service Orientation*	*Service Characteristics Conception*	Medicine-based service	Market-oriented service	Public service	Private revenue generation-oriented service
		Quality Conception	Physicians' prerogative to define	Service is defined quality to the extent it is commensurate with generally-accepted quality standards	Service is deemed 'appropriate' to the extent it is commensurate with bureaucratic or legislative requirements	No quality conception. Service is defined 'quality' to the extent it provides highest private revenue for physicians
		Service Organization	Physician-centered	Consumer-centered	Bureaucratic rules-centered	Private revenue maximization-centered
		Information Provision Role	Instruction provider	Information provider	Documentation provider	No information provision/false information provision geared toward maximization of private revenue gain
		Professional Role Relationship	Professional information exchange- and cooperation-based practice	Individual and autonomous practice	Hierarchical- and division of labor-based practice	Interest groups-based practice/practices characterized by economic-based animosity/corruption
	Control of Work Processes	*Success Criteria*	Physicians' prerogative to define	Performance point	Performing in accordance with laws, rules, procedures, duties and responsibilities	Highest private revenue generation
		Quantitative Service Assessment	Professionally autonomous	Performed regularly by management and inspection committees	Performed occasionally by state officials	Rogue autonomous
		Qualitative Service Assessment	Professionally autonomous	Performed regularly by management and inspection committees	Performed occasionally by state officials	Rogue autonomous

Business-like logic is a derivative of the societal level market logic. Business-like logic ascribes a great deal of importance to practices which could lead to cost reduction (Reay & Hinings, 2009), better management and accountability (Townley, 2002) and performance enhancement. In business-like logic, physicians are expected to provide healthcare services with an orientation toward, though not completely (thus the name business-like), business principles. Effective and efficient service provision with a customer service orientation is highly valued. In this logic, physicians are expected to view their target audience not just as patients but also consumers or customers whose needs need to be satisfied in the most effective and efficient manner possible. Physicians, when guided by business-like logic, structure and implement the content and organization of their healthcare provision practices under the principles of efficiency, effectiveness, customer service, accountability, and performance improvement.

State logic is one of the core institutions of the society. State logic refers to "the basic orientation of the state in securing social and political order" (Greenwood et al., 2010, p. 523). In viewing state logic through the lenses of highly professionalized organizations or organizational actors, governments are regarded as entities "taking direct responsibility for professional work as opposed to ratifying professional desires" (Goodrick & Reay, 2011, p. 379). In state logic, physicians are expected to provide healthcare services with an orientation toward governmental rules and standards. Physicians are employees of the state (Goodrick & Reay, 2011) and thus would see themselves as representatives of the government while providing healthcare with an ultimate obligation and aim to provide equal service for all citizens and also strive to improve general health of the population (Reay et al., 2016). Government officials hold the authority and responsibility to ensure the appropriateness of medical care provided, and physicians are expected to conform to the standards set forth by the government while organizing and delivering healthcare.

Rogue logic is not rooted in any of the seven societal level distinct institutional orders and associated logics identified by Friedland and Alford (1991) and Thornton et al. (2012), but arises from the gap or gray area of undecidability opening up out of the discrepant norms one or more of those societal level logics or their derivatives may bring with them or cause in organizational life. This indeterminate gray zone is where some or most of organizational activities and practices across a range of institutional contexts are likely to be ambiguously

situated (Land et al., 2014). Organizational actors operating in the gray zone, under the influence of divergent logics, may lack certain level of clarity regarding methods of producing order and sense making in relation to potentially conflicting constitutive expectancies of the acceptable behavior and misconduct. When there is a gray zone of obfuscation resulting from the inconsistencies or contradictions of multiple logics, the boundaries of what is acceptable and what is unacceptable may thus become constantly obscured or blurred (Land et al., 2014). Under these circumstances, organizational actors may take a calculated gamble and either "deviate" from or "reject" the institutional templates (Quirke, 2013), or may even be engaged in systemic damaging, illegal or fraudulent activities or practices (Land et al., 2014). This gray area is where most of systematically produced routine nonconformity and misconduct occurs (Linstead et al., 2014; Vaughan, 1999). Actors' systemic engagement in malfeasance or enactment of ethical misconduct is usually driven by personal gain or some other private agenda and these behaviors follow "a logic whereby the rogue is produced, and in that production, creates a boundary dividing ethical from unethical behavior … without the rogue we would never know where the boundaries of good order lie … this production … is double in sense that it is both produced by the rogue and produces the rogue" (Land et al., 2014, s. 247-248). Actors following rogue logics are generally at work, but work under the radar (without being noticed until named as such); they are only potential rogues operating in a gray zone of undecidability. Hence the "rogue is characterized by an indeterminacy that functions in the unclear borders of organizational action. The real rogue logic, however, is the process of producing rogues, and thereby determining the limits of ethical organizational action itself" (Land et al., 2014, s. 248).

It should be noted; however, when following the rogue logic, organizational actors, setting out on their own account, actively and purposely deviate from the status quo and break with the convention, customary practices and established social norms of acceptable behavior. Considering the fact that organizational actor is the agency behind deviation and the agent responsible for deviant behavior (Land et al., 2014), the degree and scope of deviation may be even greater when actors with a high level of professional autonomy and authority over the content and organization of their work are the ones themselves determining the fine line between acceptable and unacceptable behavior. Physicians are known to have complete autonomy and authority over the content and organization of their work (Friedson,

2001; Thornton et al., 2012) and the findings of this study show that they exhibit varying types and degrees of roguish behavior in the performance of their daily practices while greatly benefiting from their sacred authority and autonomy. Findings of this study reflect that physicians following rogue logics provide healthcare with an orientation toward private interest maximization. In this view, physicians regard their target audiences as commodities (the term commodity, in this study, is taken to mean "the general name given to goods and services considered as the basic objects of production and exchange" (Auld, Bannock, Baxter, & Rees, 1983, p. 45)) rather than patients, customers or healthcare beneficiaries seeking treatment and these commodities can be 'utilized' as means to reach their optimal goal: maximum private revenue generation.

These various roguish inclinations of physicians observed in this study are in agreement with the notion that "physicians are human … no one should be surprised if physicians readily succumb to excessive temptations to put their interest ahead of those of patients … acting in self-interest makes it more difficult for physicians to strive for the ideal that patient needs come first" (Light & Hughes, 2001; Sulmasy, 1992, p. 922). When enacting roguish practices, physicians use a great deal of professional autonomy and authority toward maximizing their private revenue by means of arranging for doctor's visits at their own private practice office when they are supposed to be seeing those patients at government medical treatment facilities, or by exercising various methods of overtreatment in an effort to gain more performance points and thus to collect more revenue from the government revolving funds. In this manner, physicians organize healthcare services in a way that they get the maximum private revenue in return. It is also noteworthy to mention here that these types of systemic roguish practices are widely known within and across healthcare organizations, but are condoned by professionals and others at all levels, first because they aid in maximization of private revenue for physicians, and second, in most cases, they contribute to enhanced profit generation and meeting performance targets for the healthcare organizations. The following interview excerpts illustrate this point:

> "… Now, a xxx procedure is performed, but they removed the performance points from that procedure, right? They probably thought that xxx specialists were exploiting use of that procedure by means of utilizing it as a performance point generation mechanism. But, they did not touch the performance points of xxx procedure … they do not allocate performance

> points to xxx procedure, but they allocate xxx performance points to xxx procedure. Of course, to gain performance points, you enter xxx procedure into the system though you actually performed the one without the performance points. What I mean is that the people you are dealing with are very intelligent … For instance, in one instance, a government official, who was a xxx specialist (the same as the participant's), had come to our hospital for an inspection, and I told the government official the dilemma we were in (referring to having to enter the system the procedures with performance points, versus the ones that are without), and basically said, 'my xxx specialist knows what to do' [meaning physicians are clever enough to get around this problem by entering the procedures with high performance points]. Look at this, we are being told to basically manipulate the system. Why would I need to do that?"

> "… Everyone knows about these (unethical) practices, but no one says anything. Because the work produced by physicians ultimately results in increased profits for all parties involved. I mean patients are now at the mercy of physicians and physicians can use their discretionary space as they see fit and everyone involved in this whole thing will make profit out of it. But, who will be miserable in this case? Of course, patients."

To sum up, by operating within the gray zone where there is no external intrusion into the organization and delivery of healthcare provision, physicians use their professional discretionary space on the basis of financial self-interest, which in turn may or may not result in financial gain for all other stakeholders. These rogue practices, however, ultimately result in deteriorated population health, as illustrated in the following statement by one of the participants:

> "Now, patients who have medical conditions are devastated. They are truly miserable … because they do not even know what is being done to them."

5.1. Change in Ground-level Logics

In qualitative research, although it is common to use typical text segments or quotations to justify findings (Schilling, 2006), one can also incorporate other options for data display including matrices, graphs and charts (Miles & Huberman, 1994) involving numerical data (Bowen, 2005). The style and extent of reporting and articulation will ultimately depend on

the specific research goals (Patton, 2015; Saldana, 2009), and in some cases "a numerical summary works as well as (if not better than) verbiage … numbers … [or] scores displayed in a table can go far way in breaking the monotony of words on a page and can give the research report a more 'scientific' appearance" (Bowen, 2005, p. 219). Numerical representation of findings also aids in ensuring that the results of the research are not regarded as "anecdotal" and that they are therefore more credible (Maxwell, 2010, p. 475). Reflection of qualitative data in quantitative terms can complement the participants' perspectives by providing a clearer and more in-depth understanding of what is going on in a particular setting (Maxwell, 2010, p. 479). It will also assist in adequately presenting and assessing the amount of evidence for the interpretations made in the research, which bear on a particular finding or conclusion (Becker, 1970). Hence, qualitative studies "can and often do make use of quantitative data" (Schwandt, 2007, p. 251). "Quantitizing" (Tashakkori & Teddlie, 1998, p. 126) or "quantitative translation" (Boyatzis, 1998, p. 129) of qualitative data and inclusion of the resulting numerical data in qualitative studies and reports can be complementary and beneficial (Olson, 2000), and thus may be justified based on the aims of the research (Hammersley, 1992; Heath & Street, 2008; Miles & Huberman, 1994).

Providing numbers in qualitative data is done to "facilitate pattern recognition or otherwise to extract meaning from qualitative data, account for all data, document analytic moves, and verify interpretations" (Sandelowski et al., 2009, p. 210). This is usually accomplished by means of counting the number of instances of categories or themes to describe the occurrences and distribution of action in order to "give precision to statements about the frequency, amount or typicality of particular phenomena" (Maxwell, 2010, p. 478). Numbers "in this sense of simple counts of things are legitimate and important sort of data for qualitative researchers" (Maxwell, 2010, p. 478). Numbers are of great significance in qualitative research as they are powerful rhetorical devices reflecting the labor and complexity involved in the research (John, 1992) as well as instrumental in terms of extracting the essence and meaning from (Dey, 1993), and thus are integral to qualitative data (Ryan & Bernard, 2000; Sandelowski, 2001). Specifically, displaying information and findings numerically enables the patterns to "emerge with greater clarity" (Dey, 1993, p. 198). Therefore, researchers may confirm certain patterns or regularities in the data and summarize their data numerically by means of counting (Sandelowski, 2000) with the main

aim being that the results could be presented in a format, which will be meaningful to larger audiences.

Use of numerical representation of findings have been utilized in qualitative studies in various different scientific domains to include, but are not limited to, healthcare (Cohen, Tripp-Reimer, Smith, Sorofman, & Lively, 1994; Goodrick & Reay, 2011; Özseven et al., 2014; Sandelowski & Jones, 1996; Simon, 1999), social class (Calarco, 2011; Nelson & Schutz, 2007) and justice system (McPherson & Sauder, 2013). In this study, the researcher follows the line of this tradition and attempts to enumerate the themes derived from the data analyses in order to transform a large volume of verbal data into a visual display, which otherwise could be so complex for the reader to absorb all the information conveyed to them, for a useful theoretical differentiation, representation of patterns, clarity and easy comparison. In other words, the main aim of reducing qualitative data to numbers to numerically display the findings, instead of loading it with qualitative detail as was done in the previous sections of this research, was to sharpen the focus on the key findings as well as to enable the readers to see at a glance the aggregate findings of the study in terms of logical orientations of the participant physicians. Toward that goal, the themes were numerically represented in order to more fully describe and/or interpret the logic instantiations of participant physicians for the two eras investigated in this study: Era 1 and Era 2. Though it was articulated in the preceding sections of this study, to refresh the readers' memories, the historical marker demarcating Era 1 and Era 2 is the year 2005, in, or subsequently beyond, which the supplementary laws were enacted by the government delineating and enforcing the specific rules of engagement for the implementation of PBSPS, as well as laws pertaining to privatization and corporatization of the Turkish healthcare were devised and put in place, as part of the HTP. The evaluations were accomplished by means of measuring the strength of each logic by evaluating the degree to which the physicians' belief systems and associated practices as indicated in their accounts were consistent with the belief systems and associated practices implied by the identified logic characteristics. Figures 10 and 11 illuminate the representation of the findings.

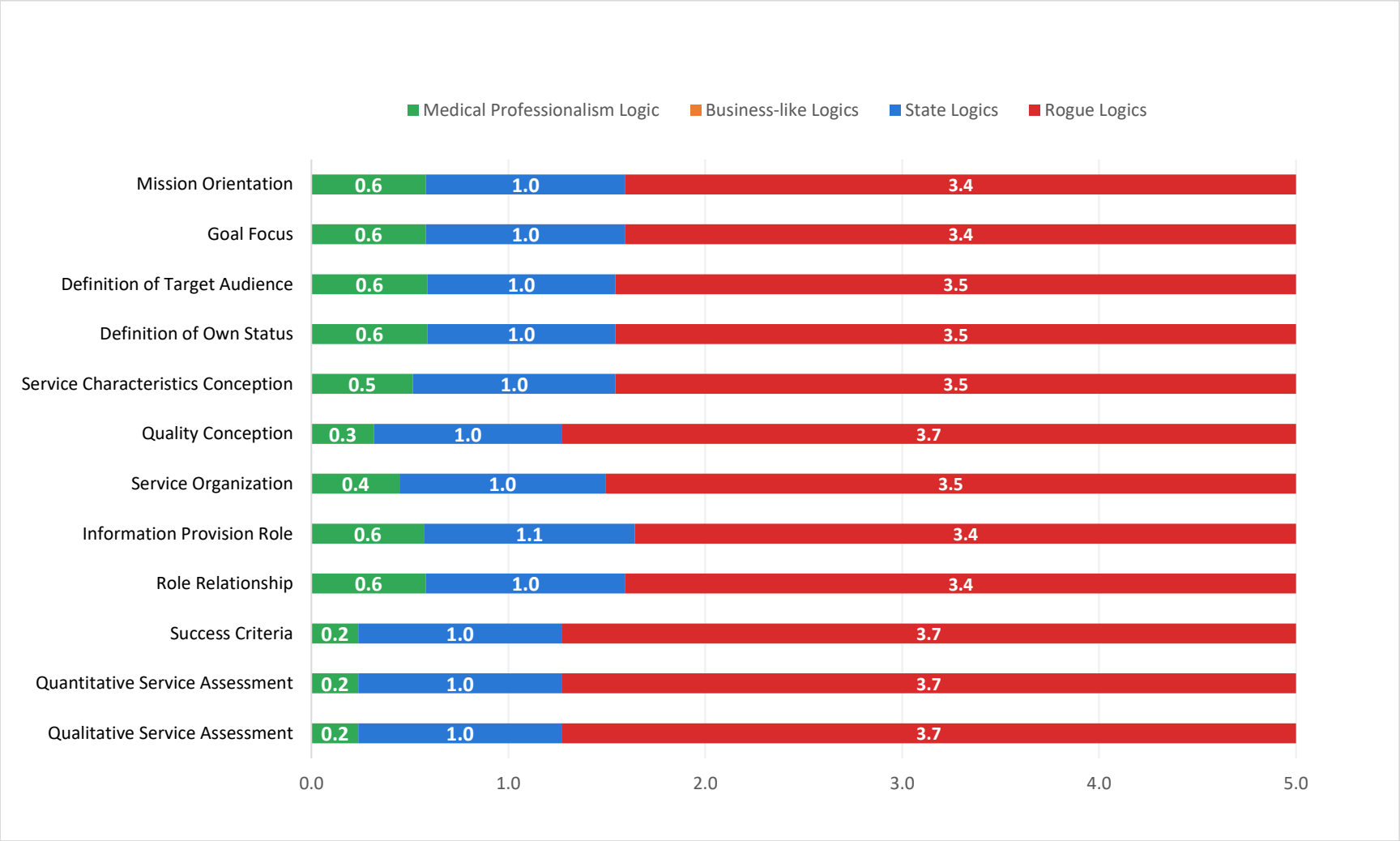


Figure 10. Participants' Logical Orientations in Era 1

Note: 0-1 = *very little influence*; 1.1-2 = *little influence*; 2.1-3 = *moderate influence*; 3.1-4 = *strong influence*; 4.1-5 = *very strong influence*

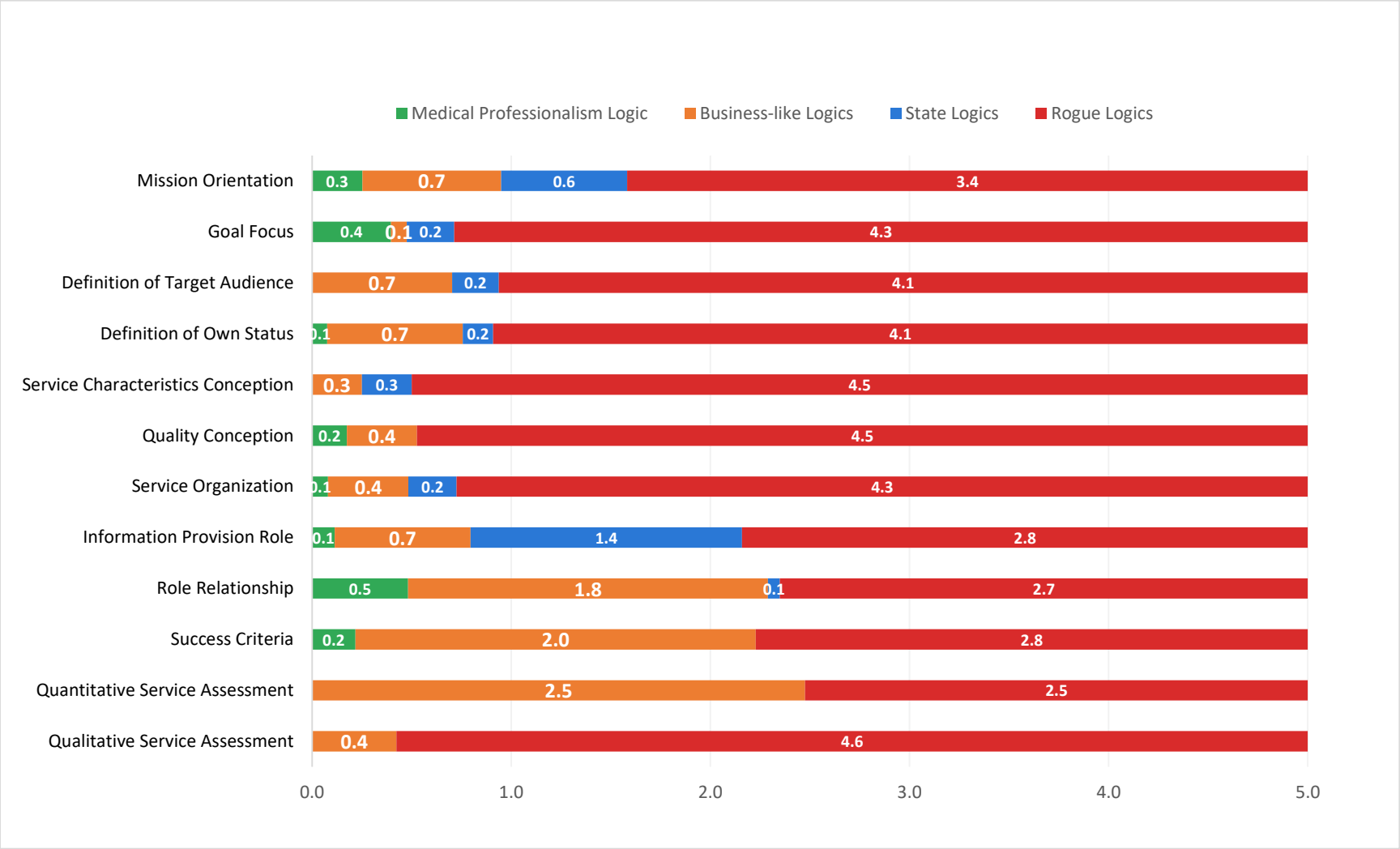


Figure 11. Participants' Logical Orientations in Era 2

Note: 0-1 = *very little influence*; 1.1-2 = *little influence*; 2.1-3 = *moderate influence*; 3.1-4 = *strong influence*; 4.1-5 = *very strong influence*

In highly institutional contexts, prevalence of particular logics or logical orientations within an organization as well as the interrelationships amongst these logics may vary across time and contexts (Besharov & Smith, 2014; Thornton et al., 2012) and the most dramatic changes are typically catalyzed by policy-driven initiatives (Fligstein & Mara-Drita, 1996; Greenwood & Hinings, 1996; Hoffman, 1997), specifically in the area of healthcare (Kitchener, 2002; Reay & Hinings, 2005; Reay et al., 2016; Scott et al., 2000). Findings of this study show that while carrying out their duties and responsibilities, ground-level actors are indeed under the influence of societal level logics or their derivatives; namely, medical professionalism, business-like and state logics, to varying degrees. However, as reflected in the Figures 10 and 11, ground level actors are also under the influence of a home-grown rogue logic operating in the gray zone where the lines between acceptable behavior and misconduct cannot be clearly demarcated (research question # 2). Physicians in this case perform a great deal of edgework within their discretionary space, a prerogative of physicians, which their professional authority and autonomy grant them, in an effort to maximize their private revenue. Rogue practices, so this study shows, are created and maintained within a gray zone, into which no one other than physicians is privileged to have access to, and physicians enjoy a great deal of autonomy and authority in expanding and pushing the limits of this area as their immediate needs dictate.

Figure 10 and 11 show the strength of influence of logic characteristics and logics for Era 1 and Era 2. In Era 1, medical professionalism logic exerts little influence on structuring physicians' cognition and guiding their decision making with reference to all of the theoretical sub-characteristics of belief systems and their associated practices discerned in the data; namely, mission orientation, goal focus, definition of target audience, definition of own status, service characteristics conception, quality conception, service organization, information provision role, role relationship, success criteria, quantitative service assessment and qualitative service assessment. State logic exerts very little influence on mission orientation, goal focus, definition of target audience, definition of own status, service characteristics conception, quality conception, service organization, role relationship, success criteria, quantitative service assessment and qualitative service assessment. The only sub-characteristic state logic exerts relatively higher influence on is information provision role with the degree of influence being little. Rogue logic seems to exert strong influence on

all logic sub-characteristics. In Era 1, business-like logic seems to exert no influence on guiding physicians' behavior during their performance of daily tasks.

In Era 2, only subtle shades of medical professionalism logic seem to continue to exert influence on cognition and decision-making processes of physicians' practice to a very little degree on mission orientation, goal focus, definition of own status, quality conception, service organization, information provision role, role relationship and success criteria. Medical professionalism logic exert no influence on definition of target audience, service characteristics conception, quantitative service assessment and qualitative service assessment attributes in physicians' daily invocation of logics at practice level. State logic seems to drift away substantially with its decreased levels of influence being very little on mission orientation, goal focus, definition of target audience, definition of own status, service characteristics conception, service organization and role relationship, and continues to have a relatively increased level of influence (little) on information provision role. Rogue logic continues to maintain its dominance in influencing structuring and guiding physicians' behavior in all logic characteristics with the strength of influence ranging from moderate to very strong. Specifically, rogue logic seems to be more influential on goal focus, definition of target audience, definition of status, service characteristics conception, quality conception, service organization, and qualitative service assessment logic attributes, with its strength of influence being very strong. Rogue logic exerts the same exact level of influence on mission orientation attribute, but reflects decreased levels of influence on information provision role, role relationship, success criteria and quantitative service assessment, with the strength of influence being moderate. In Era 2, business-like logic enters into physicians' toolkit of logics, and physicians are influenced by the prescriptions of the characteristics of this logic from very little to moderate levels in terms of deciding which practices to enact. Business-like logic exhibits moderate levels of influence on quantitative service assessment, but little influence on success criteria and role relationship attributes. The other attributes on which business-like logic exerts very little influence are mission orientation, goal focus, definition of target audience, definition of own status, service characteristics conception, quality conception, service organization, information provision role and qualitative service assessment.

Table 7. *Strength of Logic Characteristics' Influence by Respective Eras*

	Medical Professionalism Logic		Business-like Logic		State Logic		Rogue Logic	
	Era 1	Era 2	Era 1	Era 2	Era 1	Era 2	Era 1	Era 2
Mission Orientation	0.6	0.3	0.0	0.7	1.0	0.6	3.4	3.4
Goal Focus	0.6	0.4	0.0	0.1	1.0	0.2	3.4	4.3
Definition of Target Audience	0.6	0.0	0.0	0.7	1.0	0.2	3.5	4.1
Definition of Own Status	0.6	0.1	0.0	0.7	1.0	0.2	3.5	4.1
Service Characteristics Conception	0.5	0.0	0.0	0.3	1.0	0.3	3.5	4.5
Quality Conception	0.3	0.2	0.0	0.4	1.0	0.0	3.7	4.5
Service Organization	0.4	0.1	0.0	0.4	1.0	0.2	3.5	4.3
Information Provision Role	0.6	0.1	0.0	0.7	1.1	1.4	3.4	2.8
Role Relationship	0.6	0.5	0.0	1.8	1.0	0.1	3.4	2.7
Success Criteria	0.2	0.2	0.0	2.0	1.0	0.0	3.7	2.8
Quantitative Service Assessment	0.2	0.0	0.0	2.5	1.0	0.0	3.7	2.5
Qualitative Service Assessment	0.2	0.0	0.0	0.4	1.0	0.0	3.7	4.6

Note: 0-1 = *very little influence*; 1.1-2 = *little influence*; 2.1-3 = *moderate influence*; 3.1-4 = *strong influence*; 4.1-5 = *very strong influence*

In viewing the influence of logics on guiding physicians' behaviors for the two eras side by side, as depicted in Table 7, it is noticed that medical professionalism and state logics lose their relative strength of influence on almost all logic characteristics in Era 2 in comparison to Era 1 (except the success criteria attribute, on which the level of influence did not change by era), and business-like logic starts to exert very little influence in terms of all logic characteristics (except role relationship and success criteria attributes, on which it had little influence; and quantitative service assessment attribute, on which it had moderate influence). Rogue logic, however, appears to be the single dominant logic in both eras with its strength of influence ranging from moderate (lowest) to very strong (highest) (research question # 3).

Table 8. *Average Strength of Institutional Logics' Influence by Respective Eras*

	Medical Professionalism Logic	Business-like Logic	State Logic	Rogue Logic
Era 1	0.5	0.0	1.0	3.5
Era 2	0.1	0.9	0.3	3.7

Note: 0-1 = *very little influence*; 1.1-2 = *little influence*; 2.1-3 = *moderate influence*; 3.1-4 = *strong influence*; 4.1-5 = *very strong influence*

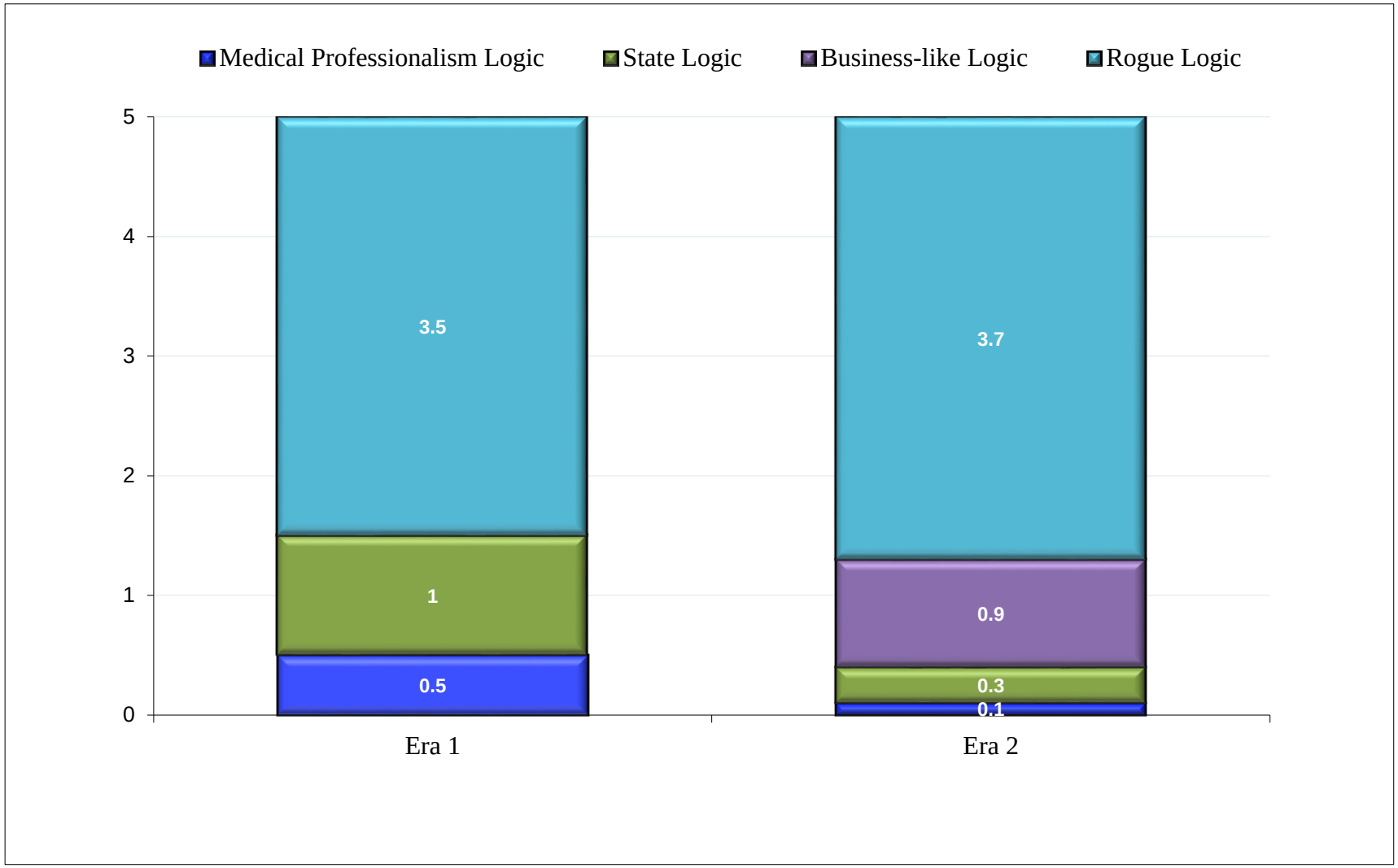


Figure 12. Display of Logic Trends by Respective Eras

In an effort to provide a single evaluation for each logic, mean values for attributes within each logic for each era was also computed (Goodrick & Reay, 2011). These evaluations were reflected in Table 8. Two significant logic constellations were observed. In Era 1, a single dominant logic (rogue) with strong influence and two considerably weaker logics; namely, medical professionalism and state, with very little influence, and another; namely, business-like logic, with no influence at all, was observed. In Era 2, a single dominant logic (rogue) with a stronger influence (compared to Era 1) was detected. Medical professionalism and state logics maintained to have very little influence, but with strikingly weaker levels of strength. Business-like logic, a new addition to the logic toolkit of physicians in Era 2, started to have a very little effect on physicians' cognitive structures and belief systems ultimately guiding their behavior. Figure 12 provides a visual representation of the data reflected in Table 8, enabling the reader to easily compare the trends of logics by the two respective eras (research question # 3).

CHAPTER VI

DISCUSSION, IMPLICATONS AND CONCLUSION

6.1. Discussion

This study reflected that professional work of physicians was under the simultaneous influences of multiple and different logics. The data analyses showed that while performing their daily duties and responsibilities resulting in carrying out certain practices, physicians were guided by the prescriptions of medical professionalism, business-like, state and rogue logics. In Era 1 (i.e., before the implementation of government policy initiatives, for which the historical marker was the year 2005), the analyses reflected that physicians were under the strong influences of rogue logics while carrying out their routine work, but the other logics which were available in their toolkit; namely, medical professionalism and state logics seemed to have virtually no influence on their enactment of practice work. Business-like logics were not at all influencing physicians' cognitive frameworks and associated practices in their day-to-day activities. In Era 2, the effects of the government policy initiative on the cognitive structures and belief systems of physicians were observed, and it was seen that a new logic; namely, business-like logic, entered the toolbox of physicians. Physicians, however, was surprisingly not affected by the prescriptions of business-like logics and did not materialize them into action in their daily practices to a significant degree. Analyses reflected that physicians were still under the influence of a single dominant logic (rogue), as was the case in Era 1. In Era 2, analyses showed relatively stronger influence of rogue logics with only subtle shades of medical professionalism and state logics (even with lower levels of influence compared to Era 1), as well as very little influences from business-like logics.

In terms of diagrammatic representation of the results, this research also adopts the use of constellation of logics as defined by Goodrick and Reay (2011, p. 399) as "the combination of institutional logics guiding behavior at any point of time … which helps us to see the ways that societal logics can combine to simultaneously influence professional work, since the concept of constellation captures the pattern in which these multiple logics are combined at a given time." In this study, two patterns of constellations were detected across the two eras

under investigation, which was a different finding compared to the study of Goodrick and Reay (2011), in which three different constellation of patterns were observed. In the first constellation observed in Era 1, the absolute dominance of rogue logics with a strong influence, and two strikingly weaker logics; namely, medical professionalism and state, with very little influence (business logics reflected no influence on physicians' cognition and behavior related to their practice work) were observed. In the second constellation observed in Era 2, rogue logics not only remained dominant, but also increased its influence on seven of the twelve logic attributes, ranging from 'goal focus' to 'qualitative service assessment,' from strong to very strong influence levels. Also, in the second constellation reflected in Era 2, medical professionalism and state logics maintained to have a very little influence, but with strikingly weaker levels of strength in comparison to influences of the rogue logics, as well as business-like logics entered the logic toolbox of physicians with very little influence on physicians' cognitive structures and belief systems guiding their behaviors. In sum, in both of the eras studied, the data reflected that only one single logic dominated the constellation of logics. In both eras under investigation, it was observed that physicians' practices almost exclusively reflected the rogue logics with virtually no influence by the medical professionalism, business-like and state logics. Though business-like logic was integrated into the toolkit of physicians in Era 2, data showed that it had almost no influence on physicians' cognitive frameworks guiding their thoughts and actions.

In the concept of constellation of logics, "multiple societal level logics coexist and collectively affect professional work for lengthy periods of time … and it is important to focus attention not only on apparently dominant logics, but also on the full set of relevant institutional logics." (Goodrick & Reay, 2011, p. 403). This research follows this tradition and concentrates on a full range of logics available to physicians in their toolkit of logics. However, it should also be noted that analyses reflected that the relative distribution of constellation of logics only minimally changed from one phase to another. As explained in detail in the preceding sections of this research, rogue logic was dominant across eras, and other available logics had only very minimal effects on physicians' cognition and behavior. Thus, the fact that rogue being the most effective influential logic in both Era 1 and Era 2 deserve discussion.

In Era 1, one would think that physicians' practices would be significantly influenced by the state, as the field was strictly regulated by the state. Also worthy of discussion is government's efforts to ensure appropriate code of conduct is adhered to by the physicians, the fact of which would be rendered possible by activities of another actor; namely, Turkish Physicians Association (TPA), introduced and integrated into the field by the government in 1953, via law no 6023. It should be noted that one of the duties of the TPA, as defined by law no 6023 was: "Association is to maintain and promote profession's traditions fed by the philosophy in which servicing public health and patients altruistically and unselfishly are regarded as ideal values of the profession." Based on the establishment of TPA, coupled with the fact that physicians go through extensive training and education at medical schools, one would also reasonably assume that physicians should show noticeable levels of ties to their professional logics and thus be guided by the norms, values and principles of medical professionalism in terms of their daily activities and practices in Era 1. It should also not go unnoticed that the Turkish government also strove to infuse business principles into the healthcare field as of the establishment of 1982 Constitution, the fact of which might have influenced the way healthcare was being delivered in the field. In Era 2, however, it would be fair to expect that physicians would show a significant amount of attachment to business-like logics, affected by the government's rigorous efforts to transform the healthcare field from a state-oriented to a business-oriented field as of the early parts of 2000s, with other aforementioned logics still being potentially influential to various degrees. However, none of these assumptions was valid. The beauty of grounded theory approach is that it focuses on the perspective of perspectives and reaches its outcomes through abstract conceptualization based on the standpoint and views of participants, and not on the preconceived assumptions (Glaser, 1978, 1998, 2001).

Previous research conducted at the micro level shows that actors, at times creatively, use, modify, blend, balance or combine logics through their interactions with others in the same or other professions or positions. A majority of these studies emphasize the role of agency of the actor in various levels of institutional work within the constraints of the existing societal level institutional orders or their derivatives. While this study also acknowledges that actors indeed do exercise a great deal of agency in their work within the confines of the cognitive and normative orders they are exposed to, as previous institutional logics research

attests to, it, by means of this study, furthers these explanations, and shows that actors use their exclusive autonomy and authority to break through these institutional spheres as rogue intrapreneurs and adopt various roguish practices solely toward satisfying their immediate private financial needs. In this study, these practices are viewed as "organizing principles" (Friedland & Alford, 1991, s. 248), "activity patterns" or material "practice[s] as a kind of institution" (Lounsbury & Crumley, 2007, s. 996). It is also recognized that "practices … are available to individuals to further elaborate, manipulate, and use to their own advantage" (Friedland & Alford, 1991; Thornton & Ocasio, 2008, s. 101).

Extant research shows that these types of corrupt practices and activities become "part and parcel of everyday organizational life," and thus are institutionalized within organizations (Brief, Buttram, & Dukerich, 2001; Misangyi, Weaver, & Elms, 2008). It was the case in this study, in which physicians, by means of utilizing their discretionary space, a prerogative of physicians, created and adopted deviant practices in pursuit of private revenue maximization - which are systemically wide-spread across healthcare organizations - that break with the demands, prescriptions or the dictates of the various logics they operate under. Rogue practices, so this study shows, are created and maintained within a gray zone, the dark side of where some or most organizational behavior takes place, into which no one other than physicians is privileged to have access to, and physicians enjoy a great deal of autonomy and authority in expanding and pushing the limits of this area as their immediate financial needs dictate. These systemically roguish practices are widely known within and across healthcare organizations, but are willfully condoned by professionals and others at all levels due to the benefits they bring to the implementers and their organizations.

The results of this study reflect absolute dominance of rogue logics both before and after the policy implementation with other available logics' influences being considerably low. The fact that business-like logic starts to exert very little influence, medical professionalism and state logics lose their influence to lower levels and rogue logics gains more influence in guiding physicians behavior post government intrusion shows that logics are indeed "historically contingent" (Thornton et al., 2012, s. 13-51). The results also reflect that rogue logics are not just "short-lived fads or fashions" (Rao et al., 2003, s. 811), but are indeed rooted in "socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals produce and reproduce their material

subsistence, organize time and space, and provide meaning to their daily activity" (Thornton et al., 2012, s. 13-51), which have become "routinized and habitual and, thus, institutionalized within the organization" (Misangyi et al., 2008, p. 752), as illustrated in physicians' comments below:

> "Our way of doing business has always been this way. I do not think there is a difference at the cognitive level between the doctor exploiting his/her patients' financial income by telling his/her patients that they need to visit his/her private practice office and pay a doctor's visit and/or surgery fee in order to get operated on at the [public] hospital [before policy implementation], and the doctor making the same money via a different method under the pay-for-performance system. To wit, this performance system is just a different and legitimated version of the previous methods doctors were utilizing to maximize their revenue by means of referral of their patients to their private practice offices [after policy implementation]" (Physician interview, 2016).

> "What did I do? I developed a philosophy for my own and said to my patients, 'if you want me to operate on you, you then will need to come to my private practice office first.' This was the correct way of doing business to me and to all my colleagues [before policy implementation]. We are now very motivated and productive, but for what? Not that we love our job or want to heal more patients. The only motivation we have is to increase our performance points and to get paid more. If we have enough performance points, then fine, we do not need to see patients. If we do not, however, we then need to do whatever it takes to collect more performance points, and we start operating like machines. While doing that, though, we unavoidably end up violating some of our professional values and norms. Within this new [pay-for-performance] system, the only and most important thing for physicians is performance points and the financial revenue they bring to physicians [after policy implementation]" (Physician interview, 2016).

By its explanatory empirical power reflecting highly-professionalized actors' ability (or agency) to move beyond existing institutional orders and systematically establish their own socio-historical "rule systems" (Jepperson, 1991) stabilizing around a particular logic (rogue), this study reemphasizes social actors' crucial agentic role in creating, embodying and enacting the logics within organizations (McPherson & Sauder, 2013; Scott et al., 2000).

Physicians, in this research, emerged to be those "actors with sufficient resources [unbridled professional authority, autonomy and control over work]" (DiMaggio, 1983, p. 14), who created and sustained new patterns of institutional practices.

6.2. Implications for Institutional Logics Theory

The findings of this study are intriguing as they reflect counterpoints to some of the ideas and/or findings presented in the majority of the extant literature. Findings of this study indeed challenge most, if not all, of the previous explanations or findings reached in previous scholarly work in the area of institutionalization and institutional logics literature.

First and foremost, according to the early institutionalism literature, "… a critical feature of organizational life is … to assume that … everyone [to include professionals] is acting in good faith … professionalization … binds both supervisors and subordinates to act in good faith." (Meyer & Rowan, 1977, p. 358; Powell & DiMaggio, 1991). Likewise, according to the professionalism literature, "professions create and maintain distinct professional values or moral obligations (e.g. codes of ethics) … inculcate 'appropriate' work identities, conducts and practices … [and thus] professionalism … is considered as a 'disciplinary logic' (Evetts, 2012, p. 5; Friedson, 2001). The findings of this study reflected that professionalism is not a binding mechanism for acting in good faith, or a disciplinary logic regulating professionals' behaviors or practices in accordance with the professional norms and values within organizational life. Data showed that highly professionalized actors (in our study, physicians), indeed utilized their authority and autonomy *professionally* for achievement of deviant purposes, which involved actors' tapping into their ability to exploit their discretionary power, afforded to them by their status and expertise, for personal gain, which, for the most part, might result in severe negative implications for the population health.

Second, the findings substantially contribute to the structure-agency debate. Early institutionalists maintained that institutions imposed strict constraints on organizational actors' the cognitive structures and associated practices in highly institutionalized contexts, which meant that they had *no hand* in changing the taken-for-granted institutional orders, which define the rule systems and organizing principles of organizational life (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Tolbert & Zucker, 1983). In a somewhat similar vein,

within the theories of embedded agency, prevailing logics are assumed to constrain the interests, values and strategies of actors within organizational fields and professional groups (Battilana, 2006; Greenwood & Suddaby, 2006; Seo & Creed, 2002). Later contributors, however, posit that organizational actors have *some hand* in manipulating and or re-structuring institutional arrangements (Besharov & Smith, 2014; Oliver C. , 1991; Seo & Creed, 2002; Smets et al., 2014; Thornton, 2004; Thornton & Ocasio, 2008). Professionalized actors' use of their *limited* agency was indeed portrayed in a study conducted by McPherson and Sauder (2013, p. 181) in which it was found that "actors pragmatically and creatively invoke available logics in order to manage everyday work, often employing 'competing' logics" of other domains. The findings of this study, however, showed that members of a highly-professionalized group could determine or the set the limits of their conditions of practice themselves and act in accordance with them. The study undertaken here, however, showed that rather than having *no hand* or *some hand* in restructuring institutional arranagements, actors actually had an *unconstrained latitude* in deciding how they wanted to structure the content and organization of their work both at the cognitive and the practice level. This study reflected that professionalized actors enjoyed the authority and autonomy their professional status, education and expertise granted them and utilized those attributes as means to satisfy their financial interests. It has been shown that "resources … serve as foundations on which an institutional logic is acted out … for example, education and expertise … or social status … and … institutional logics can be reproduced over time only to the extent that they are supported by and embedded in resources" (Misangyi et al., 2008, p. 755). Physicians, so this study showed, are highly intelligent and knowledgeable agents with a capacity to reflect and act in ways other than those prescribed by the taken-for-granted rules and order systems (Emirbayer & Mische, 1998; Garud & Karnoe, 2003; Mutch, 2007). These findings show that actors of a highly professional group can reflect extremely autonomous and agentic behaviors. They do it by means of institutionalizing alternative practices which are by no means the extensions of, and associated with, belief systems and cognitive frameworks of the ordinary organizational life; these behaviors seem to be completely 'out-of-the-ordinary.'

Third, extant institutional logics literature suggests that institutional change is associated with a new logic for the field (Lounsbury, 2002; Scott et al., 2000; Suddaby & Greenwood,

2005). When a new logic enters an established field, competition between or amongst logics occur, eventually resolving to a dominant logic (Hensmans, 2003; Hoffman, 1999; Lounsbury, 2002; Thornton et al., 2005). The results of this study showed a different pattern. Despite government's rigorous attempts to transform the healthcare to a more business-oriented field, the physicians maintained their already-existing strong attachment to their homegrown rogue logic, and reflected negligible levels of attachment to business-like logics. In other words, the field's most powerful actor's (i.e., the government) change efforts did not substantially influence the logical inclinations of the ground level implementers. This is intriguing because governments are regarded as being the most influential institutional entrepreneurs, which have the legitimately recognized formal authority (Battilana et al., 2009; DiMaggio, 1983; Fligstein, 2001; Garud et al., 2002; Lounsbury, 2002) to "reshape the social organization of the fields and/or help establish a new dominant practice" (Lounsbury & Crumley, 2007, p. 993).

Fourth, previous scholarship posits that "actors affiliated with a professional or organizational group will adhere to that group's primary logic" and that "at any one moment, professions exhibit a temporary consensus in their logical orientations" (Battilana & Dorado, 2010; Ferlie, Montgomery, & Pedersen, 2016; Greenwood et al., 2002, p. 62; McPherson & Sauder, 2013, p. 186). In rare cases, however, research delving into professionals' logical orientations while under the concomitant influences of competing logics showed somewhat of a different pattern. Studies inquiring into how professionals are influenced by the multiplicity of logics in accomplishment of their work showed that professionals enjoy substantial levels of freedom in drawing from the available logics under the confines of the existing institutional orders pertaining to professional work (Goodrick & Reay, 2011; McPherson & Sauder, 2013). However, in this study, results of the analyses reflected that physicians effectively deviated from and rejected the prescriptions of their home logic as well as the prescriptions of other available logics which pertained to accomplishment of professional work, and drew from a logic that they themselves created as a resource to frame and serve their interest as well as to achieve their individual goals.

Fifth, although extant literature suggests that the nature of the logics available within the toolbox of actors are inherently competitive, and there exists a conflict at the intersection of these various frameworks (Dunn & Jones, 2010; Greenwood et al., 2011; Lounsbury, 2007;

Marquis & Lounsbury, 2007; Pache & Santos, 2010; Purdy & Gray, 2009), this study showed no signs of conflict experienced on the part of the actors of this study. Data showed that physicians were aware of all the logical tools available to them, but were not by any means affected by the possible inherent contradictions those logics posed, because of their preoccupations to pursue their own interests, which involved their constantly drawing from their homegrown rogue logic.

Sixth, there were no traces of the processes of logic blending (Glynn & Lounsbury, 2005; Pache & Santos, 2013; Thornton et al., 2005), replacement (Greenwood et al., 2002; Hoffman, 1999), segregation (Smets et al., 2014), segmenting (Goodrick & Reay, 2011; Smets et al., 2014), bridging (Smets et al., 2014), cooperation (McPherson & Sauder, 2013; Reay & Hinings, 2009), hijacking (McPherson & Sauder, 2013), or practice improvisation (Smets et al., 2012) observed in actors' daily work, geared toward getting the job done. Instead, this study showed that ground level actors "discovered new ways of organizing … which was driven by individual agency operating somewhat under the radar" (Reay & Hinings, 2009, p. 632). Physicians used their unbridled authority and autonomy to structure the content and organization of their work toward maximizing their private financial interests.

In sum, contrary to the assertions of previous studies of institutions, in which creating, maintaining and/or disrupting institutional arrangements are imbued with emotions, and thus enactment of institutions should not be "reducible to the pursuit of rational interests" (Gilmore & Sillince, 2014, p. 327; Voronov & Vince, 2012), this study showed that the tendency of physicians toward private interest maximization and the associated patterns of practices they form and routinely enact are in line with the notion that "new institutions arise when organized actors with sufficient resources see in them an opportunity to realize interests that they value highly" (DiMaggio, 1988, p. 14). These findings are unique in that they suggest that ground level actors can create their own way of organizing, "stable designs for chronically repeated activiti[es]" (Jepperson, 1991, p. 145), geared toward serving their own interests, regardless of the dictates or prescriptions of exogenous forces such as market, state and professions.

6.3. Implications for Policy Development

As the governments of some of the other countries (for a review, see Immergut, 1992), the Turkish government directly intervenes in public affairs and takes direct responsibility to guarantee both the well-being and health of its citizens. The government accomplishes this task via issuing law texts, decree law texts, regulations, directives, policies and memorandums, which regulate how the content and organization of healthcare need to be structured throughout the healthcare organizations. Government also "takes direct responsibility of professional work as opposed to ratifying professional desires … controls professional knowledge, the credentials for professional practice, and the organization of work" (Goodrick & Reay, 2011, p. 379). These 'formal messages' permeate the organizational boundaries in the form of organizing principles, which are certain belief systems and their associated practices (i.e., institutional logics) to be enacted by organizational actors.

The Turkish government initiated a health policy reform, by means of introducing HTP and subsequently PBSPS, which have been in place for nearly the past two decades. However, it is not known, from the institutional logics perspective, whether or how this government initiative has successfully transformed the Turkish healthcare, and thus achieved its projected objectives. In order to provide some insights from the perspectives of implementers of this policy change, the study undertaken here investigates the cognitive structures and associated practices characterizing physicians' daily routine work, and attempts to suggest some areas for policy consideration, based on the results achieved. Implications of this study at the level of government policies relate to the role of government in making and enacting policy frameworks that would affect the workings of the context of healthcare.

One of the objectives of this study was to understand, by means of interpreting the viewpoints of the participant physicians, the nature of belief systems and associated practices guiding physicians' workplace behaviors. It is widely accepted that "beliefs, ideas and intentions are important to action and practice" (Hodder, 1996; Reay & Hinings, 2005, pp. 362-363), and action within any institutional order is guided by institutional logics (Friedland & Alford, 1991). In terms of their activities and practices, individual actors are embedded within these institutional environments and are subject to both formal (i.e., state) and

informal (ceremonies, rituals, etc.) influences rooted in those institutional environments. (DiMaggio, 1983). Thus, in order to make informed inferences in terms of the array of behaviors actors portray in their daily work, it is of great significance to understand and interpret the institutional logics they routinely draw from while they are at work performing their daily duties and responsibilities. "Any attempt to understand or change a social world … must attend to the influence of institutional orders on the cognition and behavior of social actors within those orders, and it must also consider the institutional impact of those social actors" (Misangyi et al., 2008, p. 754). In this study, based on the qualitative data acquired reflecting the physicians' viewpoints, a framework encompassing four different logics and their associated belief systems and practices were created. The framework of logics generated herein is believed to be beneficial for policy makers to understand the underlying cognitive structures guiding physicians' behaviors and practices. Previous research showed that policy-making and/or development efforts are indeed influenced by institutional logics (Bastedo, 2009). Thus, the findings presented in this study are thought to be potentially instrumental in terms of understanding why physicians behave the way they do, which may carry a great deal of importance in shaping the processes of future health policy making.

Institutional logics studies conducted in fields with no exogenous interventions have shown that actors strive to juggle the logics of the existing institutional orders of their field, and manage to live with them through crafting various logics combinations or designs (Jay, 2013; Pache & Santos, 2013; Smets, Jarzabkowski, et al., 2014; Smets, Morris, et al., 2012). When strict government policies are infused to a field to change or modify the existing institutional orders, however, actors at times engage in efforts to protect their professional territory, which may at times result in tense relationships between the logics being injected and the actors who are supposed to enact them, ultimately resulting in an "uneasy truce" between the government and the ground level implementers (Reay & Hinings, 2005, p. 364). In other cases, however, field inhabitants may even engage in behaviors reflecting deviation from the established state policies and attempt to set out on their own account autonomously (Quirke, 2013). Similarly, but from a practice level point of view, the results of this study showed that physicians, utilizing their unconstrained professional authority and autonomy, found ways to dexterously avoid government healthcare transformation initiatives, regardless of the dictates of rules, regulations, directives and procedures of the government

enforcing their implementation. It is known that government programs aimed to change or modify healthcare systems "depend on the cooperation of doctors, for government health programs are meaningless unless doctors will agree to treat the patients covered by these programs" (Immergut, 1992, p. 59). The results of the analyses were compatible with this thought in that physicians did not by any means show any attachment or commitment toward government policy, devised to reconfigure healthcare. Accordingly, physicians' accounts reflected that they were more inclined toward satisfying their own financial interests, rather than being oriented toward government's health policy. Findings of this research showed that physicians were prioritizing their financial interests over the prescriptions of the government. This may hold potential to be a critical issue for government officials to consider in their future endeavors to design and implement healthcare policy changes.

It is recognized that governments, by means of their legislative power, "control the incomes and activities of doctors" (Immergut, 1992, p. 58). It should be noted that besides regulative forces, culture, institutions, and social relations also influence actors' cognition and actions in important and often unconscious ways (Battilana et al., 2009), and thus appreciation of successful adoption of government-led initiatives at the organizational level requires a broader view incorporating all institutional factors impacting the adoption. It has been shown that institutional logics theory will provide a better understanding in terms of not only *whether* organizational actors adopt, but also *how* they adopt (Westphal et al., 1997, emphasis added). This study showed that physicians, who actually put logics in practice, did not successfully internalize nor went through a cognitive reframing in line with the government policies introduced to the Turkish healthcare system. This may be problematic as internalization is an important precondition for the adoption and sustainment of the new programs (Kostova & Roth, 2002). Rather than embracing and implementing the new healthcare program at the ground level, physicians indeed viewed these government policies or "programs as a threat to their professional independence" (Immergut, 1992, p. 58), enactment of which, they believed, might engender counterproductive effects or consequences. The below participant physician interview excerpt discusses this point:

> "How much longer can we be treated like this? Do you think these people (physicians) are fools? That is correct that physicians are not getting paid much by the government, but the

> government is losing more money because of the xxx TL we are not getting paid, and this results in more government expenditures."

Overall, the results reflect that the healthcare policy initiatives put in place have not significantly affected the belief systems and associated practices guiding physicians' daily work performances. Based on the analyses, a conclusion can be made that the physicians are still practicing medicine the way they see fit. Indeed, this fact is compatible with the notion that "doctors are thought to be able to set the limits to health policy and to determine their conditions of practice under government health programs" (Immergut, 1992, p. 59). The below participant physician interview excerpts provide examples:

> "You attempt to initiate a healthcare policy, but regardless of however perfect it could be, if there is a human factor involved in it, and it is problematic, then you cannot effectively implement it."

> "… Physicians set the conditions and standards of healthcare, not those so-called healthcare policies. We determine the standards of quality of the care. Because the knowledge and experience physician holds is unique. Therefore, the physician guides the entire healthcare system."

Some of the participants voiced that a mutual consensus should be reached for a successful implementation of healthcare policies:

> "If you want to really cope with these people [physicians], you need to talk to them and convince them of what you are trying to accomplish. If you convince these people, they will do whatever is necessary even before you ask them to do it."

Other participant physicians' accounts reflect that in order for them to comply with professional norms, values and principles, they first need have no financial worries (i.e., they need to be financial satisfied first). The below participant physician statements discuss this point:

> "If you provide physicians the fringe benefits they deserve as well as compensate them for their work in terms of pay, and stand beside them, they will not order needless tests or perform

needless procedures. They will not increase the outlays of the facility. This way, this facility's and the Social Security Institution's expenditures won't go up."

"There are type A and B surgeries. Type A surgeries take up your entire day. If you perform one of those in a week, you will be exhausted both because of the surgery because it may take up your entire day and the post-op visits you must perform following the surgery. Because you cannot discharge the patient for 15-20 days … Management asks us to increase the number of type A surgeries we perform. Okay. I will. But, there is currently no financial return for my doing it. In fact, I should think with a professional mindset and perform those surgeries, but they need to appropriately compensate me for it."

"Because you [management] tell people, who all work at the same hospital, whoever produces more, you will pay them more. But, the work we [physicians] perform is related to illness and healthcare? What if we do not do it? They [management] say, if we pay you xxx, then you won't work. Isn't it your job to ensure I work? If we do not work properly, you can take the appropriate measures …. I accept the fact that the (unethical) things we are doing are wrong, but just as bad is we are being channeled to do them by the performance system … but, we have to think about our financial welfare as well."

"… I cannot project how much I will earn at the end of the month. Say, you [as a physician] need to withdraw a credit from the bank, you think twice about it. Because there is no guarantee on how much you will receive in payment at the end of the month … If management is replaced, your monthly revenue changes. You cannot be sure to receive a standard salary. I believe everybody should know how much they will be making at the end of the month. Upper level government employees, like physicians, should have a set salary, which should be linked to their pension. But, it is nonexistent … Nobody believes me when I tell them my salary. To me, if the rules are reversed and physicians receive 70% [of their current cumulative monthly income] as their basic salary and 30% from the revolving funds, then the performance system would really become a reward for physicians, and physicians will work in a peaceful environment and will be more focused on their jobs."

Taken together, the results of the analyses reflect that physicians feel that the healthcare policy interventions are indeed a threat to their precious domain, a prerogative of physicians, and they do not feel that the intervention into this domain is warranted without a preceding mutual consensus on the objectives sought and the methods or processes to be adopted. This

is in line with the thought that "doctor's specialist knowledge remains irreplaceable, which itself places limits on managers' incursions into medical territory" (Hunter, 1997, p. 56). Physicians also view their "economic freedom as the precondition for professional freedom." (Immergut, 1992, p. 59; Kingma, 1999). It is difficult to determine, though, how much of the rogue practices are fueled by or resultant of these issues, the investigation of which is beyond the scope of this study. These, however, can be identified as issues for further consideration by the government health policy makers. The below text segments extracted from participant physician interviews may provide additional insights on this issue:

> "When does Hippocratic Oath come to the minds of physicians? When the practices enacted are beyond the boundaries of laws, and start pricking physicians' conscience. It is then saying, 'I have taken an oath, I should act accordingly and do it without receiving additional money for it.' Unethical behavior is to say, 'Yes, I have received the money [unwarranted payments] from the patient, but at the same time, I have saved the patient's life.' You could have done it without having received additional money [unwarranted payments] for it."

> "In the past, physicians would have private practice offices while working at the government hospitals at the same time. Physicians would make a lot of money back then this way, and really exploited the healthcare system very badly. But, now physicians are exploiting the system even more terribly. Maybe not through the private practice offices they used to own, but now under the roof of this hospital. I believe it is an aspect of the individual's characteristics. I guess it is more about the physician's general attitude and fondness for money."

> "Some physicians are abiding by the principles of Hippocratic Oath and medical necessity and some aren't. I believe this more about the character traits, moral qualities and level of conscience distinctive to the physician."

To date, "little, if anything, has yet been written on … understanding the *value systems* of medical personnel and how they respond to economic incentives … and huge knowledge gaps remain and research will need to be undertaken to a establish a reliable database for informed decision-making and policy formulation (Kingma, 1999, p. 130, emphasis added). "A more informed understanding could help policy makers interpret the forces shaping behaviors in … hospitals … and thus help them to devise and implement more appropriate

regulations" (Greenwood et al., 2011, p. 319). By means of delving into the value systems espoused and the associated practices enacted by physicians in their daily practices pertaining to the government healthcare initiatives, this study provides critical insights in terms of the ground level 'institutional' dynamics of policy implementation for government policy makers. Consequently, it is posited in this study that in order to fully appreciate and have an all-encompassing view of the workings of the healthcare system and the forces shaping or guiding the behaviors of the healthcare professionals, and thus to assist policy-makers' in developing and implementing well-informed policies, an institutional approach, as in the one conducted here, will prove significantly beneficial.

6.4. Conclusion

This study set out to examine the influence of logics on physicians' daily practices and the variations in physicians' logical inclinations as they perform their daily duties over a period of time, in which a revolutionary policy-driven initiative was implemented by the government. It sought to explore: (1) the nature and characteristics of "socially-constructed sets of material practices, assumptions, values and beliefs" (Thornton et al., 2012) (i.e., logics) in physicians' daily performance of work, (2) whether "new sets of material activities across actors" have emerged leading to "establishment of a new practice via institutionalization" (Lounsbury & Crumley, 2007, pp. 995-996), and (3) whether enactments of practice patterns or logics have witnessed any change over a period of institutional change processes (Thornton et al., 2005; Thornton et al., 2012).

The researcher was drawn to this study because extant research stops short in providing explanations for how logics become tangible in everyday practices of professionals, as they perform their daily routine, from the real-time perspectives of the actors doing the actual work. In this regard, "most studies focus[ed] only on field level actors … but they gave little attention to actors inside organizations" (Reay & Hinings, 2009, p. 632). Some of the studies attempted to devise universal institutional logics frameworks for later use by other researchers (Besharov & Smith, 2014; Pache & Santos, 2010). Other research adopted established logical frameworks or taxonomies as 'taken-for-granted' and sought to reveal the degree of consistency of these 'ideal logics' with what is happening on the ground (Goodrick & Reay, 2011; Reay et al., 2016). Although some researchers may strive to generate time-

and space-invariant general frameworks and laws of social behavior from a macro perspective or seek mechanic compatibility between universal frameworks or taxonomies and the real life experiences of persons who translate them into action, others, like the author of this dissertation, may attempt to uncover and understand the real and "deep structure" of everyday life (Hanneman, 1988, p. 16). Performing a research of this sort may reveal surprising results in terms of the diversity of the kinds of models through which ground level practices are employed in everyday life (Shoemaker, Tankard, & Lasorsa, 2004) and on the potential differences between the 'logics on the books' and 'logics in action.'

Another reason the researcher was interested in this research endeavor was to address a gap as well as possibly contribute to the institutional logics theory by means of providing insights from a practice level lens. Though institutional logics literature is replete with studies investigating how institutions and organizations mutually influence one another (Haveman & Rao, 1997; Lounsbury, 2002; Murray, 2010; Pache & Santos, 2013; Scott et al., 2000; Smets et al., 2012), research on institutional logics with a practice level focus in terms of how "social actors translate logics into action as they engage in everyday organizational work" (McPherson & Sauder, 2013, p. 166) is very rare, and thus further research in this area is certainly warranted (Barley, 2008; Hallett, 2010; Powell & Colyvas, 2008; Smets et al., 2012; Thornton et al., 2012). Specifically, from the perspective of professionals, more research is required to understand how logics are reflected in and affect professional work in various professional domains (Goodrick & Reay, 2011).

Professional groups possess unique knowledge, skill set and expertise, and the society grants them increased levels of authority and autonomy than it grants non-professionals (Larson, 1977) and their importance has increasingly been recognized across organizational sciences (Wallace, 1995). Specifically, medicine is regarded to be a prototypical profession (Hughes, 1956) with esoteric knowledge, which has economic value when applied to issues (health-related) or problems (i.e., illness) faced by individuals in a society (Carr-Saunders & Wilson, 1936; MacDonald, 1995). In the field of medicine, especially physicians receive intense socialization, orientation and education and are known to hold complete autonomy and control over the content and organization of their work (Friedson, 2001; Thornton et al., 2012). From an institutional logics perspective, individuals with strong authority, autonomy and control over a specific domain have the ability to define, defend or otherwise influence

specific institutional values and norms (Selznick, 1949; 1957), and institutions are known to "operate through the influence and agency of individuals" (Suddaby, 2010, s. 17). Physicians are thus well situated to exercise various levels of agency to interpret, negotiate and blend logics, or create logics while they perform their practical work (Currie & Spyridonitis, 2015). Though "the agency used by organizational and individual actors contributes to variation in how multiple logics become instantiated within organizations" (Besharov & Smith, 2014, p. 366), the concept of "individual level agency" has largely been given short shrift in previous institutional logics research (Smets & Jarzabkowski, 2013, p. 1283). Institutional logics literature will greatly benefit from more research exploring this phenomenon (Battilana et al., 2009; Smets & Jarzabkowski, 2013). This was one of the other reasons this study concentrated on how physicians, who belong to a highly-professionalized group, use their unconstrained authority, autonomy and control to legitimize organization and enactment of their daily practices at the cognitive level through processes of change from the lens of the institutional logics perspective with a practice level approach. Hence, this study also strove to provide accounts in "illuminating the relationship between agency and logics when multiple logics exist and hold potential to influence professional work" (Goodrick & Reay, 2011, p. 405). Consequently, the main aim of this study is to contribute to and possibly extend existing theory in the area of institutional logics, with a practice lens, by making it "more dense by filling in what has been left out – that is by extending and refining its existing categories and relationships" (Locke, 2001, p. 103) by means of conceptually comparing and integrating substantive concepts emerging from the fieldwork accomplished herein with their counterparts in the literature. This gap was due, in part, to the fact that the significance of practice level approach is often emphasized, and the lack of it is frequently lamented on, by researchers, rather than being their main focus.

This study adopts grounded theory methodology in order to explain and describe (Strauss & Corbin, 1998) patterns of physicians' behavior they enact at practice level and their cognitive roots in a generalizable manner with a primary goal to "*write about concepts, not people*" (Glaser, 1978, p. 134, emphasis in original). Drawing on physicians' own perspectives as basis for understanding their experience addresses another substantive gap in literature. As such, this reseach offers a more nuanced understanding of ground level actors' experiences than has previously been available. Qualitative methods in this respect are the

microscope through which researchers explore the details of lived experience. Throughout the study, every effort was made to ensure that an opportunity was provided to various multiple voices and perspectives to be shared. Toward reaching the broadest diversity of views, physicians from twenty-three different specialties were recruited into the study to get various standpoints related to the topic under investigation (Charmaz, 2000). Involvement of as many voices and experiments as possible in the study showed that physicians might have different views and experiences in terms of what constituted as basis for their practice enactments. By means of adopting this method, the researcher was able to have a fine-grained look at the way physicians made sense of their world, carried out their practices, and interpreted their role as a physician. The data, grounded in the accounts of physicians, arising from this research provided a rich foundation on which the substantive theory established is based.

In conclusion, this study provides a novel empirical evidence of not just how actors under the influence of multiple logics appeal to their available logic toolbox and actively and flexibly "take them up and apply them … in ways that suit the purpose at hand" (McPherson & Sauder, 2013, p. 178), but also of how they dexterously and purposely set out on their own account and move beyond the confines of the available institutional orders and successfully create and maintain a logic of their own via heavily benefiting from the autonomy, authority and control their professional domain grants them. Finally, with its unique findings reached through adoption of a sound qualitative methodology with a grounded theory design, the author of this dissertation hopes to have contributed to the institutionalization and institutional logics theory by introducing a micro-level account of an unstudied dark side of coalface practices perpetuating in the real institutional life.

REFERENCES

Ağartan, T. (2007). Contagion of reform in healthcare. In Ç. Keyder, N. Üstündağ, T. Ağartan, & Ç. Yoltar (Eds.), *Healthcare policies in Europe and Turkey* (pp. 37-54). İstanbul: İletişim Publishing.

Aggarwal, R., & Bohinc, J. (2014). Improving the American health system: moving from inglorious socialism to the free market. *Competitiveness Review, 24*(5), 482-494.

Akdağ, R. (Ed.). (2010). *Health transformation program in Turkey: Progress report.* Ankara: Republic of Turkey, Ministry of Health Publication.

Akdur, R. (1998). Healthcare Policy and Services in Turkey. *The New Turkey, 4*(23-24), 1984-1995.

Akdur, R. (2008). *Turkish healthcare from the proclamation of Turkish Republic to present.* Ankara: 12th National Public Health Assembly.

Akın, F. (2006). A meaning of 1924 Constitution in terms of modernity. *Afyon Kocatepe University Journal of Social Sciences, 8*(3).

Aksoy, B. (2007). *A professional organization's role in institutional change: The example of Turkish healthcare field.* T.R. Başkent University Social Sciences Institute, Ankara: Unpublished Doctoral Dissertation.

Aldiabat, K. M., & Navanec, C.-L. (2011). Philosophical roots of classical grounded theory: Its foundations in symbolic interactionism. *The Qualitative Report, 16*(4), 1063-1080.

Allen, M. (2011). Violence and voice: Using a feminist constructivist grounded theory to explore women's resistance to abuse. *Qualitative Research, 11*(1), 23-45.

Anayurt, O. (2003). The basic rights and freedoms in 1924 Constitution. *Journal of the Faculty of Law of Gazi University, 7*(1-2).

Ansari, S. M., & Phillips, N. (2011). Text me! New consumer practices as a catalyst for institutional change. *Organization Science, 22*, 1579-1599.

Archer, M. S. (1995). *Realist social theory: The morphogenetic approach.* Cambridge: Cambridge University Press.

Archer, M. S. (2003). *Structure, agency and the internal conversation.* Cambridge: Cambridge University Press.

Arrow, K. J. (1963). Uncertainty and the welfare economics of medical care. *The American Economic Review, 53*(5), 941-973.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405.

Auld, D. A., Bannock, G., Baxter, R. E., & Rees, R. (1983). *The American dictionary of economics.* New York: Facts on File.

Aydın, E. (2002). Health services in the foundation period of Turkish Republic. *Journal of Faculty of Pharmacy of Ankara, 31*(3), 183-192.

Bacharach, S. M., Bamberger, P., & Sonnenstuhl, W. J. (1996). The organizational transformation process: The micropolitics of dissonance reduction and the alignment of logics of action. *Administrative Science Quarterly, 41,* 477-506.

Backman, K., & Kyngas, H. (1999). Challenges of the grounded theory approach to a novice researcher. *Nursing and Health Sciences, 1,* 147-153.

Barbour, R. (2008). *Introducing qualitative research: A student guide to the craft of doing qualitative research.* Thousand Oaks, CA: SAGE Publications.

Barley, S. R. (2008). Coalface institutionalism. In R. Greenwood, C. Oliver, K. Sahlin, & R. Suddaby (Eds.), *The Sage handbook of organizational institutionalism* (pp. 490-515). London: Sage.

Barley, S. R., & Tolbert, P. (1997). Institutionalization and structuration: Studying the links between action and institution. *Organization Studies, 18,* 93-117.

Basit, T. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research, 45*(2), 143-154.

Bastedo, M. N. (2009). Convergent institutional logics in public higher education: State policy-making and governing board activism. *The Review of Higher Education, 32*(2), 209-234.

Battilana, J. (2006). Agency and institutions: The enabling role of individual's social position. *Organization, 13*(5), 653-676.

Battilana, J., & D'Aunno, T. (2009). Institutional work and the paradox of embedded agency. In R. Lawrence, R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organization* (pp. 31-58). Cambridge, UK: Cambridge University Press.

Battilana, J., & Dorado, S. (2010). Building sustainable hybrid organizations: The case of commercial microfinance organizations. *Academy of Management Journal, 53*, 1419-1440.

Battilana, J., Leca, B., & Boxenbaum, E. (2009). How actors change institutions: Towards a theory of institutional entrepreneurship. *Academy of Management Annals, 3*(1), 65-107.

Bechky, B. (2011). Making organizational theory work: Institutions, occupations, and negotiated orders. *Organization Science, 22*, 1157-1167.

Becker, H. S. (1970). Field work evidence. In *Sogiological work: Method and substance* (pp. 39-62). New Brunswick, NJ: Transaction Books.

Beech, N., & Huxham, C. (2003). Cycles of identity formation in interorganizational collaborations. *International Studies of Management, 33*(3), 28-52.

Benoliel, S. (1996). Grounded Theory and nursing knowledge. *Qualitative Health Research, 6*(3), 406-428.

Bentz, V. M., & Shapiro, J. J. (1998). *Mindful enquiry in social research.* Thousand Oaks, CA: Sage.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality.* New York: Double Day.

Bernard, H. R. (2002). *Research methods in anthropology: Qualitative and quantitative approaches* (3 ed.). Walnut Creek, CA: Alta Mira Press.

Besharov, M. L., & Smith, W. K. (2014). Multiple institutional logics in organizations: Explaining their varied nature and implications. *Academy of Management Review, 39*(3), 364-381.

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods and Research, 10*(2), 141-163.

Binder, A. (2007). For love and money: Organizations' creative responses to multiple environmental logics. *Theory and Society, 36*, 547-571.

Birks, M., & Mills, J. (2011). *Grounded theory. A practical guide.* London: Sage.

Bowen, G. A. (2005). Preparing a qualitative research-based dissertation: Lessons learned. *The Qualitative Report, 10*(2), 208-222.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research, 8*(1), 137-152.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA: Sage.

Brief, A. P., Buttram, R. T., & Dukerich, J. M. (2001). Collective corruption in the corporate world: Toward a process model. In M. E. Turner (Ed.), *Groups at work: Theory and research* (pp. 471-499). Mahwah, NJ: Lawrence Erlbaum Associates.

Brinkman, S., & Kvale, S. (2015). *Interviews: Learning the craft of qualitative research interviewing.* Los Angeles: Sage.

Broek, J. V., Boselie, P., & Paauwe, J. (2014). Multiple institutional logics in health care: 'Productive ward: Releasing time to care'. *Public Management Review, 16*(1), 1-20.

Bromley, P., & Powell, W. W. (2012). From smoke and mirrors to walking the talk: Decoupling in the contemporary world. *The Academy of Management Annals,* 1-48.

Brown, A. D., Ainsworth, S., & Grant, D. (2012). The Rhetoric of Institutional Change. *Organization Studies, 33*(3), 297-321.

Bryant, A., & Charmaz, K. (2007). Introduction. Grounded theory research: Methods and practices. In A. Bryant, & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 1-28). London: Sage.

Bryman, A. (2008). *Social research methods* (2 ed.). Oxford: Oxford University Press.

Bryman, A., & Burgess, R. (1994). *Analyzing qualitative data.* London: Routledge.

Bulmer, M. (1979). Concepts in the analysis of qualitative data. *Sociological Review, 27*(4), 651-677.

Bulut, A. (2007). The history of healthcare reform in Turkey. In Ç. Keyder, N. Üstündağ, T. Ağartan, & Ç. Yoltar (Eds.), *Healthcare policies in Europe and Turkey: Reforms, problems, discussions* (pp. 111-124). İstanbul: İletişim Publishing.

Burke, W. W. (2002). *Organization change: Theory and practice.* London: Sage.

Calarco, J. M. (2011). 'I need help!' Social class and children's help-seeking in elementary school. *American Sociological Review, 76,* 862-882.

Carr-Saunders, A. M., & Wilson, P. A. (1936). *The professions.* Oxford, UK: Clarendon Press.

Charmaz, K. (1995). Grounded theory. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49). London: Sage.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin, & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (2 ed., pp. 509-535). Thousand Oaks: Sage Publications.

Charmaz, K. (2003). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 81-110). London: Sage.

Charmaz, K. (2006). *Constructing grounded theory.* London: Sage.

Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber, & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 155-172). New York: The Guilford Press.

Charon, J. M. (2010). *Symbolic interactionism. An introduction, an interpretation, an integration* (10th ed.). Boston: Prentice Hall.

Child, J., Lua, Y., & Tsai, T. (2007). Institutional entrepreneurship in building an environmental protection system for the People's Republic of China. *Organization Studies, 28*(7), 1013-1034.

Chism, N. V., & Banta, T. W. (2007). Enhancing institutional assessment efforts through qualitative methods. *New Directions for Institutional Research, 2007*(136), 15-28.

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn.* Thousand Oaks: Sage.

Clemens, E. S., & Cook, J. M. (1999). Politics and institutionalism: Explaining durability and change. *Annual Review and Sociology, 25*(1), 441-466.

Cohen, M. Z., Tripp-Reimer, T., Smith, C., Sorofman, B., & Lively, S. (1994). Explanatory models of diabetes: Patient practitioner variation. *Social Science & Medicine, 38*, 59-66.

Colignon, R. A. (1999). *Power plays: Critical events in the institutionalization of the Tennessee Valley Authority.* Albany, New York: State University of New York Press.

Connor, P. E., & Lake, L. K. (1994). *Managing organizational change.* Westport: Praeger Publishers.

Cooper, D. R., & Schindler, P. S. (2003). *Business research methods* (8th ed.). New York: McGraw-Hill Irvin.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*(1), 3-21.

Cormac, D. F. (1996). *The research process in nursing* (3rd ed.). Oxford: Blackwell Science.

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; Merging or clear boundaries? *Journal of Advanced Nursing, 26*, 623-630.

Creed, W. E., Scully, M., & Austin, J. R. (2002). Clothes make the person? The tailoring of legitimating accounts and the social construction of identity. *Organization Science, 13*(5), 475-496.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Clark, P. (2011). *Designing and conducting mixed method research.* Thousand Oaks, CA: Sage.

Crompton, R., & Jones, G. (1988). Researching white collar organizations: Why sociologists should not stop doing case studies. In A. Bryman (Ed.), *Doing research in organizations* (pp. 68-81). London: Routledge.

Currie, G., & Spyridonitis, D. (2015). Interpretation of multiple institutional logics on the ground: Actors' position, their agency and situtional constraints in professionalized contexts. *Organization Studies, 37*(1), 77-97.

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. (2012). Institutional work to maintain professional power: Recreating the model of medical professionalism. *Organization Studies, 33*(7), 937-962.

Cyert, R. M., & March, J. G. (1963). *A behavioral theory of the firm.* Englewood Cliffs, NJ: Prentice Hall.

Dacin, M. T., Dacin, P. A., & Tracey, P. (2011). Social entrepreneurship: A critique and future directions. *Organization Science, 22*, 1203-1213.

Dacin, M., Munir, K., & Tracey, P. (2010). Formal dining at Cambridge colleges: Linking ritual performance and institutional maintenance. *Academy of Management Journal, 53*(6), 1393-1418.

D'Aunno, T., Sutton, R. I., & Price, R. H. (1991). Isomorphism and external support in conflicting institutional environments: A study of drug abuse treatment units. *Academy of Management Journal, 34*, 636-661.

Delbridge, R., & Edwards, T. (2013). Inhabiting institutions: Critical realist refinements to understanding institutional complexity and change. *Organizations Studies, 34*(7), 927-947.

Demirbilek, S. (1999). *Healthcare services in Turkey.* İzmir: İlkem Publishing.

Denscombe, M. (2003). *The good research guide: For small-scale social research projects* (2nd ed.). Maidenhead, Berkshire: Open University Press.

Denzin, N. K. (1994). The art and politics of interpretation. In L. Denzin, & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 500-515). London: Sage.

Denzin, N. K. (1997). *Interpretive ethnography.* Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. (Eds.). (1994). *Handbook of qualitative research.* Thousand Oaks, CA: Sage.

Dey, I. (1993). *Qualitative data analysis.* London: Routledge.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry.* London: Academic Press.

Dey, I. (2007). Grounding Categories. In A. Bryant, & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 167-190). London: Sage.

DiMaggio, P. J. (1983). State expansion and organizational fields. In *Organizational theory and public theory* (pp. 147-161). Thousand Oaks, CA: Sage.

DiMaggio, P. J. (1988). Interest and agency in institutional theory. In L. Zucker (Ed.), *Institutional patterns and organizations* (pp. 3-22). Cambridge, MA: Ballinger.

DiMaggio, P. J. (1997). Culture and cognition. *Annual Review of Sociology, 23,* 263-287.

DiMaggio, P. J., & Powell, W. W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review, 48,* 147-160.

DiMaggio, P. J., & Powell, W. W. (1991). Introduction. In P. J. DiMaggio, & W. W. Powell (Eds.), *The new institutionalism in organizational analysis* (pp. 1-38). Chicago: University of Chicago Press.

Dirican, M. R. (1970). A brief history of organization of healthcare services in Turkey. *Atatürk University Faculty of Medicine Bulletin, 2*(7).

Douglas, J. D. (1976). *Investigative social research: Individual and team field research.* Beverly Hills, CA: Sage.

Drisco, J. (1997). Strengthening qualitative studies and reports: Standards to promote academic integrity. *Journal of Social Work Education, 33*(1), 185-197.

Duck, J. D. (2001). *The change monster: The human forces that fuel or foil corporate transformation and change.* New York: Crown Business.

Dunn, M. B., & Jones, C. (2010). Institutional logics and institutional pluralism: The contestation of care and science logics in medical education, 1967–2005. *Administrative Science Quarterly, 55*, 114-149.

Dunne, C. (2011). The place of literature review in grounded theory research. *International Journal of Social Research Methodology, 14*, 111-124.

Easton, K. L., McComish, J. F., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research, 10*(5), 703-707.

Eisenhardt, K. M., & Graebner, M. E. (2007). Theory building from cases: Opportunities and challenges. *Academy of Management Journal, 50*(1), 25-32.

Elbek, O., & Adaş, E. B. (2009). Transformation in healthcare: A critical evaluation. *Turkish Psychiatry Association Bulletin*, 33-44.

Elsbach, K., & Sutton, R. (1992). Acquiring organizational legitimacy through illegitimate actions: A marriage of institutional and impression management theories. *Academy of Management Journal, 35*(4), 699-738.

Emirbayer, M. (1996). Useful Durkheim. *Sociological Theory, 7*(1), 109-130.

Emirbayer, M., & Mische, A. (1998). What is agency? *American Journal of Sociology, 103*, 962-1023.

Eren, N., & Tanrıtanır, N. (1998). *Republic and Health.* Ankara: Turkish Medical Association Publications.

Evetts, J. (2012). Professionalism: Value and ideology. *Sociopedia.isa*. doi:10.1177/205684601231

Fasick, F. A. (2001). Some uses of untranscribed tape recordings in survey research. *Public Opinion Quarterly, 41,* 549–552.

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156-166.

Ferlie, E., Montgomery, K., & Pedersen, A. R. (Eds.). (2016). *The Oxford handbook of healthcare management.* Oxford, UK: Oxford University Press.

Fişek, N. (1963). The unpublished scripts of Prof. Dr. Nusret Fişek - I: Healthcare management. *Health Journal, 37*(3).

Fişek, N. (1983). *Introduction to Public Health.* Ankara: Çağ Publishing.

Flick, U. (2006). *An introduction to qualitative research* (3rd ed.). London: Sage.

Fligstein, N. (1985). The spread of the multidivisional form among large firms, 1919–1979. *American Sociological Review, 50,* 377-391.

Fligstein, N. (1997). Social skill and institutional theory. *American Behavioral Scientist, 40*(4), 397-405.

Fligstein, N. (2001). Social skill and the theory of fields. *Sociological Theory, 19*(2), 105-125.

Fligstein, N. (2008). Fields, power and social skill: A critical analysis of the new institutionalism. *International Public Management Review, 9*(1), 227-253.

Fligstein, N., & Mara-Drita, I. (1996). How to make a market: Reflections on the attempt to create a single market in the European Union. *American Journal of Sociology, 102*, 1-33.

Fox-Wolfgrannm, S. J., Boal, K. B., & Hunt, J. G. (1998). Organizational adaptation to institutional change: A comparative study of first-order change in prospector and defender banks. *Administrative Science Quarterly, 43*, 87-126.

Friedland, R., & Alford, R. R. (1991). Bringing society back in: Symbols, practices, and institutional contradictions. In W. W. Powell, & P. J. DiMaggio (Eds.), *The new institutionalism in organizational analysis* (pp. 232-263). Chicago: University of Chicago Press.

Friedson, E. (2001). *Professionalism: The third logic.* London: Polity Press.

Garud, R., & Karnoe, P. (2003). Bricolage vs. breakthrough: Distributed and embedded agency in technology entrepreneurship. *Research Policy, 32*, 277-300.

Garud, R., Hardy, C., & Maguire, S. (2007). Institutional entrepreneurship as embedded agency: An introduction to the special issue. *Organization Studies, 28*(7), 957-969.

Garud, R., Jain, S., & Kumaraswamy, A. (2002). Institutional entrepreneurship in the sponsorship of common technological standards: The case of Sun Microsystems and Java. *Academy of Management Journal, 45*, 196-214.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266-275.

Giddens, A. (1984). *The constitution of society.* Berkeley and Los Angeles: California University Press.

Giddens, A. (1993). *New rules of sociological method: A positive critique of interpretive sociologies* (2nd ed.). Stanford, CA: Stanford University Press.

Gilmore, S., & Sillince, J. (2014). Institutional theory and change: The deinstitutionalization of sports science at Club X. *Journal of Organizational Change Management, 27*(2), 314-330.

Glaser, B. G. (1965). The constant comparison method of qualitative analysis. *Social Problems, 12*(4), 436-445.

Glaser, B. G. (1978). *Advances in the methodology of grounded theory.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs forcing.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (2001). *The grounded theory perspective: Conceptualisation contrasted with description.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (2003). *The grounded theory perspective II: Description's remodeling of grounded theory methodology.* Mill Valley, CA: Sociology Press.

Glaser, B. G. (2005). *The grounded theory perspective III: Theoretical coding.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Holton, J. (2004). Remodeling grounded theory: Article 4. *Forum: Qualitative Social Research, 5*(2), 1-17.

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory: Strategies of qualitative research.* London: Wledenfeld and Nicholson.

Glynn, M. A., & Lounsbury, M. (2005). From the critics' corner: Logic blending, discursive change and authenticity in a cultural production system. *Journal of Management Studies, 42*, 1031-1055.

Goldkuhl, G., & Cronholm, S. (2010). Adding theoretical grounding to grounded theory: Toward multi-grounded theory. *International Journal of Qualitative Methods, 9*, 187-205.

Goodrick, E., & Reay, T. (2011). Constellations of institutional logics: Changes in the professional work of pharmacists. *Work and Occupations, 38*(3), 372-416.

Goulding, C. (1998). Grounded theory: the missing methodology on the interpretivist agenda. *Qualitative Market Research: An International Journal, 1*(1), 50-57.

Goulding, C. (2001). Grounded theory: a magical formula or a potential nightmare. *The Marketing Review, 2*, 21-34.

Gözübüyük, A. Ş. (2013). *Constitutional law* (17 ed.). Ankara: Turhan Publishing.

Granovetter, M. (1985). Economic action and social structure: The problem of embeddedness. *American Journal of Sociology, 91*(3), 481-510.

Grbich, C. (2013). *Qualitative data analysis: An introduction* (2nd ed.). London, UK: Sage.

Greenwood, R., & Hinings, C. R. (1993). Understanding strategic organizational change: The contribution of archetypes. *Academy of Management Journal, 36*, 1052-1081.

Greenwood, R., & Hinings, C. R. (1996). Understanding radical organizational change: Bringing together the old and new institutionalism. *Academy of Management Review*, 1022-1054.

Greenwood, R., & Suddaby, R. (2006). Institutional entrepreneurship in mature fields: The Big Five accounting firms. *Academy of Management Journal, 49*, 27-48.

Greenwood, R., Diaz, A. M., Li, S. X., & Lorente, J. C. (2010). The multiplicity of institutional logics and the heterogeneity of organizational responses. *Organization Science, 21*, 521-539.

Greenwood, R., Oliver, C., Sahlin, K., & Suddaby, R. (2008). Introduction. In R. Greenwood, S. Oliver, K. Sahlin, & R. Suddaby (Eds.), *Handbook of organizational institutionalism* (pp. 1-46). London: Sage.

Greenwood, R., Raynard, M., Kodeih, F., & Micelotta, E. R. (2011). Institutional complexity and organizational responses. *The Academy of Management Annals, 5*(1), 317-371.

Greenwood, R., Suddaby, R., & Hinings, C. R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal, 45*(1), 58-80.

Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research, 19*, 38-42.

Hall, A. L., & Rist, R. (1999). Integrating multiple qualitative research methods (or avoiding the precariousness of a one-legged stool). *Psychology & Marketing, 16*(4), 291-304.

Hallett, T. (2010). The myth incarnate: Recoupling processes, turmoil, and inhabited institutions in an urban elementary school. *American Sociological Review, 75*(1), 52-74.

Hallett, T., & Ventresca, M. J. (2006). Inhabited institutions: Social interactions and organizational forms in Gouldner's patterns of industrial bureaucracy. *Theory and Society, 35*(2), 213-236.

Hammersley, M. (1992). Reconstructing the qualitative-quantitative divide. In M. Hammersley (Ed.), *What's wrong with ethnography? Methodological explorations* (pp. 159-173). London: Routledge.

Hannan, M. T., & Freeman, J. (1977). The population ecology of organizations. *American Journal of Sociology, 82*(5), 929-964.

Hannan, M. T., & Freeman, J. (1984). Structural inertia and organizational change. *American Sociological Review, 49*(2), 149-164.

Hanneman, R. (1988). *Computer-assisted theory building: Modeling dynamic social systems.* Newbury Park, CA: Sage.

Haveman, H. A., & Rao, H. (1997). Structuring a theory of moral sentiments: Institutional and organizational coevolution in the early thrift industry. *American Journal of Sociology, 102*, 1606-1651.

Heaphy, E. D. (2013). Repairing breaches with rules: Maintaining institutions in the face of everyday disruptions. *Organization Science, 24*(5), 1291-1315.

Heath, S. B., & Street, B. V. (2008). *Ethnography: Approaches to language and literacy research.* New York: Teachers College Press.

Heimer, C. A. (1999). Competing institutions: Law, medicine, and family in neonatal intensive care. *Law & Society Review, 33*(1), 17-66.

Hensmans, M. (2003). Social movement organizations: A metaphor for strategic actors in institutional fields. *Organization Studies, 24*(3), 355-381.

Herzlinger, R. E. (1999). Finding "truth" about medical care. *Journal of Health Politics, Policy and Law, 24*(5), 1077-1093.

Heugens, P. P., & Lander, M. W. (2009). Structure! agency! (and other quarrels): A meta-analysis of institutional theories of organization. *Academy of Management Journal, 52*(1), 61-85.

Hickey, G. (1997). The use of literature in grounded theory. *Nursing Times Research, 2*(5), 371-378.

Hinings, C. R., & Greenwood, R. (1988). *The dynamics of strategic change.* Oxford: Basil Blackwell.

Hirsch, P. M., & Lounsbury, M. (1997a). Ending the family quarrel: Toward a reconciliation of "old" and "new" institutionalisms. *American Behavioral Scientist, 40*, 406-418.

Hirsch, P. M., & Lounsbury, M. (1997b). Putting the organization back into organization theory: Action, change and the "new" institutionalism. *Journal of Management Inquiry, 6*(1), 79-88.

Hodder, I. (1996). The interpretation of documents and material culture. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 393-402). Thousand Oaks, CA: Sage.

Hodgson, G. M. (2006). What are institutions. *Journal of Economic Issues, 40*(1), 1-25.

Hoffman, A. J. (1997). *From heresy to dogma: An institutional history of corporate environmentalism.* San Fransisco: New Lexington Press.

Hoffman, A. J. (1999). Institutional evolution and change: Environmentalism and the U.S. chemical industry. *Academy of Management Journal, 42*, 351-371.

Hoffman, A. J., & Ventresca, M. (2002). *Organizations, policy, and the natural environment: Institutional and strategic perspectives.* Stanford, CA: Stanford University Press.

Holm, P. (1995). The dynamics of institutionalization: Transformation processes in Norwegian fisheries. *Administrative Science Quarterly, 40*(3), 398-422.

Holton, J. A. (2007). The coding process and its challenges. In A. Bryant, & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 265-289). London: Sage.

Hughes, E. C. (1936). The ecological aspect of institutions. *American Sociological Review, 1*, 180-189.

Hughes, E. C. (1956). The making of a physician - General statement of ideas and problems. *Human Organization, 14*(4), 21-25.

Hunter, D. J. (1997). *Desperately seeking solutions: Rationing health care.* New York: Longman.

Hurley, R. (1999). Qualitative methods: What are they and why use them? *Health Services Research, 34*(5), 1119-1136.

Immergut, E. (1992). The rules of the game: The logic of health policy-making in France, Switzerland and Sweden. In S. Steinmo, K. Thelen, & F. Longstreth (Eds.), *Structuring politics: Institutionalism in comparative perspective* (pp. 57-81). New York: Cambridge University Press.

Jarzabkowski, P., Le, J. K., & Van de Ven, A. H. (2013). Responding to competing strategic demands: How organizing, belonging, and performing paradoxes coevolve. *Strategic Organization, 11*, 245-280.

Jarzabkowski, P., Matthiesen, J. K., & Van de Ven, A. (2009). Doing which work? A practice approach to institutional pluralism. In L. T., R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organizations* (pp. 284-316). Cambridge: Cambridge University Press.

Jay, J. (2013). Navigating paradox as a mechanism of change and innovation in hybrid organizations. *Academy of Management Journal, 56*(1), 137-159.

Jepperson, R. L. (1991). Institutions, institutional effects and institutionalism. In W. W. Powell, & P. J. DiMaggio (Eds.), *The new institutionalism in organizational analysis* (pp. 143-163). Chicago: University of Chicago Press.

John, I. D. (1992). Statistics as rhetoric in psychology. *Australian Psychologist, 27*, 144-149.

Jones, C., & Livne-Tarandach, R. (2008). Designing a frame: Rhetorical strategies of architects. *Journal of Organizational Behavior, 23*, 1075-1099.

Kaghan, W., & Lounsbury, M. (2011). Institutions and work. *Journal of Management Inquiry, 20*(1), 73-81.

Karasu, K. (2011). Public-private partnership in organization of healthcare services. *Ankara University Faculty of Political Sciences Journal*, 217-262.

Kartal, F. (2009). Privatized citizenship: Transformation of healthcare policies in Turkey. *Public Administration Journal*, 23-43.

Khan, F., Munir, K., & Willmott, H. (2007). A dark side of institutional entrepreneurship: Soccer balls, child labour and postcolonial impoverishment. *Organization Studies, 28*(7), 1055-1077.

Kim, Y. (2011). The pilot study in qualitative inquiry: Identifying issues and learning lessons for culturally competent research. *Qualitative Social Work, 10*(2), 190-206.

Kingma, M. (1999). Can financial incentive influence medical practice? *Human Resources for Health Development Journal, 3*(2), 121-131.

Kirchhoff, A., & Lawrenz, F. (2011). The use of grounded theory to investigate the role of teacher education on STEM teachers' career paths in high-need schools. *Journal of Teacher Education, 62*(3), 246-259.

Kitchener, M. (2002). Mobilizing the logic of managerialism in professional fields: The case of academic health centre mergers. *Organization Studies, 23*(3), 391-420.

Kodeih, F., & Greenwood, R. (2014). Responding to institutional complexity: The role of identity. *Organization Studies, 35*(1), 7-39.

Kostova, T., & Roth, K. (2002). Adoption of an organizational practice by subsidiaries of multinational corporations: Institutional and relational effects. *Academy of Management Journal, 45*(1), 215-233.

Kraatz, M. S., & Block, E. S. (2008). Organizational implications of institutional pluralism. In R. Greenwood, C. Oliver, K. Sahlin, & R. Suddaby (Eds.), *The Sage handbook of organizational institutionalism* (pp. 243-275). London: Sage.

Kruger, D. (1988). *An introduction to phenomenological psychology*. Cape Town, South Africa: Juta.

Lamba, M., Altan, Y., Aktel, M., & Kerman, U. (2014). Restructration in Ministry of Health: An evaluation in terms of new public management. *Public Administration Journal, 47*(1), 53-78.

Land, C., Loren, S., & Metelmann, J. (2014). Rogue logics: Organization in the grey zone. *Organization Studies, 35*(2), 233-253.

Larson, M. S. (1977). *The rise of professionalism: A sociological analysis.* Berkeley: University of California Press.

Law, J. (2006). *After method: Mess in social science research.* London: Routledge.

Lawrence, T. B., Suddaby, R., & Leca, B. (2009). Introduction: Theorizing and studying institutional work. In T. B. Lawrence, R. Suddaby, & B. Leca (Eds.), *Institutional work: Actors and agency in institutional studies of organizations* (pp. 1-27). Cambridge: Cambridge University Press.

Lawrence, T. B., Suddaby, R., & Leca, B. (2011). Institutional work: Refocusing institutional studies of organization. *Journal of Management Inquiry, 20*(1), 52-58.

Leblebici, H., Salancik, G. R., Copay, A., & King, T. (1991). Institutional change and the transformation of interorganizational fields: An organizational history of the US radio broadcasting industry. *Administrative Science Quarterly, 36*(3), 333-363.

Lee, R. M. (1993). *Doing research on sensitive topics.* London: Sage Publications.

Lempert, L. B. (2007). Asking questions of the data: Memo writing in the grounded theory tradition. In A. Bryant, & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 245-264). London: Sage.

Light, D. W. (2000). The medical profession and organizational change: From professional dominance to countervailing power. In P. C. Bird, & D. Fremont (Eds.), *Handbook of medical sociology* (pp. 201-216).

Light, D. W., & Hughes, D. (2001). Introduction: A sociological perspective on rationing: power, rhetoric and situated practices. *Sociology of Health & Illness, 23*(5), 551-569.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lind, M., & Goldkuhl, G. (2006). How to develop a multi-grounded theory: The evolution of a business process theory. *Australasian Journal of Information Systems, 13,* 69-85.

Linstead, S., Maréchal, G., & Griffin, R. W. (2014). Theorizing and researching the dark side of organization. *Organization Studies, 35*(2), 165-188.

Locke, K. (2001). *Grounded theory in management research.* Thousand Oaks, CA: Sage.

Loewenstein, G. (1994). The psychology of curiosity: A review and reinterpretation. *Psychological Bulletin, 116*(1), 75-98.

Lok, J., & De Rond, M. (2013). On the plasticity of institutions: Containing and restoring practice breakdowns at the Cambridge University Boat Club. *Academy of Management Journal, 56*(1), 185-207.

Lounsbury, M. (2001). Institutional sources of practice variation: Staffing college and university recycling programs. *Administrative Science Quarterly, 46,* 29-56.

Lounsbury, M. (2002). Institutional transformation and status mobility: The professionalization of the field of finance. *Academy of Management Journal, 45,* 255-266.

Lounsbury, M. (2007). A tale of two cities: Competing logics and practice variation in the professionalizing of mutual funds. *Academy of Management Journal, 50,* 289-307.

Lounsbury, M., & Crumley, E. T. (2007). New practice creation: An institutional approach to innovation. *Organization Studies, 28,* 993-1012.

MacDonald, K. M. (1995). *The sociology of the professions.* London: Sage.

MacLean, L. M., Meyer, M., & Estable, A. (2004). Improving accuracy of transcripts in qualitative research. *Qualitative Health Research, 14*(1), 113-123.

March, J. G., & Olsen, J. P. (2010). *Rediscovering institutions.* New York: The Free Press.

Marquis, C., & Lounsbury, M. (2007). Vive la resistance: Competing logics and the consolidation of U.S. community banking. *Academy of Management Journal, 50*, 799-820.

Marshall, C., & Rossman, G. (1999). *Designing qualitative research* (3 ed.). London: Sage.

Mason, J. (1996). *Qualitative researching.* London: Sage.

Matten, D., & Moon, J. (2008). "Implicit" and "explicit" CSR: A conceptual framework for a comparative understanding of corporate social responsibility. *Academy of Management Review, 33*, 404-424.

Maxwell, J. A. (2010). Using numbers in qualitative research. *Qualitative Inquiry, 16*(6), 475-482.

McCallin, A. M. (2003). Designing a grounded theory study: Some practicalities. *Nursing in Clinical Care, 8*(5), 203-208.

McGhee, G., Marland, G. R., & Atkinson, J. (2007). Grounded theory research: Literature reviewing and reflexivity. *Journal of Advanced Nursing, 60*, 334-342.

McPherson, C. M., & Sauder, M. (2013). Logics in action: Managing institutional complexity in a drug court. *Administrative Science Quarterly, 58*(2), 165-196.

Mechanic, D. (1991). Sources of countervailing power in medicine. *Journal of Health Politics, Policy and Law, 16*(3), 485-521.

Metintaş, M. Y., & Elçioğlu, O. (2007). Healthcare services within the first fifteen years of the Turkish Republic (1923-1938). *Osmangazi Journal of Medicine, 29*(3), 162-170.

Meyer, J. W., & Rowan, B. (1977). Institutional organizations: Formal structure as myth and ceremony. *American Journal of Sociology*, 340-363.

Meyer, J. W., Scott, W. R., & Deal, T. (1983). Institutional and technical sources of organizational structure. In H. D. Stein (Ed.), *Organization and human services* (pp. 151-178). Philadelphia: Temple University Press.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), 1-10.

Misangyi, V. F., Weaver, G. R., & Elms, H. (2008). Ending corruption: The interplay among institutional logics, resources, and institutional entrepreneurs. *Academy of Management Journal, 33*(3), 750-770.

Morgan, G., & Smircich, L. (1980). The case for qualitative research. *Academy of Management Review, 5*(4), 491-500.

Morse, J. M. (1994). *Critical issues in qualitative research methods.* Thousand Oaks, CA: Sage.

Morse, J. M. (1998). Designing funded qualitative research. In N. Denzin, & Y. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 56-85). Thousand Oaks: Sage.

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals.* Thousand Oaks, CA: Sage.

Morse, J. M., Stern, P., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. E. (2009). *Developing grounded theory: The second generation.* Walnut Creek, CA: Left Coast Press.

Murray, F. (2010). The oncomouse that roared: Hybrid exchange strategies as a source of discretion at the boundary of overlapping institutions. *American Journal of Sociology, 116*, 341-388.

Mutch, A. (2007). Reflexivity and the institutional entrepereneur: A historical exploration. *Organization Studies, 28*(7), 1123-1140.

Myers, M. D., & Newman, M. (2007). The qualitative interview in IS research: Examining the craft. *Information & Organization, 17*(1), 2-26.

Nelson, M., & Schutz, R. (2007). Day care differences and the reproduction of social class. *Journal of Contemporary Ethnography, 36*, 281-317.

Nigam, A., & Ocasio, W. (2010). Event attention, environmental sensemaking, and change in institutional logics: An inductive analysis of the effects of public attention to Clinton's health care reform initiative. *Organization Science, 21*, 8841.

North, D. (1990). *Institutions, institutional change and economic performance.* Cambridge, MA: Cambridge University Press.

Oliver, C. (1991). Strategic responses to institutional processes. *Academy of Management Review, 16*, 145-179.

Oliver, C. (1992). The antecedents of deinstitutionalization. *Organization Studies, 13*, 563-588.

Oliver, P. (2010). *The student's guide to research ethics.* New York: McGraw Hill.

Olson, T. (2000). Numbers, narratives, and nursing history. *Social Science Journal, 37*, 137-144.

Oppenheim, B. (1992). *Questionnaire design, interviewing and attitude measurement* (2nd ed.). London: Pinter Publishing.

Özdemir, Y. E. (2001). Healthcare policies in the Republic period - Healthcare policies from the establishment of Turkish Republic to 1980s. *The New Turkey*, 257-275.

Özer, A. (1984). *1982 Constitution with legislative reasoning and comparison with 1961 Constitution.* Ankara: Science Publishing .

Özseven, M., Danışman, A., & Bingöl, A. S. (2014). Transformation or development? Towards a new Institutional logic in the management of public hospitals. *METU Studies in Development, 41*, 119-150.

Öztürk, M. (1999). Healthcare services during Turkish Republic period. *Suleyman Demirel University Faculty of Medicine Journal, 6*(1), 37-41.

Pache, A.-C., & Santos, F. (2010). When worlds collide: The internal dynamics of organizational responses to conflicting institutional demands. *Academy of Management Review, 35*(3), 455-476.

Pache, A.-C., & Santos, F. (2013). Inside the hybrid organization: Selective coupling as a response to competing institutional logics. *Academy of Management Journal, 56*(4), 972-1001.

Padgett, D. K. (1998). *Qualitative methods in social work research: Challenges and rewards.* Thousand Oaks, CA: Sage.

Pala, K. (2003). The World Bank's health policy and general health insurance for Turkey. *Community and Physician*, 115-119.

Parsons, T. (1956). Suggestions for a sociological approach to the theory of organizations. *Administrative Sciences Quarterly, 1*, 63-85.

Patton, M. Q. (1990). *Qualitative evaluation and research methods.* London: Sage.

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Pedersen, E. R., Neergard, P., Pedersen, J. T., & Gwozdz, W. (2013). Conformance and deviance: Company responses to institutional pressures for corporate social responsibility reporting. *Business Strategy and the Environment, 22*, 357-373.

Pettigrew, A. (1990). Longitudinal field research on change theory and practice. *Organization Science, 1*(3), 267-292.

Phillips, N., Lawrence, T. B., & Hardy, C. (2004). Discourse and institutions. *Academy of Management Review, 29*, 1-18.

Pidgeon, N. (1996). Grounded theory: theoretical background. In J. E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences.* Leicester: British Psychological Society.

Pidgeon, N., & Henwood, K. (1996). Grounded theory: Practical implementation. In J. T. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences.* Leicester, UK: British Psychological Society.

Polleta, F., & Jasper, J. M. (2001). Collective identity and social movements. *Annual Review of Sociology, 27*, 283-305.

Powell, W. W., & Colyvas, J. A. (2008). Micro-foundations of institutional theory. In R. Greenwood, C. Oliver, R. Suddaby, & K. Sahlin (Eds.), *The Sage handbook of organizational institutionalism* (pp. 276-298). London, UK: Sage Publications.

Powell, W. W., & DiMaggio, P. J. (Eds.). (1991). *The new institutionalism in organizational analysis.* Chicago: University of Chicago Press.

Punch, F. P. (2009). *Introduction to research methods in education.* London: Sage.

Purdy, J. M., & Gray, B. (2009). Conflicting logics, mechanisms of diffusion, and multilevel dynamics in emerging institutional demands. *Academy of Management Journal, 52*(2), 355-380.

Quirke, L. (2013). Rogue resistance: Sidestepping isomorphic pressures in a patchy institutional field. *Organization Studies, 34*(11), 1675-1699.

Raaijmakers, A. G., Vermeulen, P. A., Meeus, M. T., & Zietsma, C. (2015). I need time! Exploring pathways to compliance under institutional complexity. *Academy of Management Journal, 58*(1), 85-110.

Ragin, C., & Zaret, D. (1983). Theory and method in comparative research: Two strategies. *Social Forces, 61*, 731-754.

Rao, H., Monin, P., & Durand, R. (2003). Institutional change in ToqueVille: Nouvelle cuisine as an identity movement in French gastronomy. *American Journal of Sociology, 108,* 795-843.

Reay, T., & Hinings, C. R. (2005). The recomposition of an organizational field: Health care in Alberta. *Organization Studies, 26*(3), 349-382.

Reay, T., & Hinings, C. R. (2009). Managing the rivalry of competing institutional logics. *Organization Studies, 30,* 629-652.

Reay, T., Goodrick, E., Waldorff, S., & Casebeer, A. (2016). Getting leopards to change their spots: Co-creating a new professional role identity. *Academy of Management Journal*, amj.2014.0802.

Robson, C. (2002). *Real world research* (2nd ed.). Oxford: Blackwell Publishing.

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Saldana, J. (2009). *The coding manual for qualitative researchers.* London: Sage.

Salmon, J. W. (1987). The medical profession and the corporatization of health sector. *Theoretical Medicine, 8*(1), 19-29.

Sampson, H. (2004). Navigating the waves: the usefulness of a pilot in qualitative research. *Qualitative Research, 4*(3), 383-402.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing Health, 23,* 334-340.

Sandelowski, M. (2001). Real qualitative researchers do not count: The use of numbers in qualitative research. *Research in Nursing and Health, 24,* 230-240.

Sandelowski, M., & Jones, L. C. (1996). Healing fictions. *Social Science & Medicine, 42,* 353-361.

Sandelowski, M., Voils, C. I., & Knafl, G. (2009). On quantitizing. *Journal of Mixed Method Research, 3,* 208-222.

Schansberg, D. E. (2014). The economics of health care and health insurance. *The Independent Review, 18*(3), 401-420.

Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D. Maines (Ed.), *Social organization*

and social process: Essays in honor of Anselm Strauss (pp. 303-314). New York: Aladine de Gruyter.

Schilling, J. (2006). On the pragmatics of qualitative assessment: Designing the process for content analysis. *European Journal of Psychological Assessment, 22*(1), 28-37.

Schneiberg, M., & Bartley, T. (2001). Regulating American industries: Markets, politics, and the institutional determinants of fire insurance regulation. *American Journal of Sociology, 107*, 101-146.

Schreiber, R. S. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber, & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 55-83). New York: Springer Publishing.

Schwandt, T. (1998). Constructivist, intepretivist approaches to human inquiry. In Z. Denzin, & Y. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 221-259). Thosand Oaks: Sage.

Schwandt, T. (2007). *The Sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage.

Scott, W. R. (1987). The adolescence of institutional theory. *Administrative Science Quarterly, 32*(4), 493-511.

Scott, W. R. (1991). Unpacking institutional arguments. In W. W. Powell, & P. J. DiMaggio (Eds.), *The new institutionalism in organizational analysis* (pp. 164-182). Chicago, IL: University of Chicago Press.

Scott, W. R. (1994). Institutions and organizations: Toward a theoretical synthesis. In W. R. Scott, & J. W. Meyer (Eds.), *Institutional environments and organizations* (pp. 55-80). Thousand Oaks, CA: Sage.

Scott, W. R. (2001). *Institutions and organizations* (2nd ed.). Thousand Oaks: SAGE.

Scott, W. R., & Meyer, J. W. (1983). The organization of societal sectors. In J. W. Meyer, & W. R. Scott (Eds.), *Organizational environments: Ritual and rationality* (pp. 129-153). Beverly Hills, CA: Sage.

Scott, W. R., & Meyer, J. W. (1991). The new institutionalism in organizational analysis. In W. W. Powell, & P. J. DiMaggio (Eds.), *The organization of societal sectors: Propositions and early evidence* (pp. 108-140). Chicago, IL: University of Chicago Press.

Scott, W. R., Ruef, M., Mendel, M., & Caronna, G. (2000). *Institutional change and healthcare organizations: From professional dominance to managed care.* Chicago, IL: University of Chicago Press.

Selznick, P. (1948). Foundations of the theory of organization. *American Sociological Review*(1), 25-35.

Selznick, P. (1949). *TVA and the grass roots.* Berkeley: University of California Press.

Selznick, P. (1957). *Leadership in administration.* Evanston, IL: Pow, Peterson.

Selznick, P. (1996). Institutionalism "Old" and "New". *Administrative Sciences Quarterly, 41*, 270-277.

Seo, M.-G., & Creed, W. E. (2002). Institutional contradictions, praxis, and institutional change: A dialectical perspective. *Academy of Management Review, 27*(2), 222-247.

Sewell, W. H. (1992). A theory of structure: Duality, agency, and transformation. *American Journal of Sociology, 98*(1), 1-29.

Shmanske, S. (1996). Information asymmetries in health services: The market can cope. *The Independent Review, 1*(2), 191-200.

Shoemaker, P. J., Tankard, J. W., & Lasorsa, D. L. (2004). *How to build social science theories.* Thousand Oaks: Sage.

Shortell, S. M., & Kaluzny, A. D. (2006). *Health care management: Organization, design, and behavior.* Clifton Park, New York: Thomson Delmar Learning.

Silverman, D. (1971). *The theory of organizations: A sociological framework.* New York: Basic Books.

Simon, C. M. (1999). Images and image: Technology and the social politics of revealing disorder in a North American hospital. *Medical Anthropology Quarterly, 13,* 141-162.

Smets, M., & Jarzabkowski, P. (2013). Reconstructing institutional complexity in practice: A relational model of institutional work and complexity. *Human Relations, 66*(10), 1279-1309.

Smets, M., Jarzabkowski, P., Burke, G. T., & Spee, P. (2014). Reinsurance trading in Lloyd's of London: Balancing conflicting-yet-complementary logics in practice. *Academy of Management Journal*. doi:10.5465/amj.2012.0638

Smets, M., Morris, T., & Greenwood, R. (2012). From practice to field: A multilevel model of practice-driven institutional change. *Academy of Management Journal, 55*(4), 877-904.

Smith, J. A., & Eatough, V. (2007). *Analysing qualitative data in psychology.* (E. Lyons, & A. Coyle, Eds.) Thousand Oaks, CA: Sage Publications.

Spradley, J. P. (1979). *The etnographic interview.* New York: Holt, Rinehart & Winston.

Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. *Journal of Nursing Scholarship, 12*(1), 20-23.

Strauss, A. L., & Corbin, J. M. (1990). *Basic of qualitative research: Grounded theory procedure and techniques.* London: Sage.

Strauss, A. L., & Corbin, J. M. (1994). Grounded theory methodology. In N. Denzin, & Y. Lincoln (Eds.), *Handbook of qualitative methods* (pp. 273-285). Thousand Oaks: Sage.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* London: Sage.

Suddaby, R. (2006). What grounded theory is not. *Academy of Management Journal, 49*(4), 633-642.

Suddaby, R. (2010). Challenges for institutional theory. *Journal of Management Inquiry, 19*(1), 14-20.

Suddaby, R., & Greenwood, R. (2005). Rhetorical strategies of legitimacy. *Administrative Sciences Quarterly, 50*(1), 35-67.

Suddaby, R., & Viale, T. (2011). Professional and field-level change: Insitutional work and the professional project. *Current Sociology, 59*(4), 423-442.

Suddaby, R., Elsbach, K. D., Greenwood, R., Meyer, J. W., & Zilber, T. B. (2010). Organizations and their institutional environments - Bringing meaning, values, and culture back in: Introduction to the special research forum. *Academy of Management Journal, 53*(6), 1234-1240.

Sülkü, S. N. (2011). *The healthcare provision, financing and expenses in Turkey before and after Healthcare Transformation Program.* Ankara, Turkey: T. R. Ministry of Finance, The Presidency of Strategy Development.

Sulmasy, D. P. (1992). Physicians, cost control, and ethics. *Annals of Intemal Medicine, 116*, 920-926.

Symon, G., & Cassel, C. (Eds.). (1998). *Qualitative methods and analysis in organizational research: A practical guide.* Thousand Oaks, CA: Sage Publications.

Tang, S. (2011). *A general theory of institutional change.* NY: Routledge.

Tanör, B. (1998). *Ottoman-Turkish constitutional developments.* Istanbul: Yapı Kredi Publishing.

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social & behavioral research.* Thousand Oaks: Sage.

Taylor, S. J., & Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resource* (3rd ed.). New York: Wiley.

Taylor, S. J., Bogdan, R., & DeVault, M. L. (2016). *Introduction to qualitative research methods: A guidebook and resource* (4th ed.). New Jersey: John Wiley & Sons, Inc.

Tekin, G. (2011). *From the Ministry of Health and Social Assistance to the Ministry of Health (1920-2000).* The Institute of Turkish Revolutionary History, Ankara University, Ankara: Unpublished Doctoral Thesis.

Thomas, G. M., & Meyer, J. W. (1984). The expansion of the state. *Annual Review of Sociology*, 461-482.

Thornton, P. H. (2004). *Markets from culture: Institutional logics and organizational decision in higher education publishing.* Stanford, CA: Stanford University Press.

Thornton, P. H., & Ocasio, W. (1999). Institutional logics and the historical contingency of power in organizations: Executive sucession in the higher education publishing industry, 1958-1990. *The American Journal of Sociology, 105*(3), 801-843.

Thornton, P. H., & Ocasio, W. (2008). Institutional logics. In R. Greenwood, C. Oliver, & K. Sahlin-Andersson (Eds.), *The SAGE handbook of organizational institutionalism* (pp. 99-129). London: SAGE.

Thornton, P. H., Jones, C., & Kury, K. (2005). Institutional logics and institutional change in organizations: Transformation in accounting, architecture, and publishing. *Research in Sociology of Organizations, 23*, 125-170.

Thornton, P. H., Ocasio, W., & Lounsbury, M. (2012). *The institutional logics perspective: A new approach to culture, structure and process.* Cambridge: Oxford University Press.

Thorpe, R., & Holt, R. (2008). *The Sage dictionary of qualitative management research.* London: Sage Publications.

Tilcsik, A. (2010). From ritual to reality: Demography, ideology, and decoupling in a post-communist government agency. *Academy of Management Journal, 6*, 1474-1498.

Tinh, H. Q., & O'Connor, S. J. (2000). Strategic behavior of U.S. rural hospitals: A longitudinal and path model examination of market power, cost control, environmental and organizational characteristics on financial performance. *Health Care Management Review, 25*(4), 48-64.

Tolbert, P. S. (1985). Resource dependence and institutional environments: Sources of administrative structure in institutions of higher education. *Administrative Science Quarterly, 30*, 1-13.

Tolbert, P. S., & Zucker, L. G. (1983). Institutional sources of change in the formal structure of organizations: The diffusion of civil service reform, 1880-1935. *Administrative Science Quarterly, 28*, 22-39.

Town, R., Wholey, D. R., Kralewski, J., & Dowd, B. (2004). Assessing the influence of incentives on physicians and medical groups. *Medical Care Research and Review, 61*(3), 80S-118S.

Townley, B. (1997). The institutional logic of performance appraisal. *Organization Studies, 18*(2), 261-285.

Townley, B. (2002). The role of competing rationalities in institutional change. *Academy of Management Journal, 45*(1), 163-179.

Tracey, P., Phillips, N., & Jarvis, O. (2011). Bridging institutional entrepreneurship and the creation of new organizational forms. *Organization Science, 22*(1), 60-80.

Tunaya, T. Z. (1975). *Political institutions and constitutional law.* Istanbul: Sulhi Garan Publishing.

Tuohy, C. J. (1988). Medicine and the state in Canada: The extra-billing issue in perspective. *Canadian Journal of Political Science, 21*, 267-296.

Turkish Grand National Assembly Minutes of Proceedings. (1947). *8*, pp. 667-888. Ankara: Turkish Grand National Assembly Publishing.

Turkish Grand National Assembly Minutes of Proceedings. (1961). *5*, pp. 1-95. Ankara: Turkish Grand National Assembly Publishing.

Turkish Republic Constitution. (1921). *Government Gazette, 1*, 196-199.

Turkish Republic Constitution. (1961). *Government Gazette*, 4201-4216.

Turkish Republic Constitution. (1982). *Government Gazette, 5*(22), 1-43.

Turkish Republic Constitution: Legislative Reasoning Incorporated. (2011). *Turkish Grand National Assembly Library*, 1-393.

Turkish Republic Ministry of Health. (1993). National Health Plan. Ankara.

Turkish Republic Ministry of Health. (2003). Health Transformation Program in Turkey. Ankara.

Turkish Republic Ministry of Health. (2008). Performance management in health. Ankara.

Turkish Republic Prime Ministry State Planning Organization. (1973). *3rd five-year development plan (1973-1977).* Ankara.

Turkish Republic Prime Ministry State Planning Organization. (1979). *4th five-year development plan (1979-1983).* Ankara.

Turkish Republic Prime Ministry State Planning Organization. (1985). *5th five-year development plan (1985-1989).* Ankara.

Turkish Republic Prime Ministry State Planning Organization. (1990). *6th five-year development plan (1990-1994).* Ankara.

Turkish Republic Prime Ministry State Planning Organization. (1996). *7th five-year development plan (1996-2000).* Ankara.

Üner, R., & Fişek, N. (1961). *Studies on socialization of healthcare and application plan.* Ankara: Health and Social Assistance Publishing.

Vaughan, D. (1999). The dark side of organizations: Mistake, misconduct, and disaster. *Annual Review of Sociology, 25*, 271-305.

Voronov, M., & Vince, R. (2012). Integrating emotions into the analysis of institutional work. *Academy of Management Review, 37*(1), 58-81.

Voronov, M., Clercq, D. D., & Hinings, C. R. (2013). Institutional complexity and logic engagement: An investigation of Ontario fine wine. *Human Relations, 66*(12), 1563-1596.

Wallace, J. E. (1995). Organizational and professional commitment in professional and nonprofessional organizations. *Administrative Science Quarterly, 40*, 228-255.

Washington, M., & Ventresca, M. J. (2004). How organizations change: The role of institutional support mechanisms in the incorporation of higher education visibility strategies, 1874-1995. *Organization Science, 15*, 82-97.

Watson, T. (1994). Towards a managerially relevant but non-managerialist organisation theory. In J. Hassard, & M. Parker (Eds.), *Towards a new theory of organizations* (pp. 209-224). London: Routledge.

Wellard, S., & McKenna, L. (2001). Turning tapes into text: Issues surrounding the transcription of interviews. *Contemporary Nurse, 11*(2/3), 180-186.

Welman, J. C., & Kruger, S. J. (1999). *Research methodology for the business and administrative sciences.* Johannesburg, South Africa: International Thompson.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods.* London: Sage.

Westphal, J. D., & Zajac, E. J. (1994). Substance and Symbolism in CEOs' long-term incentive plans. *Administrative Science Quarterly, 39*, 367-390.

Westphal, J. D., & Zajac, E. J. (2001). Decoupling policy from practice: The case of stock repurchasing programs. *Administrative Science Quarterly, 46*, 202-228.

Westphal, J. D., Gulati, R., & Shortell, S. M. (1997). Customization or conformity? An institutional and network prespective on the content and consequences of TQM adoption. *Administrative Science Quarterly, 42*(2), 366-394.

White, H. (1992). *Identity and control: A structural theory of social action.* Princeton, NJ: Princeton University Press.

Whittington, R. (2006). Completing the practice turn in strategy research. *Organization Studies, 27*(5), 613-634.

Williams, E. N., & Hill, C. E. (2001). Evolving connections: Research that is relevant to clinical practice. *American Journal of Psychotherapy, 5*(3), 336-343.

Wilson, J. (2010). *Essentials of business research: A guide to doing your research project.* London: Sage.

Wimpenny, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory: Is there a difference? *Journal of Advanced Nursing, 31*(6), 1485-1492.

Wynia, M. (2009). The risks of rewards in health care: How pay-for-performance could threaten, or bolster, medical professionalism. *Journal of General Internal Medicine, 24*(7), 884-887.

Zietsma, C., & Lawrence, T. (2010). Institutional work in the transformation of an organizational field: The interplay of boundary work and practice work. *Administrative Science Quarterly, 55*, 189-221.

Zilber, T. B. (2002). Institutionalization as an interplay between actions, meanings, and actors: The case of a rape crisis center in Israel. *Academy of Management Journal, 45*, 234-254.

Zucker, L. G. (1977). The role of institutionalization in cultural persistence. *American Sociological Review*, 726-743.

Zucker, L. G. (1983). Organizations as institutions. In S. B. Bacharach (Ed.), *Research in the sociology of organizations* (pp. 1-42). Greenwich, CT: JAI Press.

Zucker, L. G. (1987). Institutional theories of organization. *Annual Review of Sociology, 13*, 443-464.

APPENDIX: EVOLUTION OF INTERVIEW QUESTIONS

OPEN INTERVIEW QUESTIONS	SEMI-STRUCTURED INTERVIEW QUESTIONS
1. How do you define your work as a medical professional?	1. Within the realms of science of medicine, what do you believe to be the primary orientation of physicians during their provision of healthcare? *Prompt: Which norm, value or belief systems do physicians draw from while practicing medicine?*
2. What do you believe as important in the performance of your work?	2. Within the realms of science of medicine, when you consider the main orientation of physicians in practicing medicine relating to before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe the norm, value or belief systems physicians primarily draw from while practicing medicine have in any way changed with the implementation of HTP and PBSPS?*
3. Are there certain principles you abide by or draw from while performing your work?	3. Within the realms of science of medicine, what do you believe to be the primary focus or objective of practicing medicine or delivery of healthcare? *Prompt: What is your general view on delivery of healthcare? What do you believe to be the end goal of practicing medicine? How and with which main*

	focus do you believe medicine is practiced?
4. Have you experienced any differences in terms of how you view your duties and responsibilities in any time in your career as a physician?	4. Within the realms of science of medicine, when you consider the main focus or objective of physicians while practicing medicine relating to before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe how and on which main focus medicine is practiced has in any way changed with the implementation of HTP and PBSPS?*
5. Do you believe the values, belief and rule systems of practicing medicine have in any way changed within the past 30 years?	5. Within the realms of science of medicine, how do you define your target audience in terms of practice-level healthcare service delivery? *Prompt: How do you perceive your target audience? In other words, in your view, who are they? How would you, if you needed to, categorize their status in terms of healthcare delivery?*
6. What are your general thoughts regarding the implementation of the HTP and PBSPS? Do you believe implementation of HTP and PBSPS has in any way affected the dynamics of provision of healthcare in the Turkish healthcare system?	6. Within the realms of science of medicine, when you consider the definition or classification of target audience in terms of practice level healthcare service delivery relating to before and after the implementation of PBSPS, have you seen, felt or have experienced any differences?

		Prompt: Do you believe how physicians view or define their target audience has in any way changed with the implementation of HTP and PBSPS?
	7.	Within the realms of science of medicine, how do you define your own status in terms of practice level healthcare service delivery? *Prompt: How do you perceive your own status or role in delivery of healthcare? In other words, what is your view on what your role is or who you are in the delivery of healthcare?*
	8.	Within the realms of science of medicine, when you consider the definition or classification of your own status in terms of practice level healthcare service delivery relating to before and after the implementation of PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe how physicians view or define themselves has in any way changed with the implementation of HTP and PBSPS?*
	9.	Within the realms of science of medicine, what do you believe to be the general characteristic feature of healthcare services? *Prompt: What is the main orientation of healthcare delivery service and how*

	would you define that characteristic feature?
	10. Within the realms of science of medicine, when you consider the general characteristic feature of healthcare services relating to before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe that the main orientation of healthcare delivery service and how its characteristic feature is defined has in any way changed with the implementation of HTP and PBSPS?*
	11. Within the realms of science of medicine, how do you view or define the concept of quality related to healthcare provision at practice level? *Prompt: What is your perception of the concept of quality? How is it viewed or should apply to medicine specifically in delivery of healthcare?*
	12. Within the realms of science of medicine, when you consider the concept of quality related to healthcare provision at practice level in terms of before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences?

		Prompt: Do you believe that physicians' perception of the concept of quality has in any way changed with the implementation of HTP and PBSPS?
	13.	Within the realms of science of medicine, according to which criteria do you believe healthcare service is organized at the practice level? *Prompt: Based on which principles or inclinations physicians organize the delivery of healthcare service?*
	14.	Within the realms of science of medicine, when you consider physicians' orientation of organization of healthcare services at the practice level relating to before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe that the manner in which healthcare service is organized has in any way changed with the implementation of HTP and PBSPS?*
	15.	Within the realms of science of medicine, what do you believe to be your role in terms of information provision or dissemination at practice level healthcare delivery? *Prompt: What is your view of communication of healthcare information in healthcare delivery?*

	Where do physicians stay in that picture? What should physicians' responsibilities be in terms of dissemination of healthcare information during delivery of healthcare?
	16. Within the realms of science of medicine, when you consider the role of physicians in terms of information provision or dissemination at practice level relating to before and after the implementation of PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe that physicians' view of their role in terms of communication of healthcare information has in any way changed with the implementation of HTP and PBSPS?*
	17. Within the realms of science of medicine, how do physicians define their professional relationship in relation to other physicians or other healthcare professionals in a healthcare practice environment? *Prompt: What is your view of physician interactions with other physicians and/or other healthcare professionals during delivery of healthcare?*
	18. Within the realms of science of medicine, when you consider

	physicians' professional relationships with other healthcare professionals at practice level relating to before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe physicians' interactions with other physicians and/or other healthcare professionals during delivery of healthcare has in any way changed with the implementation of HTP and PBSPS?*
	19. Within the realms of science of medicine, what do you believe to be the success criteria for physicians with regard to delivery of healthcare? *Prompt: What is your view on when physicians feel accomplished? What determines success for physicians in healthcare practice?*
	20. Within the realms of science of medicine, when you consider what makes a physician feel accomplished and successful in terms of before and after the implementation of HTP and PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe physicians' view of the criteria for success in a healthcare practice environment has in*

	any way changed with the implementation of HTP and PBSPS?
	21. Within the realms of science of medicine, what is your perception of the practices or procedures related to the assessment of work processes of physicians in a healthcare practice environment? *Prompt: What is your view of whether or how the work performed by you in a healthcare practice environment is evaluated?*
	22. Within the realms of science of medicine, when you consider the practices or procedures related to assessment of work processes of physicians in a healthcare practice environment in terms of before and after the implementation of PBSPS, have you seen, felt or have experienced any differences? *Prompt: Do you believe physicians' view of whether or how the work performed by them in a healthcare practice environment is evaluated has in any way changed with the implementation of HTP and PBSPS?*

CIRRICULUM VITAE

PERSONAL INFORMATION

Name: Serdal GÜRSES

Place of Birth: Adana, Turkey

E-mail: dr.serdalgurses@gmail.com

EDUCATIONAL BACKGROUND

2012 – 2017 : **Doctor of Business Administration (Ph.D.)**
Department of Business Administration
Çukurova University Institute of Social Sciences, Adana, Turkey

2010 – 2011 : **Master of Business Administration (MBA)**
Department of Business Administration
Çukurova University Institute of Social Sciences, Adana, Turkey

1997 – 2001 : **Bachelor of Business Administration (BBA)**
Department of Business Administration
Anatolian University, Eskişehir, Turkey

PROFESSIONAL BACKGROUND

2002 – Present : **Resource Manager**
39th Medical Group, Incirlik Air Base, Turkey

PUBLICATIONS IN PEER-REVIEWED JOURNALS

Gürses, S., & Kılıç, K. C. (2013). Corporate Image Aspect of Corporate Management in Healthcare Industry: Definition, Measurement and an Empirical Investigation. *International Business Research, 6*(12), 31-45.

PRESENTATIONS

Gürses, S., & Danışman, A. (2017). *Variation in Constellations of Institutional Logics at Micro Level: Investigating the Practices of Physicians.* Paper presented at the 8th Organization Theory Workshop, Çankaya University, Ankara, Turkey.

Gürses, S., & Danışman, A. (2017). *Constellations of Multiple Institutional Logics at Micro Level: Investigating the Practices of Physicians in the Turkish Health Care Field*. Paper accepted to be presented at the 33rd EGOS Colloquium (July 6-8, 2017), Copenhagen, Denmark.

OTHER PROFESSIONAL EDUCATION AND DEVELOPMENT

U.S. Fiscal Law Education. Government Accountability Office, Washington, U.S. 2011.

Certified Professional Coder. American Academy of Professional Coders, UT, U.S. 2004.