THE LEGITIMATION OF FOREIGN ORGANISATIONAL FORMS: THE ROLE OF TRANSLATION AND THEORISATION

by

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ABSTRACT

I draw on an in-depth longitudinal analysis of the adoption of an American organizational form, namely 'Academic Health Science Centre' (or 'AHSC'), in the field of the British health care from 1989 to 2009 to examine translation processes of foreign organizational forms. I draw upon two institutional approaches that have been traditionally treated separately – institutional translation and theorization – to examine how the translation was successful, given the significantly different institutional contexts of the two countries.

I found that the adoption of the new and foreign organizational form as in the present case study unfolds over three phases – activation, dormancy, and reactivation. I also found that translation and theorization operated in configurations that underpinned the three phases of the process. In addition, my empirical data also supported that translation is actually not a planned and purposeful process, as extant research implies. Rather, translation is embedded within complexity and randomness, which can be conceptualized by using the garbage can model. I thus argue that successful translation depends on the presence of various elements: strategic actors with motivation, opportunity, and capacity to promote the organizational form; existence of powerful problems; and field receptivity that facilitates the organizational form.

These findings contribute to two literatures. The first contribution is to the translation literature by providing more nuanced view of translation and a new insight into how translation actually works by drawing on the garbage can model. More importantly, they highlight the temporal dimension in the translation process. The second contribution is to the theorization literature by highlighting strategies underlying theorization that contributes to legitimacy of foreign organizational forms.

DECLARATION

Declaration of Originality

I declare that this thesis submitted for the degree of Doctor of Philosophy is my own composition. The intellectual content of this thesis is the product of my own research under the guidance of my thesis advisors. Any ideas or quotations from the work of others are fully acknowledged.

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List of Abbreviations

AAHC	Association of Academic Health Centers
AHSC	Academic Health Science Centre
AUKUH	Association of UK University Hospitals
BRC	Biomedical Research Council
BRU	Biomedical Research Unit
CHMS	Council of Heads of Medical Schools
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CVCP	Committee of Vice-Chancellors and Principals
EHMA	European Health Management Association
GMC	General Medical Committee
GDC	General Dental Committee
HEFCE	Higher Education Funding Council for England
IMHE	Institutional Management in Higher Education
JMAC	Joint Medical Advisory Committee
MRC	Medical Research Council
NAHA	National Association of Health Authorities
NHS	National Health Service
NIHR	National Institute for Health Research
OECD	Organization for Economic Co-operation and Development
RAE	Research Assessment Exercise
SGUMDER	Steering Group on Undergraduate Medical and Dental Education and Research
SIFT	Service Incremental for Teaching
StLaR	Strategic Learning and Research Advisory Group for Health and Social Care
UGC	University Grants Committee (replaced by UFC since 1989)
UFC	University Funding Council (replaced by HEFCE since 1992)

Chapter 1.

INTRODUCTION

In 2009, the British Government designated five Academic Health Science Centres (AHSCs) in England. Such organizations had existed in the U.S. for over 50 years and in many developed countries such as the Netherlands, Sweden, and Singapore. One author of the healthcare management journal in the UK even commented that "from an international perspective, it is remarkable that it had taken this construct [AHSC] so long to find its place in mainstream healthcare policy in the UK" (Davies, 2008: 3). AHSC is an organizational form of partnership between a university and healthcare providers to integrate research, education, and patient care. According to my data collections, AHSC made its first entry into the UK in 1997, introduced as a solution to the perceived problem regarding collaboration between universities and the National Health Service (NHS). Despite its appearance since 1997, it was not until 2008 when the first AHSC was established by Imperial College and its associated hospitals, followed by the government's designation of the five AHSCs in 2009. AHSC has become legitimized, gaining supports from diverse stakeholders as the appropriate and reasonable solution to problems in the British healthcare.

Inspired by this interesting phenomenon, I asked the questions: how/why did AHSC get adopted in the UK? Is it only because other countries adopted it and the UK therefore followed? Are there other explanations? Why did it take so long for AHSC to get implemented in the UK? And lastly, given that the national health systems are different, how was AHSC justified?

This research aims to investigate the translation process of foreign organizational forms by drawing on the qualitative case study of the British AHSCs. I draw upon two institutional approaches that highlight the role of agency and meaning: translation and theorization. The translation approach delineates how organizational forms, when being diffused globally, are modified to fit the receiving society (Czarniawska & Joerges, 1996; Djelic & Quack, 2003;

Sahlin-Andersson, 1996). Translation, in contrast to diffusion, which "connotes a transmission of a given entity," connotes an interaction that involves negotiation between various parties, and the reshaping of what is finally being transmitted (Zilber, 2006: 283). Despite increasing studies of translation in the literature of institutional processes (Maguire & Hardy, 2009; Zilber, 2006), existing theoretical and empirical work provides little insight into how the work of translation is actually done (Boxenbaum, 2006). Theorization is central to the institutional diffusion process. It suggests how organizational forms through the discursive construction of meaning become widely adopted, diffused, and if repeated, evolve into rationalized myths or institutions (Strang & Meyer, 1993; Tolbert & Zucker, 1994). The two frameworks are complementary (Boxenbaum & Battilana, 2005; Zilber, 2008). However, they have so far been treated separately in empirical studies of organizational institutionalism.

By taking the two approaches of translation and theorization, this research, first, shows the very detailed process of translation. I believe that by drawing on the two approaches we gain a more detailed understanding of the translation process. Translation provides the lens of more micro-constructionism of how new organizational forms are adapted to a new context, while theorization explains how new organizational form gain support from stakeholders and legitimacy, and spread within organizational fields. Second, by tracing the entire trajectory of the translation of the British AHSCs (from the first-time introduction to the creation), this thesis contributes to explaining the very process of translation. Most work on the translation process addresses comparative difference in the nature or properties of practices or organizational forms at one point in time, when they travel from one context to another. They tend to start from the point of decision to adopt or the founding, and from that point, examine how translation occurs (see for example Boutaiba & Petersen, 2003). They imply historicity in the process of translation; however, the history is more or less empirically ignored. This thesis shows that by systematically examining the translation process of ideas or organizational forms over time we could gain more understanding about the collective work of actors and the role of institutional environment in the process of translation. Third, with the inclusion of theorization in the translation process, this thesis demonstrates that the translation of foreign organizational forms relies on the work of both editing and theorizing. Not only does the work of theorizing increase powerfulness, visibility, and legitimacy for foreign organizational forms, but it also provides the

lens to separately examine foreign organizational forms (solutions), problems, and contextual factors. This leads to discovering many interesting aspects in the translation process.

It is important to understand in detail the process of translation for two reasons. First, it is concerning the problem of the paradox of embedded agency. Although increasing institutional studies seek to understand translation, most studies examine how organizational or field elements influence actors' response to incorporating circulating ideas, structures or practices into their organizations. Less attention has been paid to explore actions and actors as interesting social phenomena in themselves. Therefore we still know little about the degree of agency attributed to actors in the translation process. Hence, extant studies have not yet fully answered the question regarding the paradox of embedded agency: how do embedded actors translate and promote a new and foreign organizational form into their institutional field? Second, due to the lack of studies on actions and actors, existing studies are not useful for practical discussion. The fact that institutional theory has not been appealing to managers has been acknowledged, despite its prevalence and recognition among academics as a standard point of reference in contemporary textbooks of organization theory (Greenwood, Oliver, Suddaby, & Sahlin-Andersson, 2008). Miner (2003) acknowledged that institutional theory has failed to generate practical discussions and effects. Lawrence, Suddaby, and Leca (2009: 2) confirmed this concern, and stated that "this is a shame and a waste…much of the appeal of an institutional perspective is its 'realistic' treatment of organizations." An increasing number of institutional theorists have encouraged researchers to redirect their focus from the effect of institutions on actions to the practical work of actors in relation to institutions so as to help promote institutional notions into non-academic discourse (Lawrence et al., 2009).

This research aims to examine the successful case of the translation process of foreign organizational forms using the notions of institutional translation and theorization. I set out the thesis as follows: in chapter two I review theoretical and empirical work of institutional mechanisms and processes, institutional perspectives of translation, theorization, organizational fields, and organizational forms. I conclude common themes, debates, underlying assumptions, connections among the perspectives, and key gaps and deficiency in knowledge. Chapter 3 presents the methodology, setting out research design, describing the selected case study, and

multiple methods of data collection. Chapter four, five and six show three complementary analyses.

Chapter four examines the work of actors, mechanisms, and process underlying the translation of the AHSC organizational form into the UK. My findings unpacked the detailed translation process in terms of strategies and activities that could account for successful translation. These strategies and activities could be grouped into three dimensions: 1) contextual design of a solution, 2) strategy for gaining support and mobilizing forces, and 3) legitimation. I also found that the translation process as in the case of the creation of the British AHSCs unfolded over three phases – activation, dormancy, and reactivation prior to the implementation of the organizational form. The three overarching categories played out in different phases, whereby the first dimension was the key activity in the activation phase, the second and the third in the reactivation phase. The finding illustrates the detailed work and process of translation that contributes to the current understanding and knowledge of the translation research and could benefit practitioners in terms of adoption of new managerial innovations. In addition, the finding highlights the transformation of the organizational form occurs not only across different institutional contexts but also over time. Furthermore, since it explores the longitudinal process of translation in one institutional setting (from the first-time introduction of the foreign organizational form to its implementation and creation), it shows that the work of actors in the early stage, despite their unsuccessful efforts to legitimize foreign organizational forms and consequently no adoption, can influence later constructions of local versions of foreign organizational forms.

Chapter five examines theorization of foreign organizational forms. I found that theorization played significant role in successful translation, particularly its role in strategic framing and matching of problems and solutions so that the foreign organizational form achieves legitimacy and supports in the field.

In chapter six, I investigate the factors in the British healthcare field that conditions the translation process of AHSC over time. During my analysis of translation and theorization in the previous two chapters, I found that the translation process under my study consists of four interesting features: 1) the foreign organizational form framed as the solution to an array of

problems, 2) the existence of the solution even before some problems, 3) various actors matching problems and solutions, and 4) triggering events and context that provided an opportunity for the creation of an AHSC to be not only appropriate but also imperative. I conceptualize these factors conditioning the translation of AHSC as the garbage can (Cohen, March, & Olsen, 1972). In this analysis, I found that translation is actually not a planned process, but a coincidental and non-rational process. For translation to be successful, it requires the presence of problems, strategic actors with motivation and capacity to promote the foreign organizational form, and field receptivity. I use the features of the garbage can model – field conditions positive to and facilitating the emergence of the AHSC, and multiple actors matching problems and solutions to further explain the translation process of the British AHSCs, to develop a garbage can model of translation processes.

Based on the three complementary analyses, I propose that the translation of foreign organizational forms occurs both across organizational fields and over time. The change that occurs is not only the nature of the foreign organizational form (functions, meaning, and underlying logics); but also its associated elements such as problems and ends. For the foreign organizational form to become successfully translated and justified, it depends on not only the role of agency in translating and theorizing, but also context (timing, trends, focus of attention in the field) that provides windows of opportunity, and actors who actually pick up, frame, and construct the foreign organizational form, combining it with other elements in the way that it fit the atmosphere of the field at the given time.

I make three contributions to the translation literature. First, I provide a more nuanced view of translation by highlighting actions and strategies underlying the translation process and how these actions result in transformation of the foreign organizational form when travelling into new institutional contexts. Second, I highlight the importance of historicity in the translation process, by showing the role of multiple actors engaging in the translation process, collectively shaping the meaning of the organizational form until it is successfully translated and adopted. I argue that translation studies require a longitudinal study that shows temporal order and sequence of events, leading to successful translation. Third, by developing a garbage can model of translation processes, my research contributes to new thinking of translation that translation is a coincidental and non-rational process. For translation to be successful, it requires not only

strategic actions, but also depends on conditions of actors engaging in the translation and field conditions at the time of the translation. This highlights the strategic effect of timing in the translation process. Furthermore, my findings also have implications for theorization studies. I highlight strategies underlying theorization, which contributes to understanding of theorization especially in mature fields.

Overall, this research contributes to understanding the translation process of organizational forms with the integration of the three notions: translation, theorization, and the garbage can model. My analysis suggests that translation is a micro mechanism, in which actors based on their particularities (i.e., personal preferences, identities, and experiences with the organizational form) work to adapt the organizational form to fit their context, while theorization is a macro mechanism, in which actors engage to promote change at the field level and to confer legitimacy to the organizational form. Theorization is the act to generalize translations into rhetoric and simplified accounts so that the organizational form can diffuse within the institutional field and then in turn potentially across fields. In addition translation and theorization do not occur in sequence. Rather, they are simultaneous and interact to each other throughout the process. As a result, the translation process has a multilevel nature, entailing actions at micro- and macro levels that result in local construction of the organizational form and change in the receiving field. Additionally, the acts of translating and theorizing are guided by intentionality of the actors. Based on the present case, I made an observation that the level of intentionality to have impacts on the field determines actions and strategies of translating and theorizing. The garbage can model identifies the conditions that determine success of translation. It also provides further explanation that actors are able to review their expectations and intentions. Thus their intentionality change over time in relation to the actors' circumstances and the political/cultural contexts of the field at the time of translation. Therefore, my finding suggests that the translation process is not a rational and purposeful process, as extant research implies. Rather, translation is a non-rational and coincidental process. For successful translation, it requires not only strategic actions, but also field receptivity and arrival of actors who are activated through motivation, opportunity and capacity at the particular point in time, willing to distribute their energy to promote the organizational form.

My empirical case study occurs in the context of the British healthcare, in which there are a lot of abbreviations and acronyms. Therefore the list of abbreviations (page 10) is provided to gather the glossary of such abbreviations and acronyms throughout the thesis.

Chapter 2.

LITERATURE REVIEW

2.1. Introduction

In this chapter, I outline the theoretical framework for my research. This thesis aims to explore the translation process of organizational forms across institutional contexts, and explain how such organizational forms gain legitimacy over time in the new institutional context. Accordingly, this chapter sets out to review the literature on institutional mechanisms and processes to explore why and how organizations become similar as the outcome of institutionalization as diffusion. This also highlights institutional accounts on institutional processes underlying stability and change as well as the role of agency and meaning in the process. Then, I present an alternative theoretical approach to understanding institutionalization – the neo-institutional perspective of translation. I suggest that research that focuses on the adoption and legitimation of organizational forms in new institutional settings should be framed in the context of the translation model. The diffusion model is argued for its focus on the spread of structures or practices as passive transmission, while neglecting meaning and symbolic aspects related to them. The translation model, however, places more emphasis on the dynamic of meaning in the process of institutionalization, and highlights the result of global diffusion with local variation of the circulating ideas. In this thesis, I draw upon the approach of translation to examine how organizational forms, when being diffused globally, are modified and adapted to fit the new institutional context.

As my thesis investigates the role of agency and meaning in the translation process, I also draw on the concept of theorization as another analytical approach in this thesis. Translation and theorization are complementary perspectives, but have been treated separately in empirical studies of organization analysis. One explanation is that theorization is viewed as the central mechanism of diffusion, which is the dominant concept in the American school of institutional

theory, while translation in itself is both mechanism and process, originated from the Scandinavian school of institutional theory. Translation highlights adaptation and transformation of ideas when travelling into a new context, while theorization connects to the conferring of legitimacy through the discursive construction of meaning related to the circulating ideas. Both approaches shed light on the role of meaning and symbolic aspects of institutionalization. Together, these complementary approaches help achieve the aim of my research – to explore the role of agency and dynamics of meaning in the translation process of the foreign organizational form that leads to the legitimation of the organizational form in a new institutional context.

Furthermore, I discuss the concept of an organizational field, which I use to frame the institutional context for this study. Additionally, I discuss the concept of an organizational form, which I use to frame the object of translation (AHSC) in this study. The last subsection presents the research questions.

2.2. Institutional mechanisms and process

Over the past two decades, institutional theory has become the dominated approach in organization studies (Greenwood et al., 2008; Walsh, Meyer, & Schoonhoven, 2006). It was originally driven by observations of the homogeneity of organizations, even though they operated in different environments (Tolbert & Zucker, 1994, 1996). The primary foundational works of the new institutional theory are the articles by Meyer and Rowan in 1977, and DiMaggio and Powell in 1983 (Mizruchi & Fein, 1999). Meyer and Rowan (1977: 345) observed that "the growth of rationalized institutional structures in society makes formal organizations more common." Such institutions are rationalized myths for organizations, which come 'to be littered around the social landscape'. Likewise, while traditional work of organization studies focused on explaining variation among organizations in structure and behavior, DiMaggio and Powell (1983: 148) asked instead: "why there is such startling homogeneity of organizational forms and practices?" The process of homogeneity is conceived as *isomorphism*. Both foundational works suggest that organizations that face the same institutional pressures converge to specific organizational forms and structures in order to obtain legitimacy and increase their probability of survival.

Institutional isomorphism asserts that the similarity did not arise only from market or technical pressures as organizations seek efficiency, but also from social expectations within their environments. DiMaggio and Powell (1983) identified three mechanisms of institutional isomorphism: 1) coercive isomorphism, 2) mimetic isomorphism, and 3) normative isomorphism. Coercive isomorphism results from pressures exerted over organizations by other organizations such as regulatory agencies, those by cultural expectations in the society. Coercive pressures are not only by order of high authorities, but can also come from resource dependence with organizations. Mimetic isomorphism largely stems from uncertainty. Under conditions of uncertainty, organizations mimic others, who are seemingly more successful or influential, with expectations to gain similar benefits. Normative isomorphism is explained through the process of professionalization. The two major sources are formal education and training, and interaction through professional networks and associations. Normative pressures force organizations to conform to what constitutes a proper and moral course of action. They argued that, as fields mature, there are powerful forces pushing organizations within the same fields to become similar.

The majority of institutional studies were initially dedicated to understanding the process that leads to the outcome of isomorphism or institutionalization (Lounsbury & Pollack, 2001). Institutionalization is the process by which a set of units and a pattern of activities come to be normatively and cognitively taken for granted as a social reality (Zucker, 1977). The methodological preference towards studies of institutionalization has been macro-level, quantitative approaches (Greenwood et al., 2008; Zilber, 2006), which focus on the rates of adoption as evidence of institutionalization. This has resulted in researchers' understanding of institutionalization as diffusion – "the spread of something within a social system" (Strang & Soule, 1998: 266).

The late 1980s saw shift in the work of institutional theory to agency and institutional change. It was argued that the appearance of stability is probably misleading (Greenwood, Suddaby, & Hinings, 2002), and institutional contexts or organizational fields should be seen instead as evolving rather than static (Hoffman, 1999; Sahlin-Andersson, 1996). As a result, attention also turned to examination of legitimacy with a more agentic approach (Greenwood et al., 2008). The questions turned to: How do organizations acquire and manage legitimacy? How

do institutional arrangements change? (Greenwood et al., 2008). According to Hargrave and Van De Ven (2006: 866), institutional change is defined as "a difference in form, quality, or state over time in an institution." Change can be determined by observing and calculating difference in institutional arrangements at two or more points in time on a set of dimensions such as frames, rules, norms (Hargrave & Van De Ven, 2006). Institutional change can come in many forms, including the creation of a new institution, the elaboration of existing institutions, the decline of an institution (deinstitutionalization), and the replacement of an existing institution by a new institution (reinstitutionalization) (Hond & Bakker, 2007: 905).

In this line of research, institutional scholars have paid attention to such concepts as institutional entrepreneurship (DiMaggio, 1988; Greenwood & Suddaby, 2006; Lawrence & Phillips, 2004; Maguire, Hardy, & Lawrence, 2004; Munir & Phillips, 2005), and multiple (and sometimes 'conflicting') institutional logics (Dunn & Jones, 2010; Friedland & Alford, 1991; Lounsbury, 2007; Reay & Hinings, 2005; Thornton & Ocasio, 1999). In some research, scholars examine the interplay between many levels of analysis (Haveman & Rao, 1997; Lounsbury, 2007; Marquis, Glynn, & Davis, 2007), investigate the interaction between practices and institutions (Lounsbury & Crumley, 2007; Phillips, Lawrence, & Hardy, 2004), and includes the conceptualization of institutional work – the work of creating, maintaining, and disrupting institutions – to understand the role of agents and institutional process (Dacin, Munir, & Tracey, 2010; Lawrence & Suddaby, 2006; Lawrence, Suddaby, & Leca, 2011; Zietsma & Lawrence, 2010). The emphasis on agency and institutional change elucidates the dynamism of institutional process that contains the periods of both change and stability in the institutional life cycle.

With focus on institutional change and agency, scholars examine why and how change occurs. Many studies of institutional change highlight exogenous factors such as shocks (Fligstein, 1991), jolts (Meyer, 1982), discontinuities (Lorange, Morton, & Ghoshal, 1986), and cultural anomalies (Hoffman & Jennings, 2011) as triggers for change. According to these studies, change occurs as a consequence of these exogenous factors "smacking into stable institutional arrangements and creating indeterminancy" (Clemens & Cook, 1999: 447). A few studies focused on endogenous sources of change that precipitated actors, despite being embedded within institutional contexts, to seek change. For example, Seo and Creed (2002) suggested the possible role of endogenous contradictions within organizational fields that could

lead to change. They proposed four sources of contradictions: 1) the gaps between the performance arising from conformity to existing institutions and from functional efficiency, 2) inability of fields to adapt to jolts, 3) intrainstitutional conformity that creates interinstitutional incompatibilities, 4) isomorphism that conflicts with divergence of interests. Seo and Creed (2002) suggested that these contradictions occur at the field level, setting 'praxis' for institutional change, whereby actors "move from unreflective participation in institutional reproduction to imaginative critique of existing arrangements to practical action for change" (231).

In addition, some studies developed models of institutional process underlying both stability and change. These models realize the influence of cognitive beliefs of actors in the institutional process and symbolic aspects of institutionalization. They include the creation of meaning as a mechanism used by actors to promote change and new structures or practices. Here, institutions, despite being considered as environmental constraints, can be manipulated or strategized. Tolbert and Zucker (1996) suggested the institutional process beginning from *habitualization*, the process of generating innovations such as new structures in response to particular stimuli. This process, they noted, can be classified as the stage of preinstitutionalization. The process of habitualization is followed by *objectification*, the development of social consensus on values of new structures, leading to increasing adoption by other organizations. The final stage is *sedimentation*, the historical continuity and survival of the structure over time across generations of organizational actors. Tolbert and Zucker (1996) argued that little attention has been paid to understanding how innovations moved across organizations and became reinstitutionalized, or according to their model of change, from objectification to reinstitutionalization. Rather, most work on diffusion take on rates of adoption as an indicator of the effect of institutionalization, while mechanisms of the diffusion were more or less ignored (Tolbert & Zucker, 1996). To probe with this deficiency in institutional accounts, they referred to the concept of theorization (Strang & Meyer, 1993). For new structures to be diffused, it requires agents, or 'champions' in the organizational change literature (DiMaggio, 1988), who need to achieve two major tasks of theorizations: creating generic problems that a set of organizations are facing, and justifying a particular structure as a solution.

Elaborating the work in this line, Greenwood, Suddaby, and Hinings (2002), distilling from extant literature, outlined a six-stage model of institutional change: 1) *precipitating jolts*

such as social/technological/regulatory upheavals that disrupt existing institutions by introducing new ideas and possibility of change; 2) *deinstitutionalization*, which involves emergence of new players or institutional entrepreneurship; 3) *preinstitutionalization*, whereby new structures or innovations were developed, or solutions were sought, 4) *theorization*, in which new structures and the need for change become abstracted and justified on the basis of pragmatic and/or normative legitimacy, 5) *diffusion*, during which structures gain social consensus on their pragmatic benefits, and 6) *reinstitutionalization*, when the density of the adoption provides structures with cognitive legitimacy, reaching the status of taken-for-granted or fully institutionalized status as the natural and appropriate structures.

In conclusion, the common theme across the work on institutionalization, diffusion and adoption of structures or practices is that organizations that face the same institutional pressures conform to cultural expectations, and thus take on similar structures or practices in order to obtain legitimacy. Institutions are associated with stability. However, institutional change can occur, when shocks or anomalies such as regulatory discontinuity, social upheaval, and technological disruption disturb institutional arrangements. These changes and uncertainty allow emergence of new players or institutional entrepreneurship, who introduce innovations as solutions. Theorization is the mechanism to legitimize new structures, and shape and accelerate the diffusion.

Although increasing accounts of institutional process include construction of meaning (i.e., theorization), they still neglect motivations underlying adoption, and ideational and symbolic aspects of structures or practices when being diffused across institutional contexts. Models, prototypes, or practices together with theorizing accounts attached to them were treated as concrete objects that can be moved across organizations without any alteration by organizations who adopt them. In this thesis, I adopt an alternative theoretical approach that treat institutionalization with more interpretative lens and social constructionism – the neo-institutional perspective of translation.

2.3. Translation

Neo-institutional theorists have noted there is "a startling homogeneity of organizational forms and practices" (DiMaggio & Powell, 1983: 148). This homogenization of organizations is explained in metaphorical terms as diffusion (Sahlin-Andersson, 1996). The diffusion model provides insight for the institutional process. However, it is criticized for its focus on the spread of structures, practices, and meaning as passive transmission, while neglecting symbolic and cultural elements attached to them (Zilber, 2002, 2006). It highlights organizational isomorphism, ceremonial adoption, and decoupling as consequences of the diffusion of identical organizational structures, while suggesting legitimating accounts as 'ready-to-wear' recitations of established cultural accounts (Creed, Scully, & Austin, 2002; Meyer & Scott, 1983).

The Scandinavian school of institutional theory, in contrast, proposes that the institutional process be viewed as translation. Inspired by John Meyer's studies, this line of research, early developed in Scandinavia and thus the origin of the name, discerns institutionalization as involving the circulation or travel of ideas (Czarniawska & Joerges, 1996; Czarniawska & Sevón, 2005; Sahlin-Andersson, 1996; Sahlin & Wedlin, 2008). The work in this research stream asserts that in order for structures or practices to diffuse, actors must construct localized legitimate meaning. The replacement with the translation metaphor sheds light on accounts that meaning as well as structural and practical aspects could change as they travel through time and space. While the 'diffusion' metaphor is argued to be based on the law of physics and imply passive transmission of an entity from one area to another, the 'translation' metaphor is applied from linguistics (Czarniawska & Sevón, 1996; Sahlin & Wedlin, 2008), and calls for attention to the richness of meaning, movement, and transformation of objects being translated.

In this line of research, institutions are formed as meanings come to be shared and taken-for-granted. In contrast to the diffusion metaphor that "connotes a transmission of a given entity", the translation metaphor "connotes an interaction that involves negotiation between various parties, and the reshaping of what is finally being transmitted" (Zilber, 2006: 283). The focus on construction and negotiation of shared meanings imply the importance of venues where interactions can occur (Greenwood et al., 2002). Professional associations, ad-hoc meetings between stakeholders, journals, and news/magazine accounts are examples of such venues,

which allow organizational communities within the same field to interact. This emphasis on the importance of meaning in the translation research is also shared with organizational discourse theory (Phillips et al., 2004). Shared meaning is created from collections of text or discourse, which evolve from the ongoing process of production, distribution and consumption of texts. Studying institutional mechanism and process, the research on translation examines the ideational or symbolic aspects of a particular structure, model, or practice when it travels across institutional settings and gets adopted by organizations in one institutional context.

The translation concept was originally derived from the French philosopher, Michel Serres (Czarniawska & Sevón, 1996) that has been broadly used in actor-network theory (Callon, 1986; Latour, 1986), and adopted by Scandinavian institutional theorists of organization studies (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996) to understand organizational change and institutionalization of structures and practices. Defined by actor network theory, translation surpasses the linguistic term. According to Latour (as cited in Czarniawska & Joerges, 1996: 24), translation means in this context — "displacement, drift, invention, mediation, creation of a new link that did not exist before and modifies in part the two agents." Applied in the Scandinavian institutionalist literature, translation refers to the modification that a practice or an idea undergoes when it is implemented in a new context (Boxenbaum & Strandgaard Pedersen, 2009).

Conceptualizing translation in this way, one might ask how this perspective is then different from existing theories of organization studies such as organizational adaptation and change (Chakravarthy, 1982; Jennings & Seaman, 1994; March & Simon, 1958; Meyer, 1982; Miles, Snow, Meyer, & Coleman Jr, 1978). Both perspectives share some similar interests. They examine the phenomenon of change in organizational contexts. Both account for organizational response to environmental change for the purpose of survival. Both pay attention to actors with focus on how individuals/organizations interpret environment and enact change. The key difference lies between the logic of appropriateness and the logic of consequentiality (Czarniawska & Sevón, 1996). Translation scholars argue that organizations and individuals act according to a logic of appropriateness (March, 1981; Sahlin & Wedlin, 2008). When they enact change, their decisions for actions are based on their classifications of the situations and their identities. Hence, for translation scholars, organizations and individuals are embedded in an

environment that provides them with identities, expectations, and rules for actions (Sahlin & Wedlin, 2008). For adaptation researchers, the logic of consequentiality or rational choice is used to legitimize actions enacted (Czarniawska & Sevón, 1996). These different logics that the scholars from the two schools draw on direct their focus to different contexualization and conceptualization of the phenomenon. While the adaptation literature focuses on how actors interpret environment and thus manage strategies, structures, and slack resources in the way that are the optimal fit with environmental conditions (Bourgeois, 1981; Miles et al., 1978), the translation literature focuses on the travel of ideas, forms, or practices; and examine how actors interpret and incorporate these objects into organizations thereby enacting change (Blomgren, 2003; Brunsson & Sahlin-Andersson, 2000; Forssell & Jansson, 1996; Sahlin-Andersson, 1996). While adaptation portrays organizations as rational actors who make choices of organizational design in response to environmental change, translation deems organizations as soft actors or agents who are both constrained by and construct institutions within their field, and this interaction influences their rationales, intentions, and actions when enacting change (Brunsson & Sahlin-Andersson, 2000; Meyer, 1996). Translation recontextualizes understanding of this phenomenon by including the notions of ideas, materialization, global/local time and spaces, imitation, legitimacy and institutions. It gives broad and rich descriptions of social constructionism with focus on interaction between actors, institutions, social and temporal mechanisms at the field level, which are not highlighted in the adaptation literature. In this thesis, the phenomenon of interest is regarding change within a field that stemmed from the introduction, adoption, and legitimation of a new and foreign organizational form. It involves the notions of institutional contexts and social constructions as processes of change. The translation perspective is therefore a suitable theoretical framing and analytical approach to understand how organizations and individuals act in relation to the introduced organizational form, the situation, and institutional environment in which they are embedded.

The neo-institutional definition of translation incorporates the notion that ideas when being diffused can be changed, modified, and even transformed. This is because meanings derive exclusively from connections to other elements in the context. Meanings thus change because some contextual elements are removed, while some are newly added (Boxenbaum & Strandgaard Pedersen, 2009). When implemented, organizational forms or practices gain connection to some

new contextual elements while losing others, causing different translations of the organizational forms and practices (Boxenbaum & Strandgaard Pedersen, 2009). Scandinavian institutional accounts extend the dominant institutional accounts of diffusion, showing that the results of institutionalization can be seemingly isomorphism across geographical boundaries, and at the same time local heterogeneity in symbolic and/or material aspects of objects being translated.

Czarniawska and Joerges (1996) described the translation model in relation to organizational change as a process in which actors in local time and space disembedded an idea from its institutional environment, and translate it into an object such as a text, a picture, or a prototype, which can travel from one time and space context to another. This idea is then translated and enacted into actions, and if repeated, stabilizes into an institution, which in turn could be described through abstract ideas and so on and so forth (Czarniawska, 2009; Czarniawska & Joerges, 1996). Elaborating this line of research, Sahlin-Andersson (1996) provided a more analytical approach to the process by describing translation as an editing process, and actors that are involved as editors. Editors can be researchers, professionals, leaders, and consultants. She questioned further what was exactly translated, which she conceptualized it as 'rationalization' – "stories constructed by actors in the exemplary organization, and their own translations of such stories" (Sahlin-Andersson, 1996: 78). As the imitating organizations often have no direct contact with the imitated organizations, the distance between the original source of the ideas and the receiving entity provides a space for translation in various ways. Sahlin-Andersson studied the circulation of the customer concept into public sector organizations and the imitation of research parks in Stockholm. Both studies showed that accounts of success in relation to the imitated ideas were formulated and reformulated. For the imitated ideas to fit in local setting, similarities among adopters were emphasized, while differences were downplayed. At the first glance, the editing process seems open-ended and depends on the creativity of editors. However, she found that the process actually conformed to three editing rules – context, logic, and formulation. This insight highlights the interaction between actors and institutional environment in the process of translation.

The common theme in the translation literature is that ideas change, as they are adopted in a new place or another point in time. "To imitate is not just to copy, but also to change and to innovate" (Sahlin & Wedlin, 2008: 219). The adoption of ideas is based on both the need for

conformity with expectations, and the need for differentiation and creativity (Czarniawska & Joerges, 1996). When circulating, ideas are subject to translations, and consequently evolve differently in different settings. The result of idea circulation is thus not only homogeneity but also local variation. It provides a more dynamic lens to understand institutionalization and adoption of new structures or practices, and shows the outcomes that go beyond ceremonial adoption or decoupling of rationalized myths from day-to-day activities. The translation literature shows that the consequence can be various, from change in organizational identities, field transformation, to institutional change (Sahlin & Wedlin, 2008).

Theoretical work, as noted above, provides broad accounts of idea circulation and translation. Most empirical studies referred to these theoretical frameworks to analyze how organizations incorporate circulating ideas from environment into their formal structures. The empirical work in this research stream has a strong tradition of using qualitative, case study approaches to understanding how ideas are translated, shaped, and changed in adopting organizations or local contexts (Sahlin & Wedlin, 2008; Zilber, 2006). Further, the preferred unit of analysis is a single organization interacting with institutional environment through the process of imitation.

Some empirical studies focus on mechanisms and outcomes of translation. For example, Erlingsdottír and Lindberg (Erlingsdottír & Lindberg, 2005) analyzed the three case studies of introduction of organizational form and practices into the Swedish healthcare sector: the introduction of 'quality assurance' to the healthcare sector, the accreditation to clinical chemical laboratories, and the 'chain-of-care' project in one region in Sweden. Their findings show that translation through the process of imitation can lead to homogenization of forms (isomorphism), and in some cases it can be the adoption of names only (isonymism), or homogenization of practices (isopraxism).

Other studies examine factors or conditions within the adopting organizations that guide and influence how they respond to the circulating ideas. Frenkel (2005) showed how the translation of the family-friendly organization from the U.S. into companies in Israeli was shaped and influenced by the past, including organizational memory and managerial traditions. Powell, Gammel and Simard (2005) studied the translation of new practices within 200 U.S.

non-profit organizations, and found that their responses were influenced by key features of the respective organizations, the nature of the carriers that exposed organizations to the new idea, and selective aspects of the encounter.

Some other studies use the metaphor of translation to discern the meaning and symbolic aspects of institutionalization. Zilber (2006) explored institutionalization as translation through the discourse of high tech in Israel. She found that institutionalization involves translation across institutional spheres (from societal to organizational field levels) and translation over time. Maguire and Hardy (2009) adopted the notion of translation to study deinstitutionalization of the DDT practice. Their finding illustrates how abandonment of practices results from translations of 'problematizations' over time change discourse in the way that disrupted institutional pillars of supporting practices.

A few other studies, which also shed light on the research issue of this thesis, examine how the process and the outcome of translation are influenced by local actors and institutional forces. Boutaiba and Strandgaard Pedersen (2003) investigated how Copenhagen Business School (CBS)'s translation of the MBA program into its own identity is shaped by institutional forces at the field level, including early and late adopters, and accreditation and rankings of business school in the overall field of MBA, and internal forces including the role of strategic actors, the process of enrolling the field audience into the strategic actor's vision, and symbolic communication. Boxenbaum (2006) analyzed how a group of Danish business actors translated the American practice of diversity management into Denmark. Her study showed possible negotiation over framing of the diversity management due to difference in individual preference, strategic framing to gain resources and support, and local grounding with the existing field frame to alleviate resistance and promote implementation. In their study of the Swedish healthcare sector, Erlingsdottír and Lindberg (2005) also found that when incorporating some activities of established practices into the imitated model, the model spread across other organizations in the field. The model appeared recognizable and unique in its combination of new and existing practices.

The empirical studies, discussed above, show broad mechanisms and outcomes of translation and how translation can be shaped and influenced by several factors at both

organizational and field levels. With a prominent exception of Boxenbaum's (2006) work, we however still have little insight into the detailed process of translation, and therefore we still lack understanding of why some translations succeed and others fail (Boxenbaum, 2006). We know that the creation of meaning is central to the translation process, but still know little about how actors actually select and mobilize the local elements in their institutional context to translate and edit the organizational form; how and why actors get motivation and abilities to translate the organizational form, given that they are bound by institutions in their field; or how they rhetorically promote the imitated organizational form so that it becomes popular, powerful and rise to the focus of attention in their local field at the particular time. These dynamics of translation somehow have evaded empirical inquiry (Boxenbaum, 2005). It is not because of the total lack of interest in this question. On the contrary, the call for a more agentic approach to institutional studies has been emphasized by neo-institutional translation scholars. This limitation could be attributed to research designs and analytical focus, which are arguably not suitable to examine in detail how actors act in translation.

The lack of suitable research design and analytical focus can be explained as follows. Most writings on translation began with a strong emphasis on institutional processes through which institutions in local contexts affect the nature of organizational forms in new contexts such as their associated structures, symbolic, and contents (Boxenbaum, 2006; Frenkel, 2005). However, we have also seen some cases in which some organizational forms were perceived so foreign that they seemed impossible to be transposed over, but still could be successfully translated into a new context (Boxenbaum, 2006). Meanwhile, some cases showed that there were significant similarities between the original and the new contexts. Yet, the translation could not easily succeed, and could take long time that the translators became relatively late adopters (Boutaiba & Petersen, 2003). Because of the lack of these insights, I contend that we still know little about the degree of agency attributed to actors in translation, and we still lack understanding of how the translation process actually operates. I suggest that research on translation should stem from a focus on the influence of institutions, to a focus on sets of actions that interact with institutions in the translation process (Lawrence et al., 2011). We should examine the connection among actors, actions, and institutions; while taking into account

intentionality as well as institutional influence that actually form the dynamics of the translation process.

Another reason is that little attention in institutional studies has been paid to the dynamic movement of organizational forms from one institutional context to another. The context that should be particularly highlighted is the one in which an organizational form travels across fields that have some significantly conflicting values and beliefs. Most studies on diffusion investigated the spread of organizational forms with quantitative methods, and used adoption as the indicator of the institutionalization effect. For the translation school, it is true that there are a number of studies of the transfer of organizational forms from one place to another. However, the significance of distinctiveness and difference between the original and the receiving fields has surprisingly gained little attention. In this line of research, organizational forms are treated as rationalized myths, and actors somehow pick them up from the environment and adopt them. However, the inherent logics or values of the original field, which affect symbolic and material elements of the organizational form and can fully or partly conflict with the dominant logics and values of the new field, has not been delineated. Due to the lack of attention to this area, existing studies risk providing vague accounts or misunderstanding of how organizational forms are translated into new fields (Greenwood et al., 2008). This lack of attention is surprising, because organizational forms are closely related to the concepts of legitimacy and institutional logics (Greenwood et al., 2009). Inspired by Sander and Tuschke's (2007) work, Greenwood and his colleagues have recently called for future research to study the diffusion of organizational forms across distinct fields, particularly in cases where organizational forms move from "one institutional environment, where it is widely prevalent and taken-for-granted, to another environment, where its introduction violates all three of Scott's pillars of legitimacy." My research helps illuminate this deficiency in institutional studies.

Furthermore, another crucial reason is that little attention has been paid to the temporal dimension in the translation studies. Most empirical studies of translation focus on a group of individuals that select an organizational form or a practice from institutional environment at one point in time and adopt it. However, in the case of translation, particularly across distinct fields, it is highly likely that translation takes time and repetition to succeed, as the organizational form confronts some extent of resistance due to conflicting logics or values. Moreover, some studies

even show that the organizational form has already traveled into the receiving institutional context and appeared in sources such as journals and newspapers prior to the adoption of the organizational forms by a focal actor (Boxenbaum, 2006). That means the organizational form has already been translated by other actors in the field before a focal individual or an organization, which in some literatures could be conceptualized as a champion or an institutional entrepreneur (DiMaggio, 1988), picked it up and translated it. By examining the phenomenon at one point in time instead of as a process that contains historical and temporal dimensions, these studies risk missing intertwined causes and effects as well as actions by multiple actors that could also be active agency in translating the organizational form, refining institutions and promoting change in their field.

In conclusion, the questions of how actors translate an organizational form into their context, and how/why translations are successful remain largely unresolved. This is because of unsuited research design and analytical focus to unpack the detailed process and mechanisms of the translation. This research contributes to this deficiency by analyzing interaction of actions, actors, and institutions.

2.4. Theorization

Theorization is the central concept to understanding institutional mechanism and process. Over the past two decades, scholars have paid increasing attention to unbundling the process of theorization (e.g., Greenwood et al., 2002; Strang & Meyer, 1993; Strang & Soule, 1998; Suddaby & Greenwood, 2005; Tolbert & Zucker, 1996). Theorization connects to one of the key concerns in institutional literature, which is the conferring of legitimacy (Greenwood et al., 2002). Strang and Meyer (1993) suggested that for new structures or practices to become legitimate, they need to be theorized. According to Strang and Meyer (1993: 492), theorization is defined as "the self-conscious development and specification of abstract categories and the formulation of patterned relationship such as chains of cause and effect." Elaborating the work on theorization, Greenwood, Suddaby, and Hinings (2002) explained that theorizing accounts simplify and generalize new structures or practices and the outcomes they produce. Basically, theorization is "the process whereby localized deviations from prevailing conventions become abstracted and made available for wider adoption" (Greenwood et al., 2002: 60).

According to Tolbert and Zucker (1996), theorization consists of two major tasks: specification of a general organizational failing or a problem, and justification of new structures or practices as the solution. Greenwood, Sudday, and Hinings (2002) added that justifications can be done by predicating functional superiority or pragmatic legitimacy (Suchman, 1995), or by aligning new ideas with normative or moral approval. In effect, theorizing means framing problems, justifying solutions, and relating causally to particular outcomes.

According to the model of institutional change (Greenwood et al., 2002; Tolbert & Zucker, 1996) successful theorization is followed by diffusion. An interesting question is then how to create theorizing accounts that are so compelling and powerful that induce diffusion. Strang and Meyer (1993) propose that it depends on *who* theorize and target *whom*. They hypothesized that the more complex and abstract the theorization is, the more rapid diffusion will be, and the less diffusion will be structured by differences among adopters. In other words, more global and general theorization generates much broader and faster diffusion. This notion directs attention to culturally legitimated theorists e.g., scientists, intellectuals, policy analysts, and professionals, who can construct and promote theoretical formulations. Theorization can be both bottom-up and top-down process (Zilber, 2006), which means individuals can create their own theories, while they can also pick up global theories or models and use them in their context. In this process, culturally legitimated actors shape diffusion by promoting their theorizing accounts. However, for diffusion to occur, theorization also needs supports from other groups of actors. Therefore, it needs to be compelling to relevant audience in the field. As Strang and Meyer stated (1993: 495) "models must make the transition from theoretical formulation to social movement to institutional imperative." In addition, theorizing is also about defining populations of organizations, "where diffusion is imaginable and sensible" (Strang & Meyer, 1993: 495-496). Hence, to theorize is to address the questions: why potential adopters should attend to the behavior of one population but not others, what effects the new structure or practice will produce, and why it is needed instead of existing arrangements (Hond & Bakker, 2007: 905).

Empirical work has analyzed theorization as a mechanism for justifications of societal ideologies for changing field logic (Wright & Zammuto, 2013), justifications of innovations or new organizational form (Greenwood et al., 2002; Tracey, Phillips, & Jarvis, 2011), justifications of new practices in emerging fields (Maguire et al., 2004).

A handful of institutional research, which employs the notion of theorization to understand the role of meaning in institutional process, is presented as follows. Drawing on the case of change and the emergence of a new organizational form (multidisciplinary practice) in the professional business services in Canada, Greenwood and his colleagues suggest that professional associations play the significant role in promoting change through theorization. Their finding also extends current understanding that, in a highly normative setting, justifications are not exclusively based on pragmatic legitimacy, but also significantly on normative alignment. Suddaby and Greenwood (2005) also examined the emergence of the multidisciplinary partnerships, but, in North America. Their analysis focused on the discursive struggle and different theorizations of those who supported and those who were against the new organizational form. Their finding showed that some organizational forms are created through a discursive process of theorization. Maguire, Hardy, and Lawrence (2004) examine the emergence of new organizational fields through the case study of the emergence of the Canadian Treatment Advocates Council (CTAC), an organization that established new practices of consultation and information exchange among HIV/AIDs community organizations and pharmaceutical companies. Their finding shows how institutional entrepreneur, who do not occupy dominant positions, could employ capacity of theorization to gain supports from multiple groups of relevant actors in the emerging field. Tracey, Phillips, and Jarvis (2011) drew on institutional work to empirically examine the role of institutional entrepreneurs in creating a new organizational form by bridging institutional logics. One of the work institutional entrepreneurs engaged in is theorizing the template of the new organizational form. This insight suggests that theorizing the organizational form involves articulating the essential elements of the organizational form which are distilled from the underlying logics or values of multiple stakeholders, and formed the foundations of the new logic on which the new organizational form is based.

Despite increasing attention to unpacking the model of theorization, "current understanding of theorization is sketchy because little empirical work exists (Greenwood et al., 2002: 75). An inevitable corollary is that we still know little about the role of theorization in the translation process of organizational forms across institutional contexts. Theorization is usually understood as a macro mechanism of how organizational forms diffuse. Due to this

understanding, theorizing accounts, associated with the organizational form, are understood as moving automatically across fields that are socially constructed as similar (Strang & Meyer, 1993). Influenced by this school of thought, most scholars, who examine theorization, pay attention to the preinstitutionalization stage – how change occurs, and how a new organizational form is created and theorized by an institutional entrepreneur – rather than theorization in the diffusion stage and institutionalization per se. Therefore, we still know little the role of theorization in legitimating organizational forms when they move from one institutional field to another.

Another reason is that the Scandinavian scholars suggested replacing diffusion with the concepts of translation and editing as depictions of institutional processes. As a central component for diffusion, theorization is treated separately from the translation model. I argue that these notions can be treated as complementary, rather than separated approaches to understand institutional processes. Recently, some scholars have acknowledged the co-existence of theorization and translation in institutional processes (Boxenbaum & Battilana, 2005; Zilber, 2008), as both notions share the same interest in the work of meaning and symbolic in institutional processes (Zilber, 2008). This intertwined relationship is waiting to be unraveled to gain more understanding of the interaction between micro- and macro-level actions in institutional processes.

By adopting theorization, I argue that we can advance our understanding of translation as involving both micro and macro mechanisms. Translation provides the lens of micro constructionism to understand how actors with motivation and ability at the particular time edit symbolic and material elements of the organizational form. The selected elements of the organizational form through translations can be used by the same actors to theorize why the field needs change and render the organizational form sensible and compelling to the field audience. The tasks of theorizations are particularly useful to understand the macro mechanism in the translation process. In fact, theorization provides a more nuanced view of how editing is actually done by showing the necessary tasks (specifying problems and justifying solutions) for constructing legitimating accounts for the organizational form to be socially accepted and adopted in the new receiving field. Actions of theorizing and translating interact in attempts to legitimize a foreign organizational form. With this conceptual framework, I postulate that in the

translation process actors engage in translating the organizational form by emphasizing and/or downplaying some of its properties to render the combinations fit with the receiving field, while using these distilled properties in constructing theorizing accounts for the organizational form. These theorizing accounts form the basis not only for change within the receiving field, but also diffusion across institutional fields.

By adopting theorization in the context of the translation process of foreign organizational forms, this research also contributes to current understanding of theorization, specifically the role of theorization in the translation process. Most institutional studies choose either theorizing or translating/editing as an analytical approach to analyzing the creation of meaning and institutional process. In this thesis, I argue that theorization can also be studied as a mechanism within the translation process, in which ideas or organizational forms are successfully translated or get adopted.

2.5. Organizational fields

The idea of an organizational field is a central concept to institutional theory. It represents an intermediate level between organizations and society, and is central to understanding the process by which organizational forms or practices become disseminated (Greenwood et al., 2002). According to DiMaggio and Powell (1983: 148), organizational field refers to "those organizations, in the aggregate, constitute a recognized area of institutional life." By this definition, DiMaggio and Powell (1983) pointed that organizational field directs attention not only to competing firms or networks of organizations, but to 'the totality of relevant actors' such as key suppliers, consumers, regulatory agencies, and other organizations that produce similar products or services. Also, by this definition, organizational field suggests focus on 'sets' or 'communities' of organizations (Porac, Thomas, & Baden-Fuller, 1989) that interact with each other and influence each other in a meaningful way (Greenwood et al., 2002).

In his 1994 work, Scott provided another definition which enriches understanding of the concept of organizational field: "a community of organizations that partakes of a common meaning system and whose participants interact more frequently and fatefully with one another than with actors outside the field" (cited in Scott, 2001; Scott, Ruef, Mendel, & Caronna, 2000).

This definition further explains that the patterns of interaction among organizational communities within the field are based on shared systems of meaning, which establish boundaries of organizational communities, defined membership, the appropriate ways of behavior, and patterns of interaction between groups of organizations (Hinings, 2012; Lawrence, 1999). Over time, these shared systems of meaning might be reinforced by regulatory agencies such as the government and professional associations, which coercively and/or normatively ensure conformity of field constituents to collective beliefs and expectations. Deviations from such prescriptions cause some types of sanctions and require justification of departures from social norms (Deephouse, 1999; Elsbach, 1994; Greenwood et al., 2002).

Some scholars view an organizational field as a central arena for dialogue and discussion. Based on this view, an organizational field needs not to be formed around the same products, technologies, or industries, but around issues that bring together various constituents with different interests and purposes (Hoffman, 1999). These field constituents might have opposing and different perspectives towards the same issues that binds them together. Therefore, on the one hand, a field is conceptualized as communities of organizations bound together by shared meaning system (Scott, 2001). On the other hand a field can be viewed as a zone of institutional war (Hoffman, 1999), in which actors compete over meanings of the issues (Zietsma & Lawrence, 2010). Through the case study of change in harvesting practices in the British Columbia coastal forest industry, Zietsma and Lawrence (2010) examined the transformation of organizational fields. They extended the understanding that shared systems of meaning dominate during the institutional stability, while conflict and competition emerge when institutions go through the period of change.

In addition, an organizational field can be described as a system of relations (Greenwood et al., 2002; Sahlin-Andersson, 1996; Zietsma & Lawrence, 2010). In an organizational field, central and peripheral actors emerge. Central actors with control over resources or dominant organizations that are perceived as influential and successful are points of reference for other organizations in the field. It is widely acknowledged that central or dominant actors, particularly in mature fields, maintain their status quo, which are supported and facilitated by existing institutional arrangements, and therefore resist change. Institutional change in the mature fields is often a result of attempts and actions undergone by peripheral actors. As a reference system, an

organizational field also shapes attentions and identities of actors in the same field. Dominant organizations are seen as examples, and perceived as sharing some similarities with organizations that want to imitate. The shared belief, meaning, and conformance to the definition of what activities are all about bind the field together (Sahlin-Andersson, 1996).

Take the healthcare as an example. Although the healthcare field comprises multiple professionals and groups of stakeholders that sometimes their interests could be competing, e.g. the competing interests among medical academics, clinicians, healthcare professionals as well as hospital managers. However, the healthcare field is ultimately grounded in the common belief that it is important to improve health and well-being of patients and populations. How to improve could be different among the eye of different groups of actors. Health researchers and academics might view that healthcare should be innovative, driven by research and discovery breakthroughs. Meanwhile, clinicians might view that good healthcare has to respond to the need of patients and has to do with efficient management in delivering services, i.e. waiting-time reduction, sharing facilities for cost reduction among health providers. Whatever their interests are, their activities are formed around the issues of healthcare and patients.

As DiMaggio and Powell (1983) emphasized, organizational field needs to be defined empirically. It is an analytical construct and is identified by observers (Sahlin-Andersson, 1996). Four parts of the institutional definition of an organizational field were suggested: "an increase in the extent of interaction among organizations in the field; the emergence of sharply defined interorganizational structures of domination and patterns of coalition; an increase in the information load with which organizations in a field must contend; and the development of a mutual awareness among participants in a set of organizations that they are involved in a common enterprise" (DiMaggio & Powell, 1983: 148). Fields may empirically be defined at industrial, national, and international levels (Boxenbaum & Battilana, 2005).

Accordingly, I conceptualize the field as organizational field of various groups of actors, who define their activities as being concerned with similar issues. Their interactions, structures of relationship, and appropriate behaviors are defined by shared systems of meanings.

The organizational field under the study of this thesis is the British healthcare. The healthcare sector comprises several different professionals, e.g. clinicians, clinical academics,

managers, health authorities; and various activities, ranging from primary care to tertiary care. Despite diversity of groups of actors and activities involved, it is widely acknowledged that the healthcare sector can be regarded as an organizational field (see for example Erlingsdottír & Lindberg, 2005; Scott et al., 2000).

In this thesis, I employ the term 'healthcare' to describe the field of study. Healthcare (or sometimes referred to as health system) refers to the system of the interrelationship among organizational constituents to provide and deliver healthcare that meets the need of target populations. According to the World Health Organization (WHO), "a good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies" (World Health Organization, n.d.). According to these definitions, healthcare around the world is based on the same goal – quality health services for everyone. Differences across countries are rested upon various configurations of organizational constituents and stakeholders, structures of and interaction pattern between these organizational constituents within fields, and social construction of meaning in each national setting, which guide and shape belief, attention structures and identities for actors within each field.

My analysis focuses on the creation of a new and foreign organizational form (AHSC), which affects the change in the relationship between universities and NHS teaching hospitals in the British healthcare. There appears to be a more specific term in healthcare journals, namely academic medicine, which refers specifically to the interface between medical schools and associated hospitals (for example Davies, 2002; Ovseiko, Davies, & Buchan, 2010). Still I choose healthcare over academic medicine. This is because in my empirical analysis I found that there were several groups of stakeholders involved in the creation of AHSC (e.g., the governmental departments and agencies, funding agencies, general district hospitals, primary care providers), more than only the two communities of organizations i.e., NHS teaching hospitals and universities.

2.6. Organizational forms

The object of my analysis is the actors' construction of meaning related to the adopted foreign organizational form. How new organizational forms arise, become widely adopted, and established has been acknowledged by many influential scholars as an important area in organization studies (e.g., Daft & Lewin, 1993; Romanelli, 1991). Interest in this question dates back to Stinchcombe's (1965) seminal work in sociology, in which he proposes that the range of organizational forms existing at any point in time is a product of innovative organizational responses to environmental conditions (Romanelli, 1991; Tucker, Singh, & Meinhard, 1990). His work emphasized the connection between environments and the creation of organizational forms (Tucker et al., 1990). However, understanding new organizational forms is not without difficulties (Greenwood & Suddaby, 2006). In addition, no consensus has been reached on how organizational forms should be defined (Lewin, Long, & Carroll, 1999).

Organizational forms, according to Romanelli (1991: 81-82), broadly refer to "those characteristics of an organization that identify it as a distinct entity and, at the same time, classify it as a member of a group of similar organizations." Hannan and Freeman (1977: 935) defined an organizational form as "a blueprint for organizational action, for transforming inputs into outputs." Ingram (1996: 85) defined a form as "the combination of an organizational structure and an organizational strategy." According to Rao and Singh (2001: 244), organizational forms are defined as "novel recombinations of core organizational features involving goals, authority relations (including organization structures and governance arrangements), technologies, and client markets." Based on these definitions, organizational forms are rationalized and presented as solutions to problems.

For neo-institutionalists, problems are also socially constructed (Hargrave & Van De Ven, 2006). Therefore, organizational forms are means to legitimate ends. In institutional theory, organizational forms are regarded as "incarnations of beliefs and values" (Haveman & Rao, 1997: 1611), and are basically a meaning system or cultural entity that interplays with its environment. Greenwood and Suddaby (2006: 30) defined organizational form as "an archetypal configuration of structures and practices given coherence by underlying values regarded as appropriate within an institutional context." Thus, from a neo-institutional perspective,

organizations embody shared social meaning, which sometimes are conceptualized as institutional logics (Friedland & Alford, 1991; Kitchener, 2002; Scott, 2004; Thornton & Ocasio, 1999), and require legitimacy to be viable and "taken-for-granted as a social fact" (Rao, Morrill, & Zald, 2000: 242). In other words, they "converge isomorphically around increasingly taken-for-granted templates" (Greenwood & Suddaby, 2006: 28), shaped by shared meanings or institutional logics in the field. Based on this view, therefore, organizational forms are not only reflections of rationality and efficiency, but also formulated according to social expectations, socially perceived issues as important, and rationalized myths to achieve legitimacy (Meyer & Rowan, 1977). Organizations rely on legitimacy to avoid difficulty in attracting resources and qualified workforce. To gain legitimacy, organizations conform to institutions on which they are dependent (Meyer and Rowan, 1977). Thus, change can be explained by the prevailing institutional forces (Erlingsdottír & Lindberg, 2005).

However, organizations are not merely open systems that are influenced by institutional environment, but are also constructed by actors. Based on Selznick's (1957) work on organizational selves, Kraatz and Block (2008) contend that institutional pluralism engenders a type of self-governing pluralistic organization with "the capacity to constitute itself by choosing its identities and commitments from the menu of choices presented by its would-be constituencies and by society at large" (255). This notion highlights agency of organizational actors, despite constrains imposed by institutional environment. Since an organizational field often contains multiple social meanings, it gives actors a range of choices to construct an organizational form towards the limits imposed by institutional context.

Therefore I consider an organizational form as an open system, which embodies elements in the institutional environment and at the same time is constructed by actors through construction of social meanings and accounts of legitimacy related to the organizational form.

Most institutional studies on organizational forms focus on how new organizational forms arise, gain legitimacy, and become established in relation to institutional change (Greenwood & Suddaby, 2006; Suddaby & Greenwood, 2005; Tracey et al., 2011). Suddaby and Greenwood (2005) concluded three elements involved in the emergence and legitimation of new organizational form. First is the conferring of legitimacy that renders new organizational forms

desirable and proper (Suchman, 1995). Second is the shift in the dominant logics that frames actors' reasoning and belief (Friedland & Alford, 1991). Third is the strategic use of rhetoric or persuasive language to generate shift in institutional logics. These three elements focus on the role of language in the creation and legitimation of new organizational forms.

This thesis focuses on the conferring of legitimacy. Suchman (1995: 574) defined legitimacy as "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions." Suchman further identified three forms of legitimacy that can be used as analytical assessment: pragmatic, moral (normative), and cognitive legitimacy. The focus of this thesis is not on the emergence of new organizational forms, but on the legitimation process of a new organizational form when it travels into a new institutional setting. We know little about how organizational forms gain legitimacy when they travel across distinct organizational fields (Greenwood et al., 2008). While the organizational form diffuses, it is increasingly objectified and gains social consensus on its values. During this process it might be already perceived as legitimate in the original field. However, when it travels into a new organizational field, it might face resistance or be found conflicting with prevailing meaning and beliefs of the new organizational field. Thus, the role of actors is required in the legitimation of the organizational form.

Most research on institutional process and adoption of managerial innovations such as organizational forms explains the phenomenon through processes of mimicry (Mizruchi & Fein, 1999). The American school proposes the concept of mimicry as one explanation, and depicts the process of the innovation spreading as diffusion from one context to another. The underlying explanation is that objects achieve legitimacy because they are adopted by exemplary others, and are thought to provide some economic benefits (Scott, 2001). Organizations therefore mimic because they anticipate the similar outcomes. As a result of the increasing number of adoptions and the amount of information available in the field, objects gain social consensus on pragmatic values, before diffusing even further. When the adoptions become dense, objects achieve cognitive legitimacy, become taken-for-granted as appropriate and rational things to do (Suchman, 1995). The theoretical concept of theorization is served to explain the mechanism of how organizational forms achieve legitimacy and become widely adopted (Strang & Meyer,

1993; Greenwood et al., 2002). The outcome of the process is an observed phenomenon of homogeneity of organizational forms and practices within an empirically defined institutional context (i.e., organizational fields). Theorization serves as the mechanism for conferring of legitimacy (Greenwood et al., 2002) and constructing the discursive meaning in the institutional process.

The Scandinavian schools view such process as imitation, and use the translation metaphor to depict the process of idea or managerial innovation spreading. The research in this tradition has paid attention to the transformation of the contents and forms of ideas, when they travel. A common theme is that ideas do not remain unchanged as they travel within or between contexts, but are subject to translation (Czarniawska & Joerges, 1996; Sahlin-Andersson, 1996; Sahlin & Wedlin, 2008). Ideas are actively translated in a context of other ideas, actors, tradition, and institution. Therefore, to imitate is not only to copy, but also to change and innovate. This brings actors and interests into analysis. As diffused, ideas evolve differently in different contexts throughout their circulation. This leads to not only homogeneity, but also local variation and stratification. The term, editing, is used to depict how ideas are translated across and within context(s) (Sahlin-Andersson, 1996). Translating/editing focuses on constructions of social meaning related to the adopted organizational forms so that they become compatible with new institutional contexts.

In this thesis, I adopt the translation process to understand how new and foreign organizational forms obtain legitimacy when they travel across organizational fields. Conceptualizing the adoption of foreign organizational forms as the translation process, I specifically analyze the creation of meanings and efforts in relation to the legitimation of the foreign organizational form, by drawing on institutional approaches of translating/editing and theorizing. The translation model provides me with a more micro lens to analyzing the dynamics of the process when a new organizational form diffuses or travels into a new organizational field, especially when it travels from the original field that can be perceived as so distinct that that any ideas or innovations travel from the field could be viewed as incompatible.

2.7. Research questions

I draw on institutional research that treats the spread of organizational forms as the translation process. Ideas in the form of organizational forms, when circulating globally, are translated to fit local contexts. However, little attention has been paid to unpacking the detailed process of translation. Specifically we know so little regarding the efforts and strategies of actors in creating meaning, mobilizing symbolic and material resources in the local context, and promoting the imitated organizational form to become appealing, powerful, and legitimate in the new receiving society. Moreover, it still remains unclear how, for example, translators (e.g., researchers, policy-makers, organizational actors) work in the translation process, formulating and reformulating the idea, especially when the organizational form is "perceived as so foreign that they defy translation" (Boxenbaum, 2006: 939). I argue that the work on translation calls for more longitudinal research, in contrast with research that focuses on translation at one point in time. Such longitudinal research would be helpful in gaining further understanding of the process of translation including the effect of institutional context and the role of interacting translators in creating meaning, shaping, and promoting the translation of the organizational form into a specific one.

In the light of the literature review and discussion of deficiency, I propose the following research questions:

- How is a foreign organizational form translated across institutional contexts, and over time becomes legitimate in a new institutional context?
- What tasks of theorizations are required to legitimize a foreign organizational form? What is the role of theorization in the translation process?
- What accounts for successful translation?

Chapter 3.

METHODOLOGY

The chapter proceeds as follows. In the first section, I described the research design with three research strategies: qualitative case study, longitudinal research, and process research. Then I described methods and sources of data collection along with approaches of triangulation. Next I presented the research context, which provides the background of the translated organizational form (the U.S. AHSC), and the narrative story of the focal object of translation in this study (the British AHSC). Finally I describe the three analyses that contribute to understanding the translation process of a foreign organizational form.

3.1. Research design

This thesis aims to examine the translation process of an organizational form. Specifically, it aims to understand how an organizational form is translated so that it wins legitimacy in a new institutional setting, even though the original and the new settings are significantly different. As discussed in the chapter of literature review, I argue it is the area into which we still have little insight, and need more systematic and nuanced approaches. To explore the translation process and explain what accounts for successful translation, I employed a variety of research strategies, including a qualitative single-case study, a longitudinal study, and process research. Together, these approaches form in-depth investigation and explanation of the phenomenon of my interest with aims to elaborate existing theories of institutional translation and adoption of organizational forms.

3.1.1. Qualitative, case-study strategy

Tolbert and Zucker (1994) stated that there was little consensus on research methodology within institutional theory. Institutional studies have used a variety of research strategies and

techniques such as case studies, cross-sectional regression, and longitudinal models of various types (Tolbert & Zucker, 1994). Consequently, research methods, techniques of data collection and analysis are various. In addition, most research, particularly those influenced by the American school of institutional studies and diffusion, has used quantitative, macro-level approaches to test theory (Greenwood et al., 2008; Lawrence, Hardy, & Phillips, 2002). However, for research on translation, the preferred methodology is more interpretative, qualitative approaches (Zilber, 2002, 2008). Researchers in the translation school argue that research on institutional process needs empirical investigation of motivation and meaning underlying the adoption. Otherwise, there is high risk that false conclusions might be drawn (Zilber, 2008).

I adopted a qualitative, single-case research design because I needed an approach to analyze rich data and to further understanding and elaborate current knowledge on translation. In this thesis, I investigate how the organizational form, when being diffused globally, is translated to fit and become legitimate in the new institutional context. My framing with the 'how' question is based on the intention to describe and explain "the temporal sequence of events that unfold" over time (Van de Ven & Huber, 1990: 213), as transformation of the circulating idea and change within the receiving field occur in the translation process. Conducting a qualitative case study inevitably leads to difficulties in singling out levels of analysis (Langley, 1999). In this thesis, I focus on three levels of analysis: 1) the role of actors and meaning in the translation process as mechanisms, 2) change in the object of translation as an outcome, and 3) change in the receiving field as both mechanisms and outcomes.

Through qualitative methods and techniques, I am able to manage and process large amount of qualitative data, while interpreting, simplifying, and reconstructing new insights to fill gaps between theory and evidence. Conducting qualitative study has three purposes: generation of theory, elaboration of theory, and testing of theory (Lee, Mitchell, & Sablynski, 1999). The primary impetus for this study was theory elaboration, which "occurs when preexisting conceptual ideas or a preliminary model drives the study's design" (Lee et al., 1999: 164). In addition, one of the main reasons for conducting qualitative case-study research is to take into account the context (Langley, 1999; Saunders, Lewis, & Thornhill, 2009; Yin, 2009).

The case study is a research strategy that explores dynamics in single settings (Eisenhardt, 1989). Robson (2002: 178) defined case study as "a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence." According to Yin (2009: 13), case study is "a method of enquiry that allows a contemporary phenomenon to be investigated in context." It is thus particularly appropriate for this research as it examines the role of actors and change in material and symbolic aspects of the translated organizational form, embedded in the context of the British healthcare field. The research strategy of case study is likely to involve multiple levels of analysis (Yin, 2009). The techniques and methods of data collection are various, and tend to be used in combination (Eisenhardt, 1989), such as interviews, archives and documentary analysis, and observation. As it can involve various methods of data collection, triangulation of data is important. Triangulation refers to the use of different methods of data collection within the same phenomenon in order to contribute to the data interpretation from different views and ensure the internal validity of the study (Miles & Huberman, 1994).

In conclusion, the qualitative case-study approach is appropriate for this thesis for three reasons. First, it is the tool to develop theoretical and empirical understanding of an unfolding institutional process within its real-life context (Greenwood & Hinings, 1996; Kitchener, 2002; Yin, 2009). Second, it is the best way to offer close and detailed insight into a complex set of related practices (Eisenhardt & Graebner, 2007). Furthermore, as this study involves the analysis of the historical processes, it is best examined by a qualitative technique in order to clarify sequences of events and disentangle overlapping causal factors (Eisenhardt & Graebner, 2007).

The case study – the creation of the British AHSCs – is suitable for conducting this research. The information regarding the emergence of AHSC within England is traceable and tractable. The written documents regarding the issue are limited to countable numbers of materials, yet not too little to provide rich information for addressing research questions and conducting quality qualitative research. In addition, as AHSCs were recently established in England in 2009, the key informants at the time of their establishment are available for interviewing. Based on the available data from both interviews and documents, it is a suitable project for a doctoral research.

3.1.2. Longitudinal study

The strength of a longitudinal study is the capacity to study change and development (Saunders et al., 2009) within the phenomenon of interest. To explore the dynamic process of change, longitudinal research is necessary to provide details of how the process plays out (Siggelkow, 2007).

I adopted the longitudinal study over the cross-sectional study because the case of AHSC took a long time frame from 1987 to 2009. Within this time frame, I observed many events, multiple actors, and change in meaning of the organizational form that interacted and played out over time. If I have focused only on 2006 – 2009, when the AHSCs were created, I would have missed previous sequences of events and key actors that also influenced the translation. The longitudinal study therefore enables me to collect data at different points in time that were connected, and together constituted the dynamic process of translation of organizational forms.

3.1.3. Process research

Pettigrew (1997) defined process as "a sequence of individual and collective events, actions, and activities unfolding over time in context" (338). This definition fits with the purpose of this research, which is to understand the process of translation over time.

Process research and longitudinal research go well together, as both strategies provide researchers with the capacity to understand how and why events in the phenomenon play out over time (Langley, 1999).

Langley (1999) identified seven strategies of process research, among which three are adopted in this research: narrative strategy, temporal bracketing strategy, and visual mapping. Narrative strategy involves construction of a descriptive story from the data. Temporal bracketing strategy is used to structure the time frame from the data into successive periods to facilitate analysis of this study. Visual mapping involves creation of graphics to allow presentation of large amount of data into the forms that can be easily discerned, and is also useful to develop and verify theoretical ideas (Langley, 1999).

3.2. Data collection

3.2.1. Interview

I began my data collection by interviews. My primary contact was the former minister in the Department of Health (Professor Lord Ara Darzi), who promoted the establishment of AHSCs at the governmental level, which led to the designation process of the AHSC status in England in 2009. He then recommended other informants who were involved in the designation process of AHSC, and those who would be most able to inform the research questions concerning the idea and formation of the AHSCs in England. I then contacted all the recommended informants, and received permission to conduct interviews.

Subsequently, I visited the sites of the five AHSCs, and conducted interviews with at least one representative of each organization. During the process of data collection, I employed considerably 'a snowball technique' (Gioia, Price, Hamilton, & Thomas, 2010), by which I asked each interviewee for recommendation of whom I should meet. Taking place from September 2010 to February 2011, the interviews were conducted 18 in total, lasting from 20 minutes to one and a half hour. All interviews were recorded and transcribed, except the one in which the interviewee requested not to be recorded. In this case, the field note was taken. Each interviewee was asked to describe AHSC in general (i.e., where did it come from? What is it?), their activities or any involvement with the history and creation of the British AHSCs, their perception about AHSC and general response to the AHSC organizational form in the British healthcare. The informants include government officials, senior management and staff of the five AHSCs, and field experts (see Table 3-1 for summary). Each informant has played active roles in creating the British AHSCs, particularly during the period between 2008 and 2009. Two out of eighteen interviewees have already known AHSC and involved in discussion regarding the implementation of this idea since 1990s. Therefore, they provided rich information regarding the history and the context that was both against and supporting the development of AHSC in the field of the British healthcare over time.

As the first AHSC was created in 2007 by Imperial College and its NHS partners, followed with the government's designation of the five AHSCs in 2009, the recent history would

suggest the process that went into the formation of the AHSC in England are relatively fresh in the minds of the people who created it. The interview data thus is very important for examining the formulation and creation of AHSC during the time between 2006 and 2009. However, AHSC has been associated with the problematization of the NHS/university relationship, my research traced back to late 1980s, when the problem was first constructed and AHSC was later introduced as a solution. To examine the translation during that early period (1987 – 2005), I relied significantly on secondary accounts to understand what transpired in the process, complemented with the interviews with those who experienced and involved in the discussion of AHSC at that time.

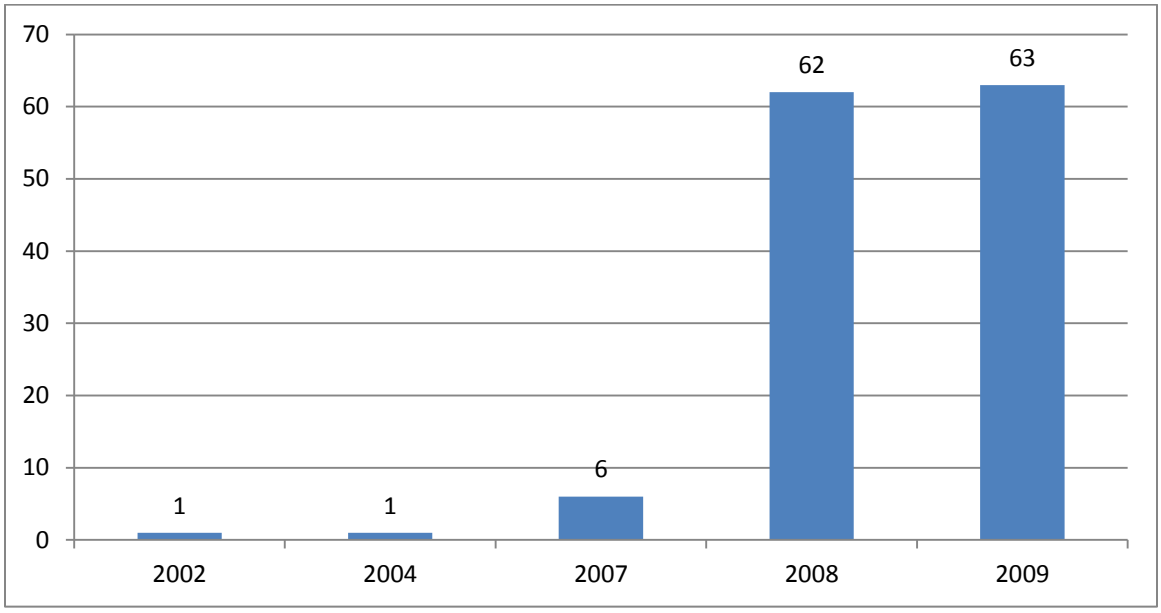
Table 3-1: Interview data table

Organizations	**Interviews**	
	Number	**Duration (min)**
Department of Health	3	73.26
AHSC 1	6	338.16
AHSC 2	3	150.16
AHSC 3	1	41.21
AHSC 4	2	101.54
AHSC 5	1	85.36
Field experts	2	75.40
Total	**18**	**865.09**

3.2.2. Secondary accounts

Following interviewees' recommendations on written documents, including books, government reports, and journal papers, which could provide useful information on the travel of the AHSC organizational form in the British healthcare, I started collecting data in the form of secondary accounts. Furthermore, I followed the bibliographies of some secondary accounts to trace relevant data in a snowball manner. After the first round of collection of secondary accounts, I began to search in Factiva (online-database providing contents from both licensed and free sources) with the term 'academic health science centre'. In this keyword search, I limited the search by specified period (between 1981 and 2009) and by specified region (UK only). The result showed the publications with the term 'academic health science centre' started from 2002 to 2009. However, the publications in 2002 and 2004 are news about AHSC in Canada; therefore, they are not included in my data collection. As a result, the term AHSC first appeared in the public media in the UK in 2007, according to Factiva (see Figure 3-1).

Figure 3-1: Keyword search in Factiva



Although the result showed the first appearance of AHSC in 2007, England actually has pre-history of translation of this organizational form that can be traced back to late 1980s. I thus

went back to the interviews and the secondary data collected so far, and found out that AHSC had been referred to in the UK with different names. Table 3-2 shows all the names invented in England to call AHSC, along with source and time of their first appearance.

Table 3-2: Names of AHSC in England

Names of AHSC in the UK	Source, year
University Hospital NHS Trust	The Richards report, 1997
University Clinical Partnership, Academic Clinical Partnership	The Nuffield Trust's report, 2000
University Clinical Centre, Academic Clinical Centre	The Nuffield Trust's report, 2001
Academic Medical Center	The Cooksey report, 2006
Academic NHS Foundation Trust, Academic Health Science Centre	Imperial College's document, 2006
Academic Health Science Centre	The Darzi report, 2007

This table shows that AHSC has been labeled with many names. One explanation is that different actors chose different names that they thought it was the most suitable for the British context, where highly integrated healthcare system and multidisciplinary practices are valued (Davies & Bennett, 2008). Some of them revealed that they chose the name that was not too medical. I used all these different names of AHSC in the keyword search.

With the interview data, the first-round collection of secondary data, and the keyword search in Factiva, common themes and stories emerged across different data sources. At this stage, I identified two more keywords for collecting more data, including 'university hospital partnership', and 'tripartite mission'. I used all the keyword searches in public source database (Google and Factiva), online government archives (the British Library and the National Archives), and healthcare-related journal database (EBSCO, Health Management Information

Consortium). This process yielded a number of relevant government policies and reports, ministerial speeches and letters, task force and work group reports, newspapers and health-related magazine articles. At this stage, I observed field actors involved in the translation process of AHSC, including the government and its agencies, the Nuffield Trust (a health policy think tank), professional associations of universities and teaching hospitals, Imperial College and its NHS partners (the first organization to create the UK's first AHSC), and Professor Ara Darzi (clinical academic and former health minister). Table 3-3 provides summary of my collection of secondary data, arranged by types of actors.

Table 3-3: Secondary data table

Data type by source		Quantity
Government reports (1989 – 2005)		18
Nuffield Trust's materials (2000 – 2007):		
	Reports	6
	Seminar notes	6
Professional associations' reports (1997 & 2006):		2
Imperial College AHSC's materials (2006 – 2009):		
	Consultation documents	31
	Audio and video	6
	Press release	12
	Power point slides	2
	Meeting minutes	1
	Clips video and audio	7
	Hard brochures and leaflets	7
	Imperial AHSC website	NA
Professor Darzi's and government materials (2006 – 2009):		11
	Reports and related documents	2
	Clip video and audio	5
	Presentation slides	2
	AHSC website	NA
Academic journals (2007 – 2009)		13

News and magazine articles (1990 – 2009)	87
Supplementary data:	
Government reports and documents (2010 – 2012)	9
News and magazine articles (2010 – 2012)	26
Books and book reviews	4

To gauge the effect of the AHSCs in England, I also collected government reports, newspapers and health journal papers, which were published between 2009 and 2012. This is to supplement my understanding of the data in terms of the effect of the adoption and general reaction of people in the field to the creation of AHSCs.

According to the data, one common theme is that AHSC was introduced as a solution to the problems of the NHS/university relationship to deliver research, education, and clinical services. The interview and written material data revealed that the creation of AHSC cannot be traced back to the movement of AHSC alone, but also to the problematization of the relationship between the NHS and the higher education sectors, which appeared to start in late 1980s. However, there are many different versions of the course of events that constituted the formation of the British AHSCs. Some inform that the problem of the collaboration between the NHS and universities begun since the establishment of the NHS in 1948. Some inform that it could be traced back to 1980, when Sir Fred Dainton on behalf of the Nuffield Provincial Hospital Trust published a report that for the first time proposed the problem of the existing arrangements between university and teaching hospital sectors. Others inform that the first-time official discussion regarding the issue started in late 1980s with the formation of the SGUMDER to analyze the problem underlying the NHS and university relationship. While some recommended examining the whole process back to the first time when the problem was conceptualized, many viewed that the story of AHSC actually started in 1997, when AHSC was initially introduced as a solution to solve collaboration arrangements between the NHS and universities.

Consulting with both interviewees and secondary accounts, I justified my data analysis from 1987 to 2009 with following reasons. 1987 was the first time when the relationship between the NHS and universities were socially problematized through the establishment of the SGUMDER, in which all the stakeholders participated. The SGUMDER called for solutions,

which later linked to the introduction of AHSC in 1997. For 2009, it was when the first five AHSCs were established in England through the government's designation process. In addition, the data between 1987 and 2009 is very rich in forms of written materials (see Table 3-3), which allows me to conduct high-quality qualitative analysis.

I believe that I have collected the complete set of data pertinent to the formation of the British AHSCs. I consider that these materials are very likely to document the strategies and activities of the key actors engaging in the translation of AHSC. Furthermore, I used triangulation approaches to ensure the internal validity of my interpretations of the translation of AHSC. I compare the accounts of the emergence of the British AHSCs across data sources i.e., interviews and secondary data including reports, archives, news and magazine articles, and journal papers. The triangulation of data contributes to my understanding of the case study and ensures the internal validity of the study.

The interviews provide interpretations of the actors involved in the translation of AHSC, especially between 2006 and 2009. Secondary data has three benefits in this study. First, they provide context of what happened in the British healthcare in relation to the formation of AHSC in a specified period of time (1987 – 2009). Second, due to the limitations of interviews, I relied significantly on secondary data to examine the translation process, especially at the early stage (prior to 2006). Finally, secondary data demonstrates the discursive and shared meaning of AHSC in England.

During the process of my data collection, I am aware of some limitations. The interview data was collected in 2010 – 2011, most of them reflected actors' interpretations in relation to AHSC in later stage. Although some interviews also included accounts of the early stage of the translation of AHSC, retrospective interviews could have the effect of postrationalization (Barley, 1986). To compensate this, I gathered all the written materials as much as possible in relation to not only AHSC, but also to the British healthcare sector in general, as shown in Table 3-3. To supplement and enrich my knowledge about the case study, I also consulted with various books and journal papers in general that can provide me with overall information regarding the British healthcare context and the idea of AHSC (e.g. Detmer & Steen, 2005b; Kastor, 2004; Spurgeon & Barwell, 1991; Stevens, 2009). These written documents provide rich and fruitful

information for this research. I believe that I have collected complete and adequate data for the analysis of this research.

3.3. Data analysis

Following Langley's (1999) suggestions for process research, I took multiple approaches to the analysis, including narrative strategy, temporal bracketing, and visual mapping, as described in the previous subsection. I also followed Miles and Huberman's (1994) coding techniques, and how to manage and present a large amount of qualitative data through developing illustrative devices, including tables and figures as necessary. This subsection describes the initial stages of my data analysis, which paved the way for the following three complementary analyses of this research.

In stage one I drew on accounts from interviews and secondary data to create a chronological order of key events. Each event was attached with interpretations, composed of ordered raw data such as quotations from interviews and extracts from documents. This analysis identified who did what and when. For each event, I also drew on other supplementary data such as reports and journal papers, which did not directly mention AHSC in their written documents, but discussed important contexts that is relevant to the formation of the British AHSC, specifically about the relationship between universities and the NHS. This was to comprise a discursive event history database (Maguire & Hardy, 2009; Van de Ven & Poole, 1990). Table 3-4 summarizes key events at each stage of the translation process.

In stage two I composed a narrative story. This narrative described two issues: 1) the situations and problems regarding the NHS/university relationship, which had paved the way for the translation of AHSC into England; and 2) the translation of AHSC, which presented the entire trajectory of the making of the British AHSC from the first introduction into the field to the establishment of the five AHSCs in England. This narrative allowed me to develop understanding of the British health context both before and after the introduction of AHSC, what occurred to the idea of AHSC in England over time, and what transpired in the translation process. I then compared my narrative account with other historic accounts whose authors wrote about the historical development of AHSC in England (Davies, 2002; Ovseiko et al., 2010;

Smith, 2001; Snowden, 2008). This comparison and juxtaposition is to ensure convergence and triangulation of events, activities, actors, and discourse about AHSC. The narrative, in turn, formed the basis of my description of the case study presented in the next subsections.

Based on the chronology of events and my composed narrative, I reconstructed the translation process by using a stage model of translation, as conceptualized by Czarniawska and Joerges (1996). Their model consists of three stages: selection, objectification, and materialization. Selection is when an idea is selected as it seems promising to solve problems. Objectification involves making the idea into a collectively understandable format so that the idea can travel around and be used repetitively. Examples of objectifying the idea are assigning new names, turning the idea into texts or images. Materialization is "when words become deeds" (Czarniawska & Joerges, 1996: 41). Using this model as an analytical framework, I recreated the translation process of AHSC. Table 3-4 summarizes key elements at each stage of the translation process.

Table 3-4: chronology of events

Translation stages	Time	Events
Problematizing and finding solutions	Nov 1987	A conference involving representatives from the higher education and the healthcare sectors established an interim Steering Group (later known as SGUMDER) to analyze the problems of the NHS/university relationship to support medical/dental education.
	1995	The House of Lords Select Committee on Science and Technology expressed concerns, on their annual report, over the NHS/university relationship and the state of clinical academic career
	Mar 1996	SGUMDER's 4th report was published, which outlined the Ten Key Principles to guide the NHS/university relationship.
Selecting – introducing and comparing with local solutions	Jul 1997	The CVCP commissioned an independent task force, led by Sir Rex Richards, to analyze the problem of clinical academic career. The Richards report recommended the implementation of AHSC (the first record of AHSC in the UK), and named such an organization as 'University Hospital NHS Trust'.
	1998	In response to the Richards report, the NHS executives, the chairmen of the CHMS and the CVCP met to discuss their concern over the NHS/university relationship. It was agreed that new structures and radical solutions should be avoided but that there would be benefit in improving collaboration and joint management processes in line with Ten Key Principles (HL, 1999). The meeting resolved to invite the Nuffield Trust to host a meeting of the key players and develop ground rules to operationalize the Ten Key Principles at local level.
	1998	The Nuffield Trust conducted a survey of heads of medical schools and associated NHS hospitals. The result confirmed the NHS/university relationship was not uniformly good, and showed a strong desire from both groups to have closer working relationship.
	1998	The Nuffield Trust's meeting was conducted, gathering chief executives of NHS hospitals, heads of medical schools, the NHS executives, and the HEFCE, to address the result of the survey and discuss about the problematic relationship between the NHS and universities.
Objectifying – promoting and incorporating various ideas	2000 – 2004	The Nuffield Trust published several reports on the NHS/university relationship. The reports promoted the adoption of AHSC, and compared the academic health situations in the U.S. and the UK. The staff of the Nuffield Trust visited the U.S. to study the American models of AHSCs.

Quiet period	2004 – 2006	Some universities and their associated NHS hospitals showed interests in the idea of AHSC, and planned to develop some structures and practices similar to some elements of AHSC. For example one partner planned to form a research consortium or research alliance across the university and the NHS partners.
Materializing and enacting	Jan 2006	The UK government by Sir David Cooksey published 'A Review of UK Health Research', addressing the significance of the translational research and the imperative of closing translational gaps in the UK.
	Feb 2006	Imperial College and its associated hospitals commissioned a feasibility study of creating AHSC.
	Dec 2006	NHS London asked Professor Lord Ara Darzi to review the healthcare in London. Professor Darzi included the establishment of AHSC in the review of improving London healthcare.
	May – Aug 2007	Imperial College and its associated hospitals conducted a public consultation process on the creation of the AHSC. The result of the consultation showed public support for the creation of AHSC.
	Jul 2007	The Darzi report, 'Healthcare for London: A Framework for Action', was published. The report included the establishment of AHSCs in London to promote innovation and research excellence in the NHS.
	Oct 2007	Imperial College London and its associated NHS hospitals created the UK's first AHSC. Its establishment was approved by the government.
	Jun 2008	The Darzi report, 'High Quality Care for All: NHS Next Stage Review', was published. The report suggested the establishment of AHSC as national policy.
	Oct 2008	The Department of Health convened a meeting for organizations interested in becoming an AHSC, and presented the government's designation process, which consisted of two phases.
	Nov 2008 – Jan 2009	The competition phase one was conducted with an international selection panel of experts invited from the countries with established AHSCs. There were 15 applications in total.
	Jan – Feb 2009	Applications were short-listed to 7. Short-listed applicants submitted application in phase two.
	Mar 2009	The UK government announced the 5 successful AHSCs.

At this stage, I found that the key actors, who had been actively involved in the translation of AHSC, were comprised of the Nuffield Trust in 1997 – 2003, and Imperial College and Professor Darzi in 2007 – 2009. I also found that there were no significant activities or resources contributed to the translation or the promotion of AHSC in 2004 – 2006.

To verify the identification of the key actors, I went back to the interview data and listed all the individuals and the organizations to which the interviews referred. The interviews revealed some individuals or organizations were more actively involved in the translation than others. One question that I asked in every interview was who were involved in promoting and adopting AHSC in England. All the interviews confirmed the significant involvement of Imperial College and Professor Ara Darzi. However, only 2 of 18 interviews also referred to the Nuffield Trust as an active advocate of the implementation of AHSC in the past. This is not surprising, as the roles of Imperial College and Professor Darzi were more recent. However, the two informants that confirmed the involvement of the Nuffield Trust were those involved in promoting AHSC since the early stage. Furthermore, the Nuffield Trust published a number of publications, which can be used as evidence to support its role. Their roles and actions are also corroborated in many government reports and news articles.

In addition, I went to other data sources, including archives, news/magazine accounts, and journal papers, and listed the key actors who promoted and created AHSCs. The result showed a comprehensive and verified list of three key actors that engaged in translating AHSC: the Nuffield Trust, Imperial College, and Professor Darzi. Table 3-5 summarizes the multiple sources of data by which the key actors are identified and verified with illustrative data segments.

The role of actors in translating refers exclusively to these three actors. I do not claim that only these three actors involved in the process, and their actions alone engendered successful translation of AHSC into existence in the UK. Still, my evidence suggests that they were key actors in leading the process through construction of meaning, and motivating other actors to enroll in their vision (cf. Maguire et al., 2004).

The Nuffield Trust became familiar with AHSC because the organization had long contact and academic relationship with the Commonwealth Fund in the U.S. The relationship

between the Nuffield Trust and the Commonwealth Fund can be traced back to 1999 (Commonwealth Fund, 2013b). They collaborated in convening and sponsoring annual symposia to bring together government officials, health researchers and practitioners from the U.S. and the UK for exchange of healthcare-related policies and strategies (Commonwealth Fund, 2013b; Nuffield Trust, 2013).

In addition, the Commonwealth Fund at that time established a task force on AHSC, which existed in 1996 – 2003. The task force was assigned to address "the impact of a changing healthcare financing system on the traditional missions of academic health centers: medical education, biomedical research, specialized healthcare services, and at many institutions, care for indigent and uninsured patients" (Commonwealth Fund, 2013a). The chair of this task force also wrote the introduction for the Nuffield Trust's report on university clinical partnership (see (Smith, 2001), which is the report that dealt directly with applying the AHSC organizational form in formalizing university/NHS hospital relationships.

Imperial College London and its associated teaching hospitals (Hammersmith hospital and St Mary's hospital) came to be involved in the translation of AHSC in 2006. In this year they announced the merger between the two teaching hospitals to become a single Trust, and the integration between the Trust and Imperial College. Their integration took form of integrated governance structures, led by a single leader – Chief Executive/Principal. They announced this new entity as the UK's first Academic Health Science Centre in 2007.

The last identified key actor is Professor Darzi, who became involved in the translation process of AHSC in 2007. While being a clinical academic at Imperial College medical school and St Mary's hospital, Professor Darzi was asked by NHS London to review healthcare and find strategies to improve healthcare in London to be as high standards as other capitals in the world. One of his recommendations in this review is London should have a number of AHSCs, if London wants to be a capital of excellence and a leader in healthcare. Then when he became the health minister under the Brown premiership, he promoted the establishment of AHSCs to be included in the government's health political agenda.

Table 3-5: Identification of the key actors with evidence from multiple data sources

Translators	Data source	Illustrations
The Nuffield Trust (1998 – 2004)	Interview	"The Nuffield Trust, it has changed a lot since under the new management but under the old management it had a very particular style which was sort of getting chief execs of NHS Trusts together over dinner or people together over dinner in the evening. So, that was London centric. Then there is a couple of people who are interested in this intellectually, who published stuff with Nuffield Trust" (interview, former staff, Nuffield Trust).
		"We had various attempts to tackle the problem of implementing AHSC in the past. In 2002 we got somebody from the Nuffield Trust to produce a piece of research, a book on historic academic medical science centres" (interview, senior management, AHSC 2).
	Archives and reports	"The Nuffield Trust became involved in this initiative following a meeting in June 1998 between Sir Alan Langlands and the Chairmen of the Council of Heads of Medical Schools and the Medical Committee of the Committee of Vice Chancellors and Principals. The meeting noted that relationships were not uniformly good and that the Ten Key Principles might be better facilitated by the development of supplementary guidance. It was decided to ask the Nuffield Trust to host a meeting to explore the matter in more detail" (Nuffield Trust Working Group, 2000: 5).
		"It was agreed to invite the Nuffield Trust to organise and host a small seminar of key players to discuss the development of ground rules to operationalise the Ten Key Principles at local level" (House of Lords Science and Technology Committee, 1999).
		"A search of British academic journals reveals very limited research or commentary on academic health organizations…A search of the Department of Health website reveals a similar dearth. Only one foundation, the Nuffield Trust, has engaged with this topic, seeking to provide a new conceptual framework and terminology" (Davies, 2002: 4).
		Only publications by the Nuffield Trust regarding AHSC in 2001 – 2004.
	News, magazines, and journals	"In his report Clinical Academic Careers, Sir Rex Richards recommends that more work be done to explore the concept of the university hospital trust. That challenge has been taken up by the Nuffield Trust, which is co-ordinating a review of the interface between academic medical centres and the teaching hospitals with which they are most closely associated" (extracts from Health Service Journal, 4th March 1999).
		"In addition to aligning various academic and clinical funding streams at the level of funding agencies, the medical community in England considered facilitating translational efforts through the alignment of academic and clinical missions at the level of universities and teaching hospitals. Between 2001 and about 2004, the Nuffield Trust for Research and Policy Studies in Health Services, an

Translators	Data source	Illustrations
		independent foundation, published a report and hosted a series of events exploring the idea of "university clinical partnership" and the case for adopting North American AHSC models in the United Kingdom" (Ovseiko et al., 2010: 1285).
Imperial College (2006 – 2009)	Interview	[The interviewee was asked regarding the motivation for setting up the AHSC] "I think it's very much by Lord Darzi's personal vision, plus also the example of Imperial College" (interview, Department of Health). "There was this kind of rumbling discussion [about AHSC]…and then somehow out of all of that you know, I don't know how it happened, Imperial College kind of emerged" (interview, AHSC).
	Archives and reports	"There is no recommended relationship model to which an NHS Trust and its partner university should work. In some cases, existing structures could be made to work better. In others, universities and Trusts might follow the US Academic Medical Centre model, as Imperial College and St. Mary's and Hammersmith NHS Trusts are doing with their plan to create the UK's first Academic Health Sciences Centre" (Cooksey, 2006: 72).
	News, magazines, and journals	"Imperial College, London, which is among the world's most highly rated universities for biomedicine, has created the UK's first [Academic Health Science] centre, involving a merger with two teaching hospitals" (Davies, 2008: 3).
Professor Darzi (2006 – 2009)	Interview	[The interviewee was asked regarding the motivation for setting up the AHSC] "I think it's very much by Lord Darzi's personal vision, plus also the example of Imperial College" (interview, Department of Health).
	Archives and reports	Two healthcare reviews: 1) Healthcare for London: A Framework for Action, and 2) High Quality Care for All: NHS Next Stage Review Final Report, published by Professor Darzi in 2007 and 2008 respectively, on behalf of Department of Health.
	News, magazines, and journals	"For too long, university-based research in the UK has failed to translate into improved clinical practice. Health minister Ara Darzi has recognised that the situation must change by integrating research, clinical care, and education through close collaboration between universities and hospitals. Darzi envisages that this collaboration could take the form of Academic Health Science Centres (AHSCs), which have proved successful in the USA, Canada, and Sweden. AHSCs" (Lancet, 2008: 508). "Although this idea was attractive to many NHS and university leaders, these proposals did not attract much interest from policy makers, and without political blessing organizational leaders have not been able to marry. Such blessing came later from Professor Lord Ara Darzi, an academic surgeon at Imperial College London and minister in the Department of Health" (Ovseiko et al., 2010: 1285).

3.4. The case study

3.4.1. The translated organizational form – Academic Health Science Centre (AHSC)

AHSC is an organizational form of the partnership between a university and affiliated healthcare providers to support the integration of research, education, and clinical services or 'the tripartite mission'. This type of organization has existed in the U.S. for over 50 years (Wartman, 2007), and also in Canada, the Netherlands, Sweden, and Singapore. The internationally-renowned examples include the Johns Hopkins Medicine, Massachusetts General Hospital, Harvard Medical School, Hillis Miller Health Science Center, and Texas Medical Center, in the United States; the Karolinska Institutet in Sweden, the Leiden University Medical Center in Netherlands; and the Sunnybrook Health Sciences Center in Canada. In the USA, it is known as 'Academic Health Center' or 'Academic Medical Center', while in the Netherlands and Canada, it is known as 'University Medical Center' and 'Academic Health Science Centre' respectively (Davies, 2009). For the sake of parsimony, the term 'academic health science centre' or AHSC will be used throughout the thesis. Notwithstanding different names and national health systems, AHSC is an international phenomenon (Davies & Smith, 2004; Smith & Whitchurch, 2002).

In the UK, the AHSC organizational form traveled into the field since 1997, and was officially implemented by the UK government in 2009. Despite the spread of AHSC across many countries, most studies of AHSC (at least published in English) focus first and foremost on the U.S. model, whether their contributions are to health policy and administration (e.g. Anderson, Steinberg, & Heyssel, 1994; Detmer & Steen, 2005b; Weiner, Culbertson, Jones, & Dickler, 2001); or used the American AHSCs as case studies to make contributions to the area of organizational studies (e.g. Kitchener, 2002). In the UK it is commonly known that, among AHSCs in different countries, the U.S. AHSC is the most well-known internationally and the most influential in the UK (Bannon, 2008; Davies, 2009). The extract from the British health journals shown below also helps illustrate the influence of the U.S. AHSC in the UK.

> The AHSC idea [was] absent from policy prior to the Darzi review [in 2007]. Now that this has changed, AHSC leaders and policy makers are, inevitably, looking to the

> international literature for evidence relevant to the development of AHSCs in England. The vast majority of literature available in English on AHSCs comes from the USA (Davies, 2009: 176)

However, some might argue that the two countries' healthcare systems are extremely different. The U.S. is largely privately owned and operated sector with the healthcare provisions from insurance programs such as Medicare and Medicaid. The UK's health system, however, is a public sector, funded through the taxation system, and thus subject to a high level of direction from the Department of Health (Davies, 2002). Basically, political and cultural contexts as well as funding arrangements are considerably different between these two countries. Therefore, it is an interesting case study to examine how the organizational form that could be perceived very foreign and from a very different context could be translated with success.

The reasons why the U.S. AHSC is the most influential can be explained by DiMaggio and Powell's (1983) concept of field structure and diffusion. In the U.S., there are approximately 125 AHSCs (Blumenthal, 2005; Davies, 2002). These organizations constitute a large community within the U.S. healthcare sector. The AHSC community is well organized with a representative of the Association of Academic Health Centers (AAHC). The AAHC has established criteria for membership, and at present has 96 members in total (see the association's official website: http://www.aahcdc.org). The role of this professional association is to represent the community to outsiders, and also host internal discourses for the members to exchange ideas and initiatives with regard to good practices, leadership and strategies for managing the tripartite mission, the role of AHSCs in improving health policies, and environmental challenges. The association conducts varieties of activities to promote and advertise the values and contributions of the American AHSCs to the nation and the world through forum meetings, reports and publications. Recently, the AAHC has become more global. In 2008, it founded the Association of Academic Health Center International (AAHCI) to build an international network that connects the AHSC-type organizations around the world to promote best practices and international collaboration. In addition, the AAHC is a charter member of the M8 Alliance, an international network of academic health organizations, and educational and research institutions for exchange of knowledge and cooperation (Association of Academic Health Centers, n.d.). Established in 2009, the M8 Alliance has provided academic foundation to the World Health

Summit – the annual forum for health dialogue and a platform for future considerations of global medical developments and health challenges (World Health Summit, n.d.). By connecting with and founding many international organizations and networks, the AHSC has become more globally diffused. This is in line with institutional theory accounts in terms of diffusion. Institutional researchers of globalization often view international organizations as a central mechanism in promoting the diffusion of ideas (Frenkel, 2005).

Apart from the AAHC, other health policy-related organizations such as the Blue Ridge Group, the Commonwealth Fund and the Institute of Medicine have contributed to the discourse by producing substantial volumes of empirical studies on AHSCs and providing related policy analysis and recommendations (Davies, 2002). With the availability of information regarding the U.S. AHSC and advocacy from such highly-legitimate organizations as these professional associations, think tanks, researchers, and international organizations contributing their resources and energy to the discourse, AHSC especially the U.S. version has become globally diffused and most influential. Another element that motivates the diffusion of the U.S. AHSC could be attributed to world ranking of these U.S. AHSCs. For example, the Johns Hopkins Medicine and Harvard Medical School are ranked the world-top medical schools and hospitals, according to U.S. News & World Report.

The availability of information, the roles of advocate agency, and world ranking have developed institutional forces, particularly normative and mimetic pressures, which shaped and accelerated the adoption of generalized the AHSC organizational form across countries. It is interesting for future research to study the spread and institutionalization of AHSC around the world. It would be interesting to trace and track development of this organizational form in time that could potentially lead to the emergence of a new field. However, this aspect is out of scope of this thesis, as I focus more on unpacking the translation process of AHSC within the UK. Nevertheless this description enriches my understanding and helps explain why the UK is subject to the translation of AHSC from the U.S.

The remainder of this part will be devoted to describing the characteristics of the U.S. AHSC. Relying on the book chapters (Blue Ridge Academic Health, 2000; Blumenthal, 2005;

Bond & Kohler, 2005; Galvin, 2005) and AAHC's reports, I identify the characteristics of the U.S. AHSCs, as shown in Table 3-6.

Table 3-6: Summary of the characteristics of the U.S. AHSC

Characteristics	The U.S. AHSCs
Healthcare system	Largely private-operated
Established	Approximately in 1950s
Number of AHSCs	125
Organizational stakeholders	o Medical schools o Faculty practice plan o Affiliated hospitals o Insurers o Industry o Patients, students, professional workforce
Goal	To improve health of individuals, communities, and the general population
Missions	o Tripartite mission (education of health professionals, research, and clinical care) o Provisions of rare and high technology medical services o Continuous innovation in patient care o Community healthcare or safety net, i.e. social mission for poor and uninsured patients
Goods	Public and merit goods i.e., health professionals, research (e.g., basic science, biomedical research, clinical research that enables innovation in the clinical care), specialized services (e.g., burn, transplant), and safety net caring for poor and uninsured patients in the community
Mechanisms of establishment	Self-appointed by the board consensus of universities and hospitals
Governance models	o Single leadership, i.e. a university owns hospitals such as Johns Hopkins o Multiple leadership, i.e. representatives in the shared board such as Harvard Medical School and its hospital partners
General discourse	o Financial viability o Societal roles and contributions to the stakeholders (patients, communities in which they reside, the country, and the private sector)

Definitions of AHSC are broad and vary, and there seems to be no precise and universally-accepted definition (Anderson et al., 1994). This results in no consensus on the

number of AHSCs in the U.S. However most lists approximate the number ranging from 100 to 125 (see Anderson et al., 1994; Davies, 2002). There is even a repeated saying "if you've seen one academic health center, you've seen one academic health center" (Aaron, 2001). Still, the most notable definition of the U.S. AHSC is provided by the AAHC. In this regard, I also compared and juxtaposed the AAHC's definition provided in the publication in 2008, and that of the Commonwealth Fund in the 2003 article, in order to generalize the main concept of this organization, and help identify the frame of the U.S. AHSC (see Table 3-7).

Table 3-7: Comparison of the definitions of the U.S. AHC available in 2001 & 2007

Source	Definitions
Commonwealth Fund, 2003	"An academic health [science] center consists of allopathic U.S. medical schools and their closely affiliated or owned educational and clinical institutions. In many cases, [AHSCs] also include other health professional schools (public health, nursing, pharmacy, dentistry, allied health professions). Recently, the clinical component of the AHC has become increasingly diverse. For much of the 20th century, AHCs' clinical facilities typically included hospitals and faculty group practice plans…The AHC sector thus constitutes an increasingly diverse and evolving set of institutions. However, this variety should not obscure the commonality among AHCs. All include a medical school, and all these medical schools must, to serve their core missions, remain involved in the delivery of healthcare services either through ownership of or close affiliation with inpatient, outpatient, and community-based providers of healthcare services" (Commonwealth Fund, 2003: 1).
Association of Academic Health Center, 2007	"An academic health [science] center is an accredited, degree-granting institution of higher education that consists of: a medical school (either allopathic or osteopathic), one or more other health professions schools or programs (e.g., Allied Health Sciences, Dentistry, Graduate Studies, Nursing, Pharmacy, Public Health, Veterinary Medicine), and an owned or affiliated relationship with a teaching hospital, health system, or other organized healthcare provider" (Wartman, 2007: 1).

Based on these two definitions, AHSC is an organization consisting of academic institutions and healthcare providers that formalize relationship with integrated structure and aligned culture to manage and synergize the tripartite mission to improve healthcare for patients and the general population. Despite the variety of AHSC in terms of members, governance and structural arrangements, AHSCs share common purposes and missions – to improve health of patients and the general populations (Biles, 1997; Blue Ridge Academic Health, 2000; Blumenthal, 2005; Wartman, 2007). In this endeavor, AHSCs have roles and capacities that

make them distinctive from other organizations in the healthcare system (Blumenthal, 2005). Therefore, AHSC has played a vital role in the healthcare system: training physicians and health professionals, conducting cutting-edge biomedical research, applying innovations in medical practice, providing specialized services, and providing safety net care for poor and uninsured patients (Blumenthal, 2005; Detmer & Steen, 2005a).

In the U.S., there is widely-held opinion that there is tremendous diversity in the structures of AHSCs, and that each one is unique in terms of their structures. Health management scholars have attempted to address this heterogeneity by delineating key dimensions and building archetypal structures based on these dimensions (see, for example, Culbertson, Goode, & Dickler, 1996; Weiner et al., 2001). Nonetheless, there is now an accepted view that AHSCs can be broadly categorized into two structures: an integrated structure with single owners such as the Johns Hopkins Medicine, to a partnership structure such as Harvard Medical School (cf: Wartman, 2007). Normally, how an organization works is that the main revenue comes from clinical activities, which in turn support research and teaching (Blumenthal, 2005; Jones & Sanderson, 1996). Other revenues come from funding, grants, and contracts from government agents such as National Institute of Health (NIH) and private sector.

It is noteworthy that not every AHSC is financially successful or sustainable. In the U.S., two main themes dominate debates about AHSC, including financial viability and its societal role. "Advocates of public policy to improve financial stability have, not surprisingly, based their arguments on the public interest activities of AHCs, so these two themes are inextricably linked" (Davies, 2002: 7). Because of these aspects, AHSC is perceived as a distinctive organizational form. Policy makers embrace its distinctiveness, defining policies that support its existence. In the late 1990s, some AHSCs had financial problems, which led to bankruptcy or disintegration of integrated academic systems, including the dissolution of merged groups and divestment of teaching hospitals by medical schools (Davies, 2002). Based on these evidences, this organizational form does not always bring economic returns or guarantee financial survival. On the contrary, there are a couple of evidences, showing that it can be risky adopting one. In addition, most records of AHSC performance available are those in the U.S. Not much can be found in the countries such as the Netherlands, in which AHSCs also exist and their national

health systems are similar to the one in the UK. It thus does not guarantee economic returns or efficiency. The question is why then the UK adopted it.

Although some AHSCs were not financially successful, some are world-renowned organizations, ranked ones of the best in research, education, and/or clinical practices. In the U.S., the debate about the financing of AHSC is linked to discussion of their societal role, which contains a powerful normative tone.

In this part of the subsection, I describe the characteristics as well as general model and strategic framework of the U.S. AHSC, which is the most influential in the creation of AHSC in the UK. Next, I will describe the organizational field of interest in this thesis and the story of the translation and creation of the British AHSC.

3.4.2. Organizational field – the British healthcare

As noted in the literature review on organizational field, field in this research is conceptualized as organizational field of various groups of actors, who define their activities as being concerned with similar issues. Their interactions, structures of relationship, and appropriate behaviours are defined by shared systems of meanings.

The field of interest in this thesis is the national healthcare system in England. This field consists of several organizational communities, including the NHS (England's public healthcare service), universities as key suppliers of health professionals and research, the government and its regulatory and funding agents, patients, and industry. Within the NHS, it can be divided into two main groups: health authorities and healthcare providers. The healthcare providers consist of 3 levels: 1) primary care, i.e. general practitioners; 2) secondary care, i.e. acute hospital trusts, mental health trusts; and 3) tertiary care, i.e. specialist hospitals. All these healthcare providers are subject to the Department of Health's directions and monitoring of finance and quality through the NHS health authorities such as Strategic Health Authorities (SHA) and the Monitor. Some of the NHS healthcare providers, especially acute and specialist hospitals collaborate with universities to deliver teaching, research, and patient care. The hospitals that have close collaboration with universities used to be known as *teaching hospitals* or *university hospitals*. In

this thesis, the relationship between universities and these associated NHS hospitals is my primary concern.

3.4.3. The case study – the NHS/university relationship and the change from the adoption of AHSC

The relationship between universities and NHS hospitals is characterized by multiple professions, such as researchers, clinical academics, clinicians, managers, etc., with differential level of interests in research, education, and clinical care. Both universities and the NHS hospitals are significantly dependent on the government's funding. However, the NHS gains more interest from the government, because it is publicly-run, reliant on the tax system, and considered as one of the most meaningful sectors to the country.

In England, universities including medical schools are self-governing organizations, but are partly funded by the government through statutory education and research funding councils. The NHS hospitals are public organizations, almost entirely reliant on public funding, and gain a high degree of direction from the Department of Health. It was reported that 61% of university activity in 2004 (Universities UK, 2004) and 87% of healthcare activity in 2005 (Organisation for Economic Co-operation and Development, 2007) were publicly funded. Thus, despite different governance and accountability, both entities are significantly dependent on the government's public funding.

In terms of culture and goals, universities focus on education and research, particularly basic sciences, and achieve legitimacy through a number of publications and university rankings. NHS hospitals' priority is patient care, with focus on financial sustainability, which could be achieved through efficiency and effectiveness in operation and management. The NHS's interest is more in clinical research that has an effect on patient care. Despite these differences, they are interdependent and have formed informal partnership to provide teaching, research, and patient care. For example, academic staff under employment of a university holds honorary contracts with the NHS to provide clinical services, while NHS hospitals and its clinical practitioners provide education and training to medical students. The interdependence of the two organizations has been built on separate governance and accountability. In working together,

universities and their NHS partners rely on cross-representation in the board, day-to-day communication among leaders, and some financial liaison mechanisms such as SIFTR and knock-for-knock system[1] (Davies, 2002). This uncosted system supported shared services such as laboratories, premises, student accommodation and costs associated with patient care and educational duties of clinicians. Across the data sources including both interviews and archives, it is noted that conflicts has existed in the relationship between the two sides, while these existing collaborative arrangements were viewed as inadequate and ambiguous. The AHSC was introduced to transform this contractual relationship to the formalized partnership with clearly-defined governance arrangements, joint structure and emphasis on shared culture.

Next, I chronologically outline the context of the translation of AHSC in 1980 – 2009, which depicts the empirical case of the translation – from the field problem at the time of the introduction of AHSC to the establishment of the five AHSCs in England.

1980 – 1996: the field problem at the time of the first entry of AHSC – the problematization of the NHS/university relationship

Over time since the establishment of the NHS in 1948, there have been tensions in balancing the three activities of research, teaching and patient care between universities and the NHS (Davies, 2002). Traditionally, these tensions were contained through technical liaison mechanisms, i.e. knock-for-knock system. In 1980s, however, there were considerable changes in the field, i.e. budget cuts in universities and financial constraints in the NHS, which led to the concerns over the future of medical education in the UK (Steering Group on Undergraduate Medical and Dental Education, 1989). The General Medical Council (GMC), a free-based charity with statutory responsibilities to maintain a register of medical practitioners, warned that the present and future standard of medical education might become lower, due to these changes.

[1] Knock-for-knock was financial arrangements between universities and the NHS hospitals, in which both parties agree not to cross-charge for the services of their staff. "Clinical training for the students is provided in NHS teaching hospitals with which the medical schools are associated. University clinical staff provides services to NHS patients, and NHS doctors undertake some undergraduate teaching under the system of uncosted mutual assistance known as 'knock for knock'" (Croham, L. 1987. Review of the University Grants Committee. London.).

The GMC Education Committee, which has statutory obligation to ensure high standards of medical education, also reported in 1987 and 1988 the difficulties medical schools were experiencing in achieving educational objectives (Steering Group on Undergraduate Medical and Dental Education, 1989). In addition, surveys by the University Hospital Association and the National Association of Health Authorities (NAHA) showed reductions in clinical academic staffing in medical schools.

In February 1987, the review of the University Grants Committee, led by Lord Croham (hence referred to as the Croham report), was published and led to the establishment of the University Funding Council (UFC). The Croham report drew attention to the need for better coordination of medical education at all levels. Then in November 1987, in responding to the increasing concerns and the Croham report's suggestion on better coordination, a conference involving all the main bodies with direct interests in medical education was conducted, which led to the establishment of the joint Steering Group on undergraduate medical education and research (SGUMDER) to consider the relationship between the university and the NHS sectors, and how the coordination for medical education can be improved (Steering Group on Undergraduate Medical and Dental Education, 1989). SGUMDER was composed of representatives from both universities, the NHS, the Department of Health, the Department of Education, statutory funding bodies for research and education, and professional associations of both universities and teaching hospitals. Within its four published reports from 1989 to 1996, it highlighted that the problem of medical/dental education and research could not be simply put down to resources or the universities alone, but greater emphasis should be put on the commitment of the NHS to medical education, and the overall collaboration between the two organizations. In its fourth and last report, the close collaboration was emphasized as key to determining the future quality of the nation's healthcare (Steering Group on Undergraduate Medical and Dental Education and Research, 1996). SGUMDER established the Ten Key Principles (see Appendix A) to promote shared goals and collaborative working between the NHS and the university sector at both national and organizational levels. The Ten Key Principles became the accepted rules of engagement between the higher education and the NHS (Langlands, 2003; Nuffield Trust Working Group, 2000).

Since the establishment of the SGUMDER, the importance of collaboration between NHS and universities had been recognized. And the need for change to closer relationship between them was considered and promoted. For example, in response to the SGUMDER's reports, the UFC examined the effects of the NHS reforms on medical education and research, and published two reports in 1991 and 1992. The Higher Education Funding Council (HEFCE, replacing the UFC since 1992) established a working group to investigate the relationship between universities and the NHS, and provided recommendations to the SGUMDER. It suggested the Ten Key Principles be revised and close monitoring of the balance of clinical and academic work conducted by university staff was needed if the quality of teaching and research is to be maintained (Joint Medical Advisory Committee, 1995).

1997 – 2006: the introduction and movement of AHSC in England

While the Ten Key Principles were widely embraced by the government, funding councils, and NHS health authorities to guide the joint policies for medical education and research in the country, the principles were considered by some universities and NHS teaching hospitals, as too broad and did not solve neither the relationship issues between them or the problem of clinical academic staffing. In 1994, the House of Lords Select Committee on Science and Technology specifically expressed concern over clinical academic careers, and singled it out as an urgent issue. In their report, the interrelationship between teaching, research, and clinical practices was emphasized and came together under clinical academics. Clinical academics are defined as "members of a university, with a medical or dental degree and some specializing training, working in its medical or dental school; their activities are divided between patient care, teaching undergraduates, training young doctors and dentists for clinical accreditation, research, supervision of research, as well as considerable administration and committee work required in the NHS and in higher education" (Richards, 1997: 6). Basically, clinical academics are the medical professionals that work for both universities and NHS teaching hospitals, and are required to deliver research, teaching, and clinical practices. The House of Lords Select Committee addressed that the recruitment and retention of clinical academics were found to be poor. "The disincentives to an academic medical career are now so great as to warrant an immediate enquiry in their own right" (Select Committee on Science and Technology, 1997).

In response, the Committee of Vice-Chancellors and Principals (CVCP) commissioned an independent task force, chaired by Sir Rex Richards, to investigate the issues of clinical academics. The deliberations of this task force were later published as *Clinical Academic Careers*, or known as the Richards report, in 1997.

One of its recommendations is more work should be done to explore the concept and model of 'University Hospital Trust'[2] (another name used to call Academic Health Science Centre), as found in the U.S., Canada and some European countries.

> Form of governance which give greater weight to the academic mission of university hospitals, and service funding which enjoys some degree of protection, are needed," if the country is to remain a leading centre of medical academia and practices (Richards, 1997: 71).

Tracking the archival documents regarding the NHS and universities, I found that AHSC first appeared in the Richards report. This first entry was also corroborated by my interview data. Based on this report, AHSC was introduced as a new solution to the unsolved problem of staffing arisen across the relationship between universities and NHS hospitals. However, the Richards report did not define AHSC. Therefore, the meaning of the AHSC was still broad and seemed incompatible with the British context.

The Richards report became influential in the field. Its recommendations were supported by the House of Lords Select Committee, and universities and NHS partners. In response, Sir Alan Langlands, then the NHS executive and the Chairman of the Council of Heads of Medical Schools (CHMS) and the Medical Committee of the CVCP had a meeting in 1998. The meeting

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[2] Academic Health Science Centre, as mentioned above, has different names in different countries and at different times. In the U.S., it is known as Academic Medical Center or Academic Health Center. In Canada, it is Academic Health Science Centre. In the Netherlands, it is University Medical Centre. In the UK, before the AHSC label became widely accepted, such organization was known as 'teaching hospital', 'university hospital', 'university teaching hospital', and 'main university hospital' (Davies, S. 2002. Identity and Ideology. ***A Comparative Study of Academic Health Organisations in the UK and USA. London, UK: The Nuffield Trust***.). For the sake of simplicity, the term 'AHSC' will be used throughout the entire thesis.

agreed that the relationship was not uniformly good. However, it reckoned that the Ten Key Principles might be more suitable for the UK context than radical change in structure such as establishment of an AHSC. However, the meeting agreed that the quest for mechanisms to improve collaboration between universities and NHS hospitals should still be pushed forward. The meeting resolved to invite the Nuffield Trust to host a meeting among the heads of medical schools and associated NHS hospitals in order to explore the matter in more detail.

In 1998, the Nuffield Trust conducted a survey of heads of medical schools and associated NHS hospitals. The survey's result confirmed the perception that the relationships between the two organizations were 'not uniformly good' (Nuffield Trust Working Group, 2000), and showed desire from both sides for a closer working relationship (Smith, 2001). A meeting, hosted by the Nuffield Trust, was then held in November 1998, with the aim of "considering a joint strategic approach and to examine ways of developing the interface at [organizational] level" (The Nuffield Trust's report, 2000: 5). The working group found that the Ten key Principles are limited as a device to govern the NHS/academic interface. "They lack a modern strategic context and are neither sufficiently broad nor detailed enough to address all the aspects of the shared agenda" (Nuffield Trust, 2000: 5). The Nuffield Trust promoted the creation of the AHSC like those in the U.S., while giving a new term for such organizational form, 'University Clinical Centre', for implementation in the UK.

The Nuffield Trust continued promoting the implementation of University Clinical Centre, by publishing studies of the U.S. AHSCs in comparison with the academic health context in the UK. They also organized social events for heads of universities, medical schools, and NHS teaching hospitals for discussion on the issue. Despite some interests among organizational actors, AHSC did not gain much attention from the government and the NHS in general (Davies, 2002).

While AHSC did not gain support from the government, the NHS authorities, and other NHS healthcare providers in England, this organizational form was spread in many countries in Europe. In the Netherlands, the similar organizational form to AHSC was created in 2001 by the government, under the label of 'University Medical Centre.' The discussion about AHSC was rich outside the UK. In 2001 – 2002, the Organisation for Economic Co-operation and

Development (OECD) Programme on Institutional Management in Higher Education (IMHE) hosted international forums to examine the key organizational issues emerging in the relationship between health services, teaching, and research. The forums were participated by representatives from North America, Europe, and Australia (Davies & Smith, 2004). The event in 2001 was said to be the first international meeting to consider this subject matter (Davies & Smith, 2004).

During this period, AHSC became popular outside the UK. More countries were interested and adopted this organizational form. However, this new organizational form did not gain attention from the central actors in the British healthcare field such as the government and the NHS in general. Therefore, after 2002, efforts to promote the adoption of AHSC in England gradually faded away, but the discourse on AHSC still remained at periphery in the healthcare context, kept alive by some universities and teaching hospitals who were interested in the adoption of the organizational form.

2006 – 2009: the creation of AHSCs

In 2006, due to financial crisis and economic recession the government announced consolidation of funding for health research from different government agencies into a single fund. Following this agenda, the Chancellor of the Exchequer invited Sir David Cooksey to review the arrangements for the public funding for health research in the UK. The review found that the UK health research has made great contributions to the nation's healthcare and economy.

> The quality of the health research base, combined with a national health service, creates a major selling point that attracts R&D investment from the pharmaceutical and biotechnology industries, which form a major part of the UK knowledge economy (Cooksey, 2006: 3).

However, the Cooksey review reported that the UK might not gain full economic and health benefits from public investment in health research. This is because there is no overarching strategy for prioritizing all types of research, and there are two gaps in the translation of health research: 1) translating discoveries from basic science into new products and approaches to treatment of disease and illness, 2) implementing the new products and approaches into clinical practice (Cooksey, 2006). Closing translational gaps required strong collaboration between

academics and clinicians to conduct research in accordance with patients' needs, and reduce the time required in translational research. It was estimated to take 17 years from research discoveries to patient benefits. The Cooksey's report's recommendations for the funding arrangements of health research were accepted by the Treasury in December 2006. The report suggested devoting a greater share of funding to translational research. The report's problematization and recommendations to increase investment in translational research was widely acknowledged by stakeholders in the field (Ogilvie, Craig, Griffin, Macintyre, & Wareham, 2009).

AHSC reappeared in 2006, when Imperial College and its associated NHS hospitals announced their plan for integration and publicly expressed their interest in forming the first AHSC in the UK. In 2007, after conducting public consultation with various stakeholders regarding their integration, Imperial College London and its associated hospitals together created the UK's first AHSC. Following Imperial College, other universities and healthcare partners were also keen on creating AHSCs. For example, the university and its associated hospitals in Warwick planned to become an AHSC. The West Midlands minister Liam Byrne said "most of the research money is being spent in Oxford, Cambridge and London, and we want to bring some of it to the West Midlands" (extracts from Coventry Evening newspaper, 2008). In London, Queen Mary, University of London, and King's College also announced plans to become AHSCs.

Also Professor Ara Darzi, then the Paul Hamlyn Chair of Surgery at Imperial College and an honorary consultant surgeon at St Mary's Hospital, was requested by NHS London in 2006 to review the healthcare in London. Following this process, the report on *Healthcare for London: A Framework for Action* was published in 2007. One of Professor Darzi's recommendations to improve London healthcare in this report is London should have a number of AHSCs like other countries to remain a capital of excellence and a leader in healthcare practices and services. Arguably, this was when the AHSC organizational form was back into attention of the government and the NHS once again.

The Healthcare for London report engaged an extensive and wide range of people, including NHS professionals – GPs, hospital doctors, nurses and other front-line NHS staff – as

well as a poll of 7000 Londoners, academic institutions, London Councils, the Mayor, and London MPs (Carnall, 2007; NHS London, 2007). The objective of the review is to develop and change London's healthcare that reflects the capital's international and world-class status. The report pointed out the case for change, envision future health needs, and design future models of delivery, in which AHSC was included as one solution. This report emphasized the need for setting up AHSCs as a strategy to promote London as the cutting-edge of research and clinical excellence and to close translational gaps addressed in the Cooksey report. The report also identified six criteria evaluation of AHSC applicants. These were: (1) integrated governance; (2) internationally-recognized excellence in research and clinical practice; (3) clear, integrated funding streams for research and teaching; (4) integrated leadership and career paths; (5) joint programs which combine research and clinical work; and (6) commercial expertise (Darzi, 2007).

In 2008, Professor Darzi was appointed as Parliamentary Under-Secretary of State in the House of Lords at the Department of Health. He was assigned with leading a review to determine directions of the NHS for the next ten years and reporting back to the Prime Minister. The Review brought together thousands of clinicians and patients to determine the direction for the health service (Darzi, 2008). In 2008, Professor Darzi then published the report *NHS Next Stage Review: High Quality Care for All*, which outlined the government's plans to reform the NHS in England over the next decade. The publication of the report coincided with the NHS's 60th anniversary. The review aimed to shift the focus of health service from increasing the quantity of care to improving the quality. The main theme of the report is to give patients more power and influence on the NHS's service provisions.

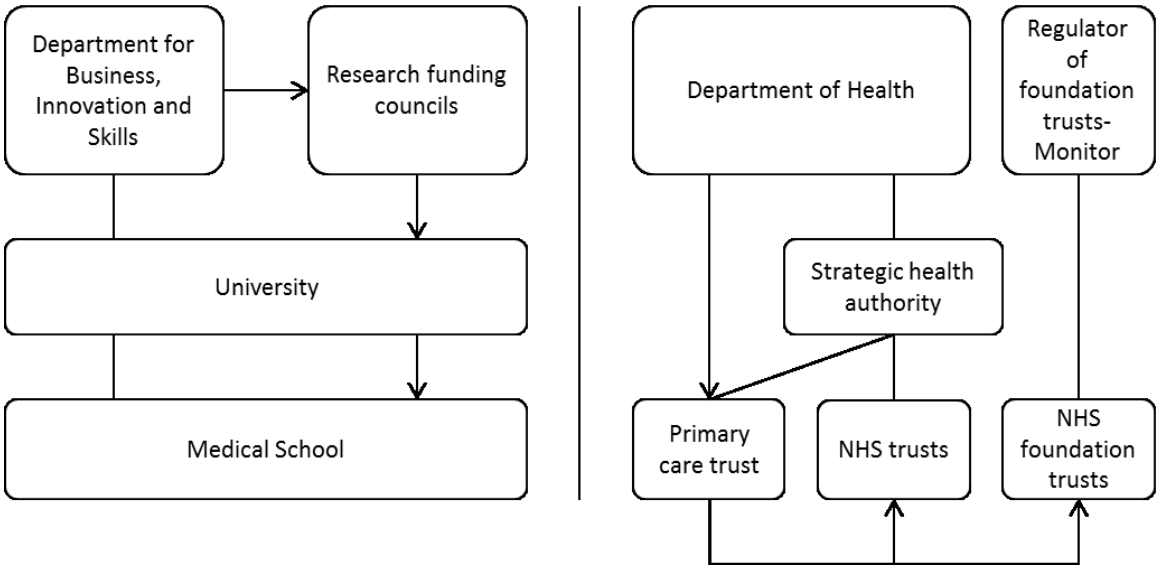
His report was welcomed by the policy makers (Taylor, 2008). One recommendation in the Darzi review remained – to establish a number of AHSCs – but this time not only in London, but across England. It called for the NHS research to be led by AHSC. The review represented the government's commitment to fostering the creation of AHSCs, and catalyzed even more other universities and healthcare partners across the country to move towards this new organizational form.

As a result of this process and review, the Department of Health established a competition process for the AHSC designation. Those, who already labeled themselves as an AHSC such as Imperial College, must also reapply for this accreditation. The UK government announced the process for the official AHSC recognition and the criteria for selection. An international panel of experts was established to award this status (Darzi, 2007, 2008). The selection panel included representatives from AHSCs in the U.S., the Netherlands and Sweden. In 2009 the UK government announced the five successful AHSCs in the UK, including Imperial College AHSC, UCL Partners, King's Health Partners, Cambridge University Health Partners, and Manchester Academic Health Science Centre (see Appendix C).

Although there are only five recognized as AHSCs at present, the accreditation process of AHSC prompted other universities and NHS partners to move towards the AHSC organizational form. In addition, it is interesting to look at the trajectory of the creation of AHSC in the UK. AHSC has travelled from the position where it was indifferent by policy makers and the NHS to the position where it became legitimate.

In summary, universities and NHS hospitals have historically been separated in terms of structures and culture. However, in effect, they are interdependent in delivering research, education, and clinical care. Figure 3-2 illustrates the separation between universities and the NHS. The Figure is adopted from Ovseiko et al's (2010) paper. Arrowed lined indicate funding channels. Straight lines indicate reporting and accountability.

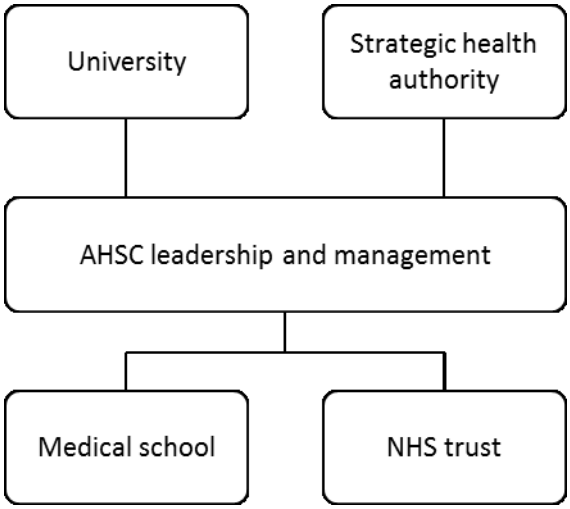
Figure 3-2: The separated structure between universities and the NHS before the implementation of AHSC



Source: Ovseiko, P. V., Davies, S. M., & Buchan, A. M. 2010. Organizational Models of Emerging Academic Health Science Centers in England. Academic Medicine, 85(8): 1282-1289.

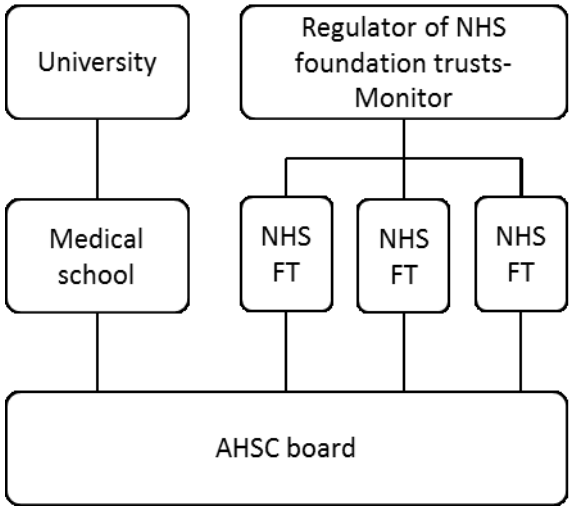
After the UK government announces the five successfully designated AHSCs in 2009. Two types of AHSC structures were created in England – the integrated structure and the partnership structure. Figure 3-3 illustrates the integrated structure of AHSC. Figure 3-4 shows the partnership structure.

Figure 3-3: The formalized partnership by the adoption of the AHSC integrated structure.



Source: Ovseiko, P. V., Davies, S. M., & Buchan, A. M. 2010. Organizational Models of Emerging Academic Health Science Centers in England. Academic Medicine, 85(8): 1282-1289.

Figure 3-4: The formalized partnership by the adoption of the AHSC partnership structure



Source: Ovseiko, P. V., Davies, S. M., & Buchan, A. M. 2010. Organizational Models of Emerging Academic Health Science Centers in England. Academic Medicine, 85(8): 1282-1289.

Chapter 4.

FINDINGS: THE TRANSLATION PROCESS MODEL

4.1. Introduction

In this chapter, I examine the translation process of the AHSC organizational form from its first appearance to its adoption (1997 – 2009). The chapter consists of four parts. First, I describe the method of analysis. Second, I describe the relationship between universities and the NHS during the period of institutional stability that preceded the translation. Then, I identify the field conditions at the time of institutional change, which allowed the problematization of existing structures and practices underlying the relationship and the translation of the AHSC organizational form into the field. Finally, I analyze the detailed translation process with a focus on the strategies and actions of the key actors, and the means-ends frames of the AHSC organizational form, that were constructed and transformed over time.

My findings, in line with other empirical studies of the translation process, show that organizational forms are not readily adopted as ready-to-wear garments, but their functional and symbolic aspects are deconstructed, filtered, and repackaged into the context of the new receiving field (Frenkel, 2005). Based on a close analysis of how actors translated the AHSC organizational form in the field of the British healthcare, I show that the translation of foreign organizational forms was enabled by field change, and how it was performed by the role of strategic actors.

4.2. Method and analysis

Based on the narrative description, and the reconstruction of the chronology of events by using a stage model of translation as described in the previous chapter (see Table 3-4), this study unpacks the detailed translation process with a particular focus on the role of actors and the creation of meaning.

First, I use the case study design to illustrate the translation process of organizational forms. I started by providing a description of the relationship between the universities and NHS teaching hospitals during the period of institutional stability. Then I described the field conditions that led to institutional change in the field, and consequently the translation of the AHSC organizational form into England. Then, to analyze the translation process, I adopted the analytical approach of field frames. A field frame refers to a widely legitimate means and valued ends in a certain area of practice (Boxenbaum, 2006). A frame has "the durability and stickiness of an institutional logic, but akin to strategic framing, [and] it is endogenous to a field of actors and is subject to challenge and modification" (Lounsbury, Ventresca, & Hirsch, 2003: 72). In this study, I used the analytical approach of field frames in two areas. First I identified the means-ends frames that emerged during the period of institutional change. Second I identified the means-ends frame of the AHSC organizational form that arose during the translation in England.

With regard to the means-ends frames of the AHSC organizational form during the translation, I identified the frames of AHSC across data sources (interviews, archives, and government reports), comparing and juxtaposing among the identified frames. At this stage, I found that AHSC in England contained multiple means-ends frames, constructed by different actors that played the active roles in the translation of the AHSC organizational form at different times. Aligning between the key actors (the Nuffield Trust, Imperial College, and Professor Darzi) and the change in means-ends frames over time, I found that the translation process of the AHSC organizational form was constituted of three phrases, including activation, dormancy, and reactivation.

Consulting with the theoretical and empirical work on translation, I found that no work has addressed the temporary suspension of the handling of ideas, except Røvik's (2011) work.

Røvik proposed an alternative metaphor – virus – to theorize organization's handling of management ideas. His virus-inspired theory offers concepts including infectiousness (when an organization decides to adopt ideas), immunity (when the organization reacts to the idea that could lead to non-adoption, isolation, or rejection), replication (when the idea is translated into practice), incubation (when the idea stays in latency before materialization), mutation (the similar concept to translation, which is transformation of the idea to fit the adopting organization and involves various actors to transfer and implement it), and dormancy (when the idea remains in the organization for a long period, shifting between the states of activeness and inactiveness). Inspired by his virus metaphor, I applied his concepts to better fit my case, and consequently labeled phases of my translation process as follows: *activation, dormancy, and reactivation*. The two frames of AHSC emerged: one in the activation phase, and the other in the reactivation phase. I then mapped the means-ends frames of the AHSC organizational form in simple forms. To ensure accuracy, I also drew upon other data sources including news, magazines, and healthcare journal papers, to identify another set of means-ends frames in each phase, and compared to my first set of frame identification. All the frames are matched. Figure 4-4 and Figure 4-5 present the frames of the AHSC organizational form in each phase.

Next, I addressed how the translation of the AHSC organizational form in England succeeded. In other words, I examine how the AHSC organizational form became legitimate and was adopted, with a focus on the strategies and actions of the identified key actors. I sifted through the narrative, and consulted the cross-referenced raw data when appropriate, with the aim in mind to find evidence of actions done to promote or affect the adoption and meaning of the AHSC organizational form. Using an open-coding process, I focused on each data source, abstracted actions into first-order categories, and worked across data sources to find similarities and differences of the first-order categories. Building on the raw data, this coding is an inductive process with a focus on the actions in which the key actors engaged to promote the adoption of the AHSC organizational form. Then I grouped them into second-order themes (Strauss & Corbin, 2008), using theoretical and empirical work of translation to guide me (e.g., Boutaiba & Strandgaard Pedersen, 2003; Boxenbaum, 2006; Boxenbaum & Gond, 2006; Sahlin-Andersson, 1996). At this stage, I found that these second-order themes of actions were associated with particular objectives and outcomes that resulted in the translation of the AHSC organizational

form to fit the new context. These objectives and outcomes are the three aggregate dimensions of my translation process model – contextual design of a solution, strategy for gaining support and mobilizing forces, and legitimation of the organizational form.

Following my labeled three phases of translation (activation, dormancy, and reactivation) and my coding of actions and strategies, I formulated the translation process of foreign organizational forms (see Figure 4-2). Figure 4-3 shows the data structure, highlighting first-order categories, second-order themes, and aggregate dimensions. Table 4-2 shows supporting evidence for the coding. This analysis formed the complete trajectory of the translation of the AHSC organizational form in England, illustrating the role of actors, the creation of meaning, and the transformation of the organizational form in the translation process.

4.3. Finding – The translation process model

4.3.1. The relationship between universities and the NHS during the institutional stability

In England, the education of undergraduate medical students is primarily the responsibility of universities, and funded by the government through Higher Education Funding Council in England (HEFCE). Universities are required to provide education that meets the standards set by the General Medical/Dental Council (GMC, GDC). The NHS is required by law to provide facilities for clinical teaching and employ staffs who provide such clinical teaching.

With regard to research, university medical schools focus on basic sciences, and achieve legitimacy through publications, and university and medical school rankings. NHS hospitals' priority is patient care, with focus on the quality of health services and financial sustainability that could be achieved through efficiency and effectiveness in operation and management. The NHS's interest is thus in clinical research that can improve patient care. Despite these differences, they are interdependent. Universities need hospitals to provide training for medical students and laboratories to conduct basic research. NHS hospitals need university staff, particularly clinical academics, to provide specialist service and conduct clinical research that is beneficial to patient care. Based on this interdependence of providing research, education, and patient care, universities and some NHS hospitals (also known as teaching hospitals) have formed special relationship of collaboration in the national healthcare system, helping teaching

hospitals gain special status and perceived different from other healthcare providers. This special status is characterized by specific additional funding for teaching hospitals to conduct research and education (known as SIFT), close association with medical schools and universities incurring some shared costing systems (known as knock-for-knock), and provisions of specialist or tertiary care for patients.

Since the establishment of the NHS in 1948, there were tensions in balancing these three activities between universities and the NHS. The interdependence of the two entities was built on separate governance and accountability to different governmental departments and agencies. The main issues arising across the interface between the NHS and universities included funding arrangements, financial arrangements for shared facilities and staff, and staff employment. Traditionally, these tensions were contained through day-to-day communication between leaders of the two entities and some technical liaison mechanisms, i.e. knock-for-knock system and SIFT. For example, "clinical training for the students is provided in NHS teaching hospitals with which the medical schools are associated. University clinical staff provides services to NHS patients, and NHS doctors undertake some undergraduate teaching under the system of uncosted mutual assistance known as 'knock for knock" (Croham, 1987: 71).

In addition to the staff's services, the knock-for-knock system supported other shared services such as facilities, premises and student accommodations. In other words, the interdependence between universities and associated NHS hospitals at that time relied significantly on trust and good relationship between the heads of the two entities, and in some places with established practices of liaison (i.e. a representative of the medical school sitting in an office at the associated hospital). SIFT is another financial tool, which the Department of Health compensates NHS teaching hospitals for additional costs stemmed from teaching and research.

4.3.2. Field conditions and the problematization of the structures and practices between universities and the NHS (1989 – 1997)

The NHS was created in 1948 as a wholly nationalized healthcare system. It has been established on two main principles: (1) funding from taxation and (2) free of charge for all on the

basis of need (Spurgeon & Barwell, 1991; World Health Organization, 1999). After the NHS's inception in 1948, the health policy had been characterized as fairly modest adjustments to the NHS's original design. However, in late 1980s, the UK healthcare system experienced tremendous changes in its institutional structure.

The need to constrain public expenditures from the mid-1970s, mainly due to the sharp increase in oil prices and the resulting global economic recession (World Health Organization, 1999), prompted the UK government during Margaret Thatcher's premiership to consider how to make the NHS more efficient. This resulted in the major NHS reform in the UK's history. The Thatcher government introduced the internal market policy, described in the 1989 White Paper Working for Patients, and subsequently enacted into law as the NHS and Community Care Act in 1990 (UK Parliament, 2010).

The internal market policy was based on the purchaser-provider split. Traditionally, doctors determined which services to be provided to patients and management of hospitals were centralized and led by the government. The reform changed the field into the new structure, in which commissioning bodies would act on behalf of patients to buy services which were really needed (UK Parliament, 2010). Health authorities, who became purchasers, were given budget by the government to buy services from healthcare providers such as hospitals. For hospitals to be entitled as providers, they need to become NHS Trusts, which were at that time new organizations with their own management authority. The new policy aimed at improving the NHS's efficiency and quality of health services. The internal market policy therefore drew on the market logic, to transform the field into the business-like healthcare. Despite several changes over the past 20 years, the purchaser-provider structure has remained the same until the present day. Healthcare providers, following this institutional change, are subject to demands of not only the government and its agencies as funders, professional associations that maintain norms and institutions of professions, but for the first time also to patients as clients.

In line with the scheme of budgetary restrictions, the government also imposed a policy to restrict the allocation of research funding for universities and hence also medical schools. The government introduced the Research Assessment Exercise (RAE), which has remained in effect until today, to assess research conducted in universities and determine the allocation of funding

for each university accordingly. The implications of these policies for the relationship between universities and associated NHS teaching hospitals were profound. Universities more than ever focused on basic science research to achieve high RAE, while NHS teaching hospitals emphasized priority to service commitments. The difference in their priorities and goals became more salient. The below quotation from the interview with a senior management at one of the five British AHSCs illustrates the influence of the political context on the relationship between universities and associated NHS hospitals at that time:

> My interpretation of our recent history, recent being the last 3 decades or so in the UK, is that universities and their hospitals had somewhat drifted apart… the NHS became a very target driven culture, four hour waits, 18 week waits, endless targets, which really dominated the mindset of those running the hospitals. The academic agenda became sort of second order stuff. It also became an increasingly management-led culture, as opposed to a clinician-led culture. The university side, I think, the RAE has something to do with it, because, as you know, the RAE is all about publications and citations (interview, senior management, AHSC3).

Due to the NHS reform and the government's overall budget cut in public sectors, there was concern over the implications of these changes for the medical education sector (Steering Group on Undergraduate Medical and Dental Education, 1989):

> The introduction of the internal market in the National Health Service and the arrival of accountants to take the places of the hospital secretary and matron put an end to the "knock-for-knock" arrangements whereby the medical school and hospital assisted each other with clinical care and teaching. Both institutions have had to spend considerable time, effort and money determining which is responsible for what, a largely paper-driven exercise that has obscured the primary objectives to the detriment of patients and students (extracts from Times Higher Education newspaper, 2008).

In November 1987, a conference involving all the key stakeholders with an interest in medical education was convened, consequently establishing the joint Steering Group on Undergraduate Medical Education (SGUMDE) with the following remit:

> In light of the NHS reform outlined in the White Paper Working for Patients, the Steering Group was established to consider how the current arrangements for undergraduate medical education can be improved to ensure that the policies and programs of the bodies concerned are properly co-ordinated and directed (Steering Group on Undergraduate Medical and Dental Education, 1989: 1).

In other words, it analyzed the impact of the reform and considered change in the existing co-ordination arrangements at national and organizational levels with aims to maintain support and commitment of the key stakeholders to medical education. Its remit was later extended to include dental education in 1988, and research in 1990 (Steering Group on Undergraduate Medical and Dental Education and Research, 1996). Consequently the name of the steering group was changed to Steering Group on Undergraduate Medical and Dental Education and Research or SGUMDER. The SGUMDER was composed of representatives of the key stakeholders from universities, the NHS, the Department of Health, the Department for Education, funding bodies such as HEFCE, and professional associations of both universities and teaching hospitals (see Appendix B for the detailed members of the group).

Within its four published reports from 1989 to 1996, it highlighted that existing practices underlying the co-ordination such as liaison and consultation were "not enough for effective collaboration." The closer co-ordination arrangements, especially between universities and NHS teaching hospitals, were needed, if the country wanted to sustain and enhance standards of medical/dental education and research. In their final report, close collaboration was emphasized as key to determining the future quality of the nation's healthcare (Steering Group on Undergraduate Medical and Dental Education and Research, 1996). The SGUMDER established the Ten Key Principles (see Appendix A) to promote shared goals and collaborative working between the NHS and the higher education sector at all levels – governmental, regional, and organizational levels. The Ten Key Principles became the accepted "rules of engagement" that guide co-ordination across the sectors (Langlands, 2003).

Since the establishment of the SGUMDER, two issues emerged. First, the importance of collaboration between NHS teaching hospitals and universities had been recognized. The need for change in the NHS/university co-ordination arrangements was considered and promoted. For example, in response to the SGUMDER's reports, the University Funding Council (UFC, now

known as HEFCE) commissioned two task groups to examine the effects of the NHS reforms on medical education and research, and published two reports in 1991 and 1992. The HEFCE also established a task group to investigate the relationship between universities and the NHS, and provided recommendations back to the SGUMDER. It suggested the Ten Key Principles be revised and close monitoring of the balance of clinical and academic work conducted by university staff was needed if the quality of teaching and research was to be maintained (Joint Medical Advisory Committee, 1995).

Second, increasing attention was paid to the problems on financing and staffing issues arising across the relationship between universities and the NHS. In 1997, the Committee of Vice-Chancellors and Principals (CVCP) established an independent task force to examine the problem of the NHS/university relationship, specifically the issue of the management of shared staff i.e., clinical academics. The task force published a report, known as the Richards report. One of its recommendations was "more work should be done to explore forms of governance that give greater weight to the academic mission of university hospitals" (Richards, 1997: 71), and the UK should explore the models of academic health organizations existing in North America and Europe. It was agreed by my interviewees and confirmed by multiple data sources that this was the first appearance of the AHSC organizational form in the UK, as a solution to the problematizations of the NHS/university relationship. Figure 4-1 presents the means-ends frame during the period of institutional change in the British healthcare field.

Figure 4-1: Means-ends frame of the field during institutional change

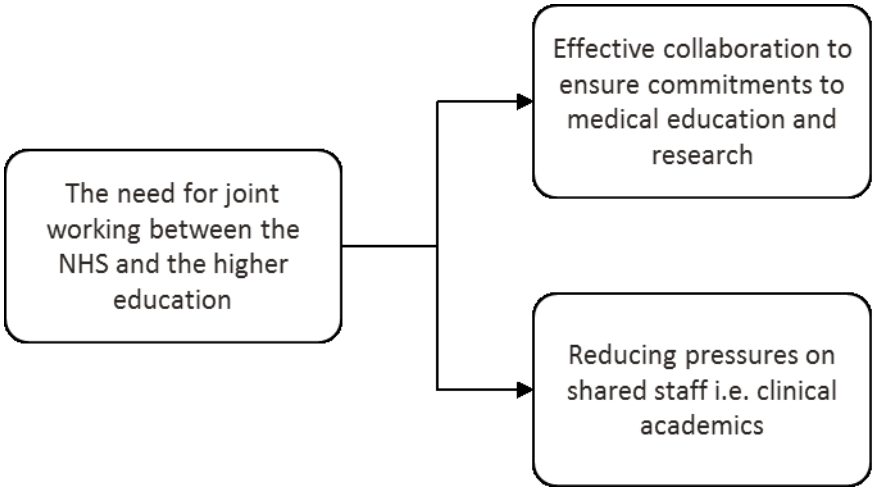


Table 4-1 presents the examples of archival materials and government reports that discussed the issues of the NHS/university relationship, published in 1989 – 1997.

Table 4-1: examples of archival materials used for analysis

Year	Examples of the archival materials produced by key actors
1989	SGUMDE's interim report[3] on the implications of the NHS reform on medical/dental education
1990	SGUMDE's 2nd report on the implications of the NHS reform on medical/dental education
1991	University Funding Council's 1st report on the effects of the NHS reforms on medical and dental education and research
1992	University Funding Council's 2nd report on the effects of the NHS reforms on medical and dental education and research
1994	The report 'Supporting research and development in the NHS' by a task force, commissioned by Department of Health
1995	House of Lords Select Committee on Science and Technology's report on medical research

[3] SGUMDE stands for Steering Group on Undergraduate Medical and Dental Education. Later when its remit included research, its name changed to SGUMDER – Steering Group on Undergraduate Medical and Dental Education and Research.

	and the NHS reform. This report singled out the problem of clinical academic career as an urgent issue.
1996	SGUMDER's forth report on the implications of the NHS reform on medical/dental education and research
1997	The report 'Clinical academic careers' by a task force, commissioned by Committee of Vice Chancellors and Principals

At the time of the field change, the structure and practice of healthcare was interrupted by the shift in logics (from the logic of medical professionalism to the market logic). The transformation of the dominant logic, and hence the field structure and identities of organizational forms, led to a considerable amount of uncertainty (Beckert, 1999). The adverse trend in clinical academic staffing and the GMC/GDC's report on difficulties of medical schools in attaining educational objectives intensified uncertainty in the field. The heightened uncertainty enabled actors to deviate from following existing institutions and open up possibilities for change, as actors struggled to gain and maintain status, while simultaneously engaging in efforts to construct new and stable rules that accommodate their interests (Lounsbury, 2002; Powell, 1991). I argue that an early step to do so can be done through problematization.

A problem is generally defined as a gap between desired outcomes and deficiency, doubt, or inconsistency perceived in the current situation. For problems to become so powerful that they have potential to drive change, problems must be framed by field-level actors or gain wide attention of the stakeholders in the field (Lounsbury & Crumley, 2007; Strang & Meyer, 1993). In this case, the SGUMDER, consisting of all the key stakeholders such as the government and professional associations, was established to define problems and find solutions to reduce uncertainty. By problematizing, the field actors defined what stakeholders should be involved in change, and shaped how change should occur, which determined the desired outcome. In the present case, the desired outcome was to find mechanisms that generate efficient joint working between universities and NHS hospitals, to alleviate the intensified tensions due to policy change, and to ensure that the NHS continued their support for education and research. This resulted in the implementation of the Ten Key Principles to guide co-ordination. The Ten Key Principles were created within the existing rules within the field as guidance for coherence between the NHS and the higher education sector. It was officially endorsed by the Department of Health and the Department for Education. However, as the Ten Key Principles did not

radically change existing structures and practices of inter-organizational relationship between NHS and universities, this solution was widely accepted and brought only incremental change to the institutional field.

The problematization of the NHS/university co-ordination arrangements and the Ten Key Principles as a solution became widely known through discourses sequentially hosted by the SGUMDER and reports by several commissioned task forces. However, as the Ten Key Principles was loosely enacted as guidance, and only provided a broad framework for joint working, without sanctions or established bodies to ensure conformity, it is sensible to say that the field still opened up opportunities for actors to find solutions that best accommodate their interests. Although the Ten Key Principles were endorsed by the government and adopted as principles for joint working, in practice nothing changed. Universities and associated NHS hospitals still found it difficult to collaborate and prioritize activities. The two entities still experienced an unprecedented decrease in the number of clinical academics due to "overwhelming pressures and workload from the two masters" (Richards, 1997: 3). And these problems were claimed to be a consequence of the inefficient and inadequate collaboration arrangements between NHS and universities. Therefore, under such circumstances and despite the existence of local solutions, alternative solutions were still to be found.

The uncertainty precipitated change. However, it was not the only factors. The present case study revealed that change was also provoked by endogenous contradictions (Seo & Creed, 2002), which in this context refers to the inter-organizational contradiction between universities and associated NHS teaching hospitals due to different goals and priorities. By this logic, the external actors would be, for example, the government, patients, and industry. When the NHS/university relationship was problematized, field-level negotiations followed over how to manage the relationship in order to reduce the uncertainty and to achieve the desired end. As the field is occupied with multiple organizational communities with differential levels of interests in education, research, and patient care, each organizational community competed over the solution that suited their interest the most. This reflected the misaligned interest that shaped the field-level negotiation over the problem framing of the NHS/university relation. This is in line with Seo and Creed's (2002) notion of latent contradictions that lead to change within organizational fields. They suggested that endogenous contradictions set the stage for 'praxis', by which actors

move "from unreflective participation in institutional reproduction to imaginative critique of existing arrangements to practical action for change" (Seo & Creed, 2002: 231).

Although the archival data from this period did not provide the direct evidence to support this endogenous contradiction, the data from interview and news and magazines revealed this internal cause for change. For example:

> The problem with the university versus NHS is that the university had high regard to the research. I remember, and I would never admit this, that the dean of the medical school at the time told me the reason that you do clinical practices is you actually have your experimental material to do trials. NHS has no regard to the university. These guys are pointy heads. They are purely publications and research (interview, senior management, AHSC 1).

The context of the UK healthcare at the moment of change was characterized by 4 conditions: 1) uncertainty due to institutional transformation in the field; 2) the emergence of field-recognized problem that followed the institutional transformation; 3) a locally-innovated solution that was not clearly defined, was loosely established and thus still failed to solve organizational problems; and 4) the competing interests between groups of actors in the field. These conditions enabled actors to find alternative solutions. Through framing of the interdependence between universities and NHS hospitals as a unique relationship and the local solution that failed to solve organizational problems, it was suggested the UK explore organizational forms in other countries that could serve such a unique relationship (Richards, 1997). It was this context of comparing their situations to others that prompted actors to propose foreign organizational forms as solutions.

Interestingly, this early attempt at translation of foreign organizational form across institutional settings did not start from a construction of problems through comparison with seemingly more successful others, as would be implied by neo-institutional translation and imitation literatures (Sahlin-Andersson, 1996). On the contrary, problem framing in this case study was born from the radical change in the British context, and because the local solution (in this case, the Ten Key Principles) was perceived as limited to solve the problem.

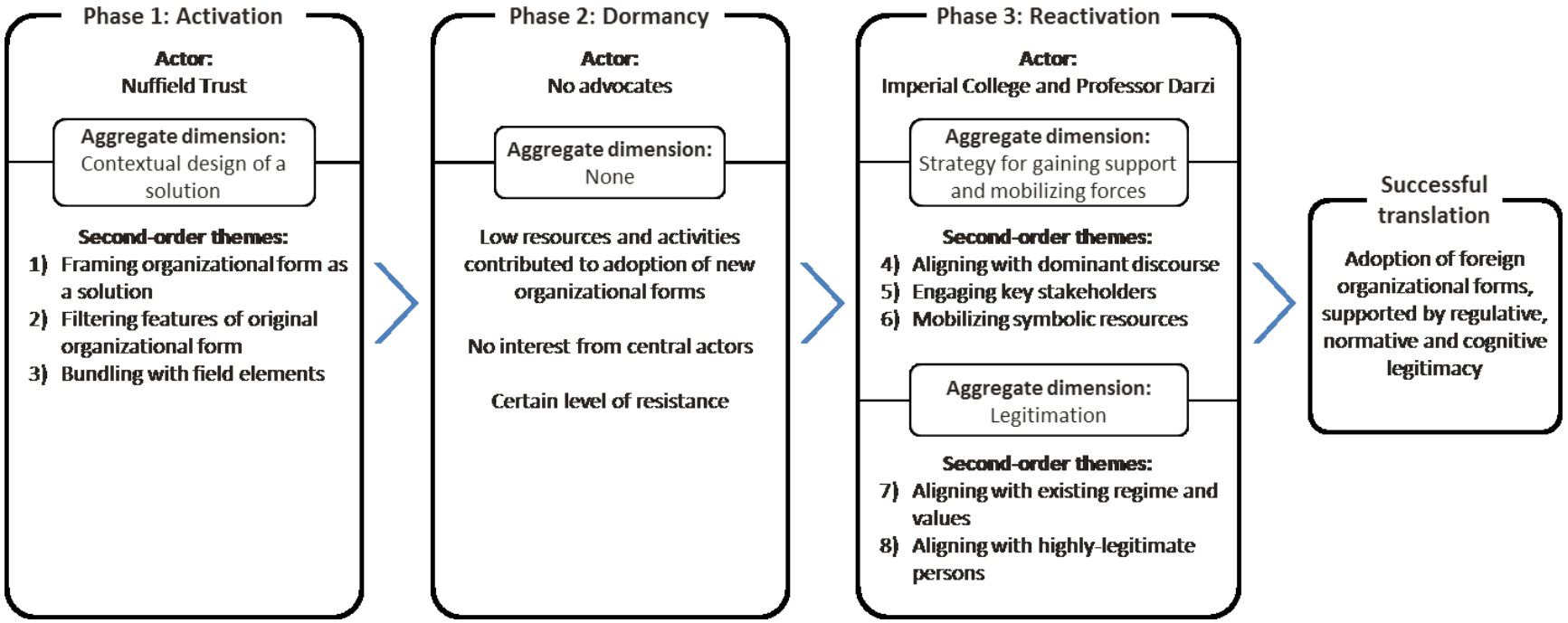
Although some field conditions facilitate the translation of organizational forms that is novel to the field, it does not guarantee the adoption. Actions are needed to gain attention and confer legitimacy to organizational forms within the new field. To do that, actors need to translate the new and foreign organizational form so that it wins legitimacy. In the next section, I examine the translation process.

4.3.3. Translation

I have reported that the primary analysis resulted in identifications of the key actors in the translation of the AHSC organizational form, and division of the translation process of the AHSC organizational form into three phases: the Nuffield Trust in the activation phase, the dormancy phase (without an advocating actor), and Imperial College and Professor Darzi in the reactivation phase.

The coding process, which is outlined in this chapter's section 4.2 Method and Analysis, yielded three aggregate dimensions on which the translation process is built (see Figure 4-2). These three aggregate dimensions are (1) contextual design of a solution, (2) strategy for gaining support and mobilizing forces, and (3) legitimation. In the activation phase, the Nuffield Trust performed the dimension (1) contextual design of a solution in the activation phase. In the reactivation phase, Imperial College and Professor Darzi performed the dimension (2) strategy for gaining support and mobilizing forces, and the dimension (3) legitimation. Figure 4-3 shows the data structure, containing categories, themes, and dimensions. Table 4-2 shows the supporting evidence for the coding.

Figure 4-2: The translation process model



Phase 1: Activation

In the activation phase, concerns over medical education and research and the ability of the NHS to support them were widely recognized, thanks to the role of the SGUMDER in instigating and hosting discussion regarding these issues. In line with this concern, another problem arose with regard to a decrease in the number of clinical academics who worked under pressure between universities and NHS hospitals. The 1997 Richards report suggested the UK look at the AHSC organizational form in the U.S. and Europe to solve the problems of the clinical academics.

The local solution – the Ten Key Principles – was constructed by the SGUMDER, which mainly highlighted significance of collaboration between the NHS and the higher education sector with focus on the governmental level, and no technical mechanisms suggested for inter-organizational collaboration. It was agreed that the AHSC organizational form be avoided, but its structures and mechanisms of joint management could be useful as a supplementary guidance to operationalize the Ten Key Principles into practical and measurable mechanisms. The Nuffield Trust was invited to perform this task.

Aggregate dimension: Contextual design of a solution

In the activation phase of translation, the actor (the Nuffield Trust) engaged in construction of the foreign organizational form to fit the new context, labeled in this study as contextual design of a solution i.e., designing the combination of the symbolic and functional elements of the AHSC to give reasons for its existence and make it suitable and useful in the British healthcare context. Based on my analysis, there were three second-order themes of this dimension: 1) framing organizational form as a solution, and 2) filtering features of original organizational form, and 3) bundling with field elements. These actions formed the basis of the initial means-ends frame of the AHSC organizational form in the British healthcare.

Figure 4-3: Data structure

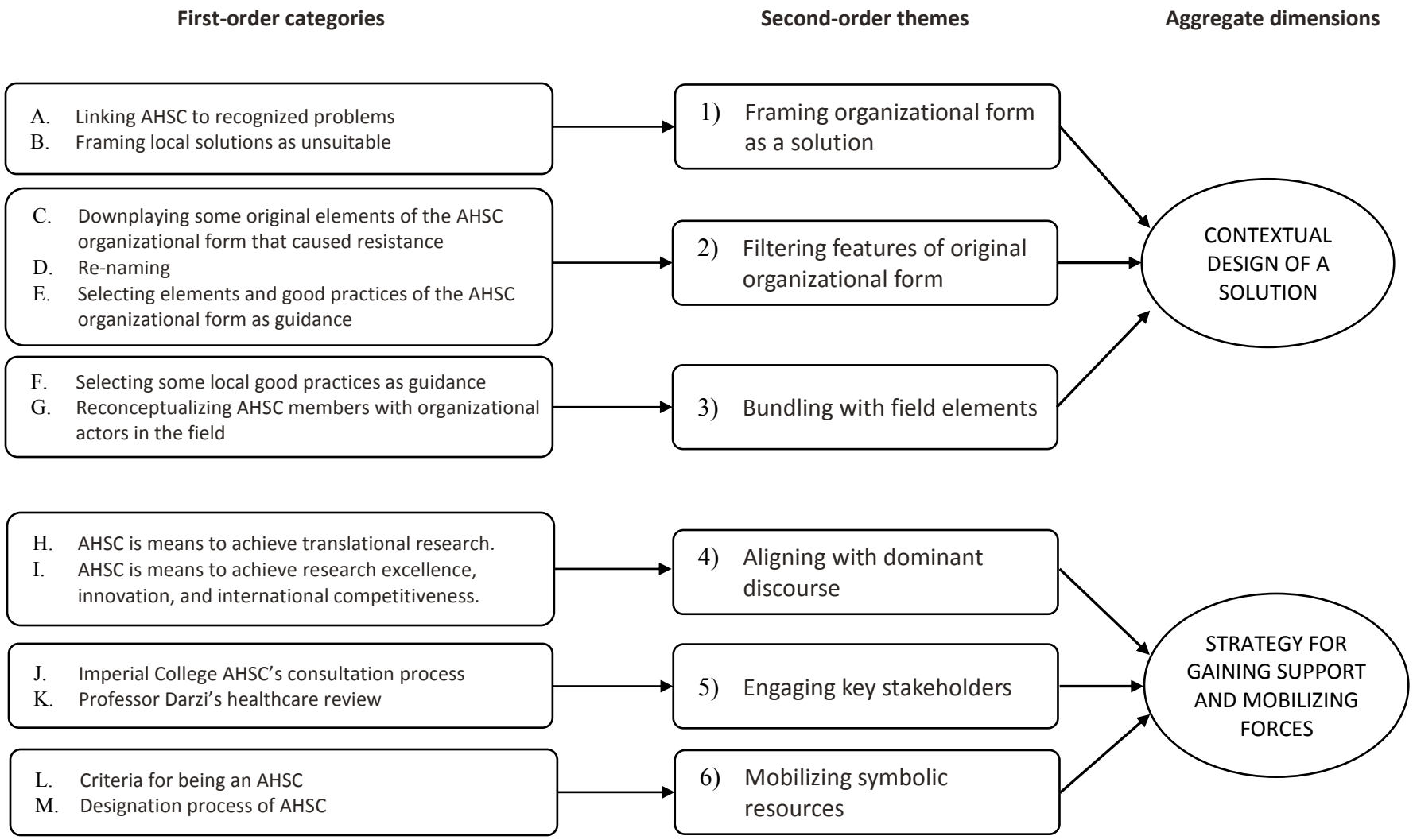


Figure 4-3 / continued

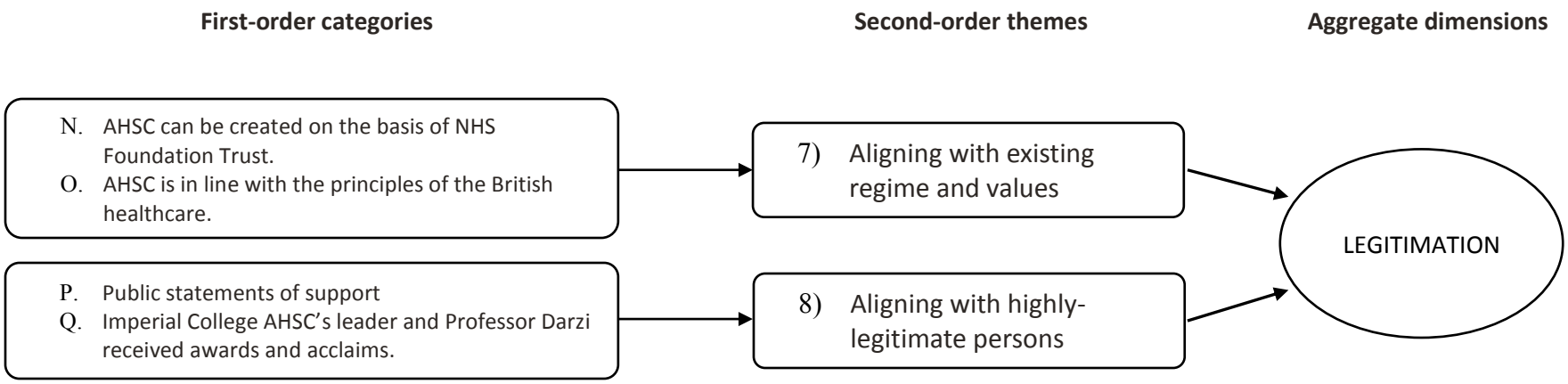


Table 4-2: Supporting Evidence for the actors' actions in the translation process of the organizational form

Phase 1: Activation	
Second-order themes and first-order categories	Representative Data
Aggregate dimension: contextual design of a solution	
1) Framing organizational form as a solution	
A. Linking AHSC to recognized problems	A1. "The philosophy of [University Clinical Centre] supports the emphasis given by SGUMDER's Second Report: that liaison and consultation are not enough for effective collaboration" (Nuffield Trust Working Group, 2000: 6).
	A2. "The Richards Report on clinical academic careers suggested that existing governance arrangements might be inherently inimical to the academic mission and proposed that the concept of an integrated teaching and research hospital should be explored, using models from North America and Europe" (Davies, 2002: 10).
	A3. "The NHS and universities needed to work together to reduce pressures on clinical academics so they could dedicate more time to research and improve their research assessment exercise performance…Consideration should be given to the concept of a university clinical partnership" (extracts from Times Higher Education magazine, 1997).
B. Framing local solutions as unsuitable	B1. The working group found that the Ten Key Principles are limited as a device to govern the NHS/academic interface" (Nuffield Trust Working Group, 2000: 5).
	B2. "The context of NHS/university relations has become increasingly complex and has outgrown

Phase 1: Activation		
Second-order themes and first-order categories		Representative Data
		the current framework [the Ten Key principles]…[This] should be reconceptualized using the introduction of a new term – University Clinical Centre" (Smith, 2001: 20, 24).
2) Filtering features of original organizational form		
C. Downplaying some original elements of the AHSC organizational form that caused resistance	C1.	"[Integrated] organisational structures in the NHS and higher education are thought by some to be incompatible, joint working would require fundamental reorganisation - this would not be welcomed" (Smith, 2001: 48).
	C2.	"The importance of the insights from these visits [in the U.S.] is more about an approach to partnership and the mechanisms for developing partnership than the particular governance structure employed. Joint management, in this conception, is more fluid than a merger implies and is not necessarily about integrating structures" (Smith, 2001: 54 – 55).
D. Re-naming	D1.	Naming AHSC as University Clinical Centre (or sometimes Academic Clinical Centre)
	D2.	"This policy slant, reinforced by the absence of a Johns Hopkins model, means that thinking about AHCs as integrated entities is much more difficult in Britain than is the case in the USA. This is reflected in the absence of any satisfactory British terminology for academic health organisations…The Nuffield Trust has suggested 'University Clinical Centre' as an alternative term, but this has yet to be widely adopted" (Davies, 2002: 7).
E. Selecting elements and good practices of the AHSC organizational form as	E1.	"In the US the development of mission statements has been an important process in the

Phase 1: Activation		
Second-order themes and first-order categories		Representative Data
guidance		ownership and establishment of joint working" (Nuffield Trust working group, 2000: 16).
	E2.	"It is not our intention to be prescriptive about the forms of local governance…In the U.S. it is commonly stated that 'if you've seen one Academic Medical Centre, you've seen one Academic Medical Centre. The same might be said of centres in the UK" (Nuffield Trust working group, 2000: 14).
3) Bundling with field elements		
F. Selecting some local good practices as guidance	F1.	"There are some very good examples of collaboration in the management of research, through collaborative committees or joint offices for R&D [in the UK]. The Medical School has a real say in the allocation of funds and the Trust benefits from focused and dynamic research that is fed back into service. Where collaboration has been achieved so have effective systems of financial allocation" (Nuffield Trust working group, 2000: 18).
G. Reconceptualizing AHSC members with organizational actors in the field	G1.	The Nuffield Trust researcher described that in the U.S. there were 125 AHSCs, then he identified organizations in the UK that could be considered as counterparts. "In the UK, the principal clinical partners of the 23 medical schools have largely self-identified themselves by participation in the UK University Hospitals Forum" (Davies, 2002: 13).

Table 4-2 / continued

Phase 2: Dormancy	
First-order categories	Representative Data
Low resources and activities contributed to the adoption of the new organizational form	"The National Health Service has been failing the public for years because of the historical divide between university medical schools and hospitals. The system is broken. Although universities' biomedical research is world class. Institutions are pushed away by a "Stalinist" NHS. The consequence is that while we are second only to the US in biomedicine and have four of the top universities in the world in this area, we are way down the table when it comes to clinical outcomes. Until five years ago, the historic split was accepted by both sectors as a face of life" (interview, Imperial College AHSC leader, Times Higher Education, 2008). No evidence of Nuffield Trust's activities and publications, or governmental reports on the AHSC topic during this time
No interest from the central actor	"When I came back from the U.S. and I had to give a presentation at the Nuffield Trust on what I did. They got a respondent in, who was leading strategy in the Department of Health at that time. So I went to my presentation. He said that this is a topic that it needed time and strategy and never came into the agenda for years. So nobody is looking because it is of no interest of British policy makers" (interview, former staff, Nuffield Trust). "It has been observed that the concept of the academic health centre has virtually no currency in the UK" (Davies, 2002: 9).

Phase 2: Dormancy	
First-order categories	Representative Data
A certain level of resistance	"The chief challenge to shared governance is thought to be the attitude towards the initiative in the rest of Wales; it is thought that other institutions would see shared governance and increased alignment as 'unfair' and to the detriment of the contribution of others in Wales" (Smith, 2001: 59). "This denial of the exceptional nature of AHSCs makes the continuation of specific funding to privileged institutions appears anachronistic. The result is a climate in which debate about medical school/NHS relationships has been seen as recherche and motivated by a sense of entitlement. Claims to a distinctive role have been resisted…There is no counterbalance to this in terms of awareness from policy-makers that academic health organisations might have particular contributions to make in pursuing national policy goals." (Davies, 2002: 12).

Table 4-2 / continued

Phase 3: Reactivation	
Second-order themes and first-order categories	Representative Data
Aggregate dimension: strategy for gaining support and mobilizing forces	
4) Aligning with dominant discourse	
H. AHSC is means to achieve translational research.	H1. "When I was doing the London report, there was quite a big mindset or trend in looking more at translational research. And you can't do translational research without a very strong partnership or ownership of clinical practices" (interview, Professor Darzi, 2009). H2. "The motivation [for setting up the AHSCs] I think is born of a historic desire, which we can argue, play in the last 20 years of effective joint working between the universities and the leading teaching hospitals around integrating their tripartite mission; combined with a growing realization bearing in mind the great AHSCs in other countries of the benefits; combined with the growing imperative in this country around realizing the benefits of translational research – Sir David Cooksey's report, which is critical here looking at how we bridge translational gaps in terms of the UK science" (interview, senior staff, Department of Health).
I. AHSC is means to achieve research excellence, innovation, and international competitiveness.	I1. "NHS London director of strategy Paul Corrigan says that as the new wave of academic health science centres are comparing themselves with the best in the world, 'and the point of world comparators is to succeed in world terms', such institutions are different from the NHS, which has historically compared itself with itself" (extracts from Health Service Journal

Phase 3: Reactivation	
Second-order themes and first-order categories	Representative Data
	magazine, 2008).
	"AHSCs help to ensure that research breakthroughs lead to direct clinical benefits for patients. In 2005, the top sixteen ranked hospitals in the US were all AHSCs. Clearly AHSCs are a model of healthcare organisation London needs to explore if the capital wants to be at the cutting-edge of research and clinical excellence" (Darzi, 2007: 26).
	I2. "AHSC is very clear and obvious routes in terms of international competitiveness" (interview, senior staff, Department of Health).
5) Engaging key stakeholders	
J. Imperial College AHSC's consultation process	J1. "The consultation is being conducted by the two Trusts and Imperial College London. It offers everyone the chance to influence the proposal and the Secretary of State's decision to accept or reject it" (extracts from Imperial College AHSC's consultation document, 2007).
K. Professor Darzi's healthcare review	K1. "The review engaged an extensive and wide range of people, including NHS professionals – GPs, hospital doctors, nurses and other front-line NHS staff – as well as a poll of 7000 Londoners, academic institutions, London Councils, the Mayor, and London MPs" (Carnall, 2007).
6) Mobilizing symbolic resources	

Phase 3: Reactivation	
Second-order themes and first-order categories	Representative Data
L. Criteria for being an AHSC	L1. Professor Darzi proposed six criteria for being an AHSC in his 2007 report *Healthcare for London: A Framework for Action*: 1) integrated governance (ranging from full merger to federated partners or delegated authorities), 2) internationally-recognized excellence in research and clinical practice (with the ability to be a leader in the UK), 3) clear integrated funding streams for research and teaching, 4) integrated leadership and career paths, 5) joint programs which combine research and clinical work, 5) commercial expertise to market research and benefits the country's economy (Darzi, 2007: 105).
M. Designation process of AHSC	M1. "Despite [no funding for being an AHSC], we had 15 applications for the first round. You have to remember something about the NHS. The thing about the NHS is, once there is a competition, they go for it. Because this was more than the badge. Being the AHSC, industry might give you more money or you might get more grants from what other means because you are using the badge" (interview with Professor Darzi).
	M2. "The amount of competitive activity, the competitive frenzy that's unleashed by the competition, a competition with no prize other than a badge was quite extraordinary" (interview with senior management, AHSC 5).
	M3. "In recognition of the global dimension, we will establish an international panel of experts to award this status" (Darzi, 2008: 57).
Aggregate dimension: legitimation	

Phase 3: Reactivation	
Second-order themes and first-order categories	Representative Data
7) Aligning with existing regime and values	
N. AHSC can be created on the basis of NHS Foundation Trust.	N1. "The opportunity to create the UK's first Academic NHS Foundation Trust has arisen as a new and entirely different option for providing the best in clinical care in the context of a world class research environment. This model of research and patient care thriving side-by-side has been pioneered by leading hospitals and universities in north America and Europe with excellent outcomes for patients" (extracts from the interview of the leader of Imperial College AHSC, available in Imperial College AHSC news release, 2006).
	N2. "The AHSC can be created within existing NHS legal structures. Although the goal will be to become an Academic Foundation Trust (FT), the AHSC will need to operate as an NHS Trust until the second stage of the process - an FT application - can be made" (extracts from Imperial College AHSC's consultation document, 2007).
O. AHSC is in line with the principles of the British healthcare.	O1. "For the first time in this country we seek to truly integrate biomedical research and healthcare provision to provide the best healthcare in the world, free at the point of delivery" (extracts from Imperial College AHSC's brochure, 2008).
	O2. "The consultation paper on the proposal to create an AHSC through the merger of St Mary's and Hammersmith Hospitals Trusts and Imperial College, together with a draft response, were discussed. It was noted that health inequality and equal access were both issues which the AHSC would have to address. It was agreed that a paragraph should be added to the

Phase 3: Reactivation	
Second-order themes and first-order categories	Representative Data
	Trust's response welcoming the opportunity to engage in debating the issues and that the response should be widely circulated to interested parties such as NHS London, Prof Sir Ara Darzi and the PCTs" (Imperial College's meeting minutes, dated 25 July 2007).
8) Aligning with highly-legitimate persons	
P. Public statements of support	P1. "The moment has been a long time coming," declared Sir Alan Langlands, sometime chief executive of the NHS in England. The moment he was referring to—the imminent emergence of a system of academic health science centres in England—was greeted last week…The culmination of several decades of fretting over what Sir Alan described in his opening address as the health service's essentially casual relationship with research, the new centres are intended to close the gap between medical academia and the NHS" (extracts from the British Medical Journal magazine, 2009).
	P2. "England's health secretary, Alan Johnson, announced on 9 March that five centres have been awarded academic health science status. Mr Johnson said, 'I congratulate the successful candidates, who have demonstrated their enthusiasm and commitment to the vision of bringing together world class research, teaching, and patient care to improve health in local communities as well as internationally through their global reach…In times of economic uncertainty it is even more important that we continue to support this country's knowledge industries to ensure that we benefit from the competitive edge which they provide'" (extracts

Phase 3: Reactivation	
Second-order themes and first-order categories	Representative Data
	from the British Medical Journal magazine, 2009).
Q. Imperial College AHSC's leader and Professor Darzi received awards and acclaims.	Q1. "In 2009, Professor Smith's pioneering role in establishing the AHSC was recognised in the NHS Leadership Awards, where he was named Innovator of the Year. In addition, the Health Service Journal recently listed Professor Smith in its 2006-09 rankings of the top 30 most powerful people in NHS management policy and practice in England, where he was the only NHS Chief Executive included" (Imperial College London news release, 2010).
	Q2. "This year's Health Service Journal's (HSJ) ranking of the 50 most powerful people in NHS management policy and practice in England puts Professor Smith in 13th position – the highest-placed trust chief executive. Professor the Lord Darzi, who is honorary Trust consultant surgeon and head of the division of surgery at Imperial College London, was ranked second" (Imperial College Healthcare NHS Trust news release, 2009).

1) Framing organizational form as a solution

The first action in the translation process of organizational forms is the actor matching the organizational form to problems. Problems could be generic that imply the natural occurrence of change (Greenwood et al., 2002), or have been widely recognized in the field, waiting for suitable solutions. In the present case, it is the latter, which allowed the actor to initially anchor the foreign organizational form within the new context.

At the outset, the Nuffield Trust referred to the concerns expressed in the SGUMDER's report and their call for new mechanisms for better collaboration between the NHS and universities, as stated:

> Liaison and consultation are not enough for effective collaboration. Both parties [higher education and the NHS should] recognize their unity of purpose and combine in a joint enterprise to achieve it (extracts from the SGUMDER's 2nd report: 2).

The Nuffield Trust emphasized the recommendation in the 1997 Richards report that the UK should explore the academic health organizations existing in the U.S. and Europe to solve clinical academic career in crisis. In other words, the Nuffield Trust highlighted the linkage between the problematization of the NHS/university relationship and the AHSC organizational form (the solution).

In addition, the Nuffield Trust viewed the local solution – the Ten Key Principles – as too limited and not detailed enough to capture real complexities of the relationship between universities and associated NHS hospitals. While the SGUMDER placed more emphasis on the issues of medical education and research, the Nuffield Trust extended the concern to include all the three overlapping activities, research, education, and clinical services. The Nuffield Trust viewed that it was not only about the role of the NHS in medical education and research, but also the role of the universities in supporting clinical care that needed to be emphasized. This interdependent role, the Nuffield Trust emphasized, required both entities to develop joint working to deliver research, education, and clinical care. The quotation below illustrates how the Nuffield Trust framed the local solution – the Ten Key Principles – as unsuitable for managing the relationship between universities and NHS teaching hospitals:

> There is a need for a new framework to address joint working between university hospitals and medical schools…The working group found that the Ten Key Principles are limited as a device to govern the NHS/academic interface. They lack a modern strategic context and are neither sufficiently broad nor detailed enough to address all the aspects of the shared agenda (Smith, 2001: 20).

Further, the Nuffield Trust emphasized that the management between universities and NHS hospitals could take form of the partnership structure with joint objectives, and referred to the examples of the AHSC organizational form in the U.S. The Nuffield Trust made visits to several AHSCs in the U.S. (Smith, 2001; Davies, 2002), and presented their experiences in the way that AHSC could be created in England. Interestingly, the Nuffield Trust clearly referred to the examples of the American AHSCs, the original name was not adopted. Rather, the Nuffield Trust invented the new name – University Clinical Centre (or sometimes Academic Clinical Centre) and promoted this new name to be adopted in the UK.

While the American version of the AHSC organizational form is generally described as means to achieve the tripartite mission through integrated structure and culture, and as healthcare delivery for the uninsured group (see Table 3-6), the Nuffield Trust described the AHSC organizational form under the name of University Clinical Centre as means to achieve not only the tripartite mission but also something more specifically involved with its institutional context – the integration between NHS hospitals and universities and the issues of clinical academics. In other words, the American version of the AHSC organizational form is framed with a focus more on activities regardless of the institutions involved and their societal roles in providing healthcare for the uninsured group, whereas the British version of the AHSC organizational form was initially framed with more emphasis on the integration of the two entities as a consequence of initial concerns over threatened standards of medical education and research and clinical academic career in crisis. Specifically, the actor constructed a functional aspect to the organizational form, assigning a raison-d'être to the organizational form within the new field (Boxenbaum & Gond, 2006).

By framing AHSC as the solution to the field's problems – the problematic relationship between universities and associated NHS hospitals, and a decrease in the number of clinical academics – the Nuffield Trust engaged in contextual design of the organizational form as a

solution. The Nuffield Trust modified the functional and symbolic aspects of the organizational form in order to make it fit better with the context of the receiving field.

2) Filtering features of original organizational form

It is widely known that the AHSC organizational form has diverse models of structures, ranging from fully-integrated structure with a single management led by either a medical school or a hospital to partnership structure in which a representative from each organization is present at the board. AHSCs in the U.S. are so diverse to the extent that there was a repeated saying that: "if you've seen one academic health [science] center, you've seen one academic health [science] center" (Aaron, 2001).

When the AHSC organizational form was first introduced in 1997, there was however understanding that it was the model of 'one organization' under a single management or a kind of merger (Smith, 2001), which were perceived that either a university owned a hospital or a hospital owned a medical school.

In the U.S., it is legitimate to form such an organizational form with single management, as organizational actors in the healthcare field have independent authority in designing their own structures with little intervention from the government. In the UK, in contrast, although universities are independent, the NHS is largely controlled by the government through the tax system and centralized management for the national healthcare system. Universities and NHS hospitals had different priorities and accountabilities. In addition, they had different measures of success, which was a consequence of the political context. For universities, the RAE led to a primary focus on research, while the NHS gave priority to clinical services. As one of the most well-known governance structures of the AHSC organizational form in the U.S. is the integration of the tripartite mission under single ownership and leadership of medical schools, such as Johns Hopkins (Davies, 2002), some perceived AHSC too foreign and unsuitable for the British healthcare context. It was impossible at that time for non-healthcare organizations such as universities to own hospitals in England. Furthermore, there was strong opposition to AHSC among other non-teaching healthcare providers, as the organizational form was viewed as elitist, and there was concern that it could generate unfairness in the communities of healthcare in competition for government funding. An interview that the Nuffield Trust conducted with the

University Hospital of Wales and the University of Wales College of Medicine, which showed interest in developing joint working similar to AHSC, gave an example of the existence of such opposition:

> The chief challenge to shared governance is thought to be the attitude towards the initiative in the rest of Wales; it is thought that other institutions would see shared governance and increased alignment as 'unfair' and to the detriment of the contribution of others in Wales (Smith, 2001: 59).

Thus there was a certain level of resistance to the notion of one organization that could bring such radical change to the NHS structure. There was also a certain level of resistance to the adoption of AHSC, as this new organizational form was perceived as conflicting with the political context, existing inter-organizational structure, and value of fairness of the receiving field.

To translate the AHSC organizational form to fit in the British healthcare context, the Nuffield Trust downplayed the certain types of governance structures of AHSC such as Johns Hopkins, where a university owns hospitals, and conceptualized the AHSC organizational form in the way that it was a flexible organizational form with joint objectives, which could go with any types of governance structures. The Nuffield Trust labeled it with a new term University Clinical Centre (see Davies, 2002; Nuffield Trust Working Group, 2000; Smith, 2001). Albeit different names, University Clinical Centre was similar to the AHSC organizational form in terms of managing the tripartite mission, joint strategy and aligned managerial functions between the two entities. The decision to name AHSC as University Clinical Centre (or sometimes Academic Clinical Centre or Partnership) also contributed to adapting AHSC to the new field. Fundamentally, it was an attempt to avoid resistance to the AHSC organizational form by attaching a new label. By downplaying some elements of the original version of the organizational form that could block the entry of the organizational form into the field, the Nuffield Trust translated the foreign organizational form into the format that was acceptable in the British healthcare context.

> A University Clinical Centre is a virtual body, and its composition, beyond the core membership of university hospitals and medical schools is flexible and will develop over

> time. The term 'centre' does not, in this context, relate to a centralized body nor necessarily imply physical co-location (Nuffield Trust, 2000: 5 - 6).

The key of developing University Clinical Centre was to develop joint working mechanisms between universities and NHS hospitals, which was similar to AHSCs in the U.S. but not necessary to be single management or leadership. The Nuffield Trust was not prescriptive about the forms of governance and structure, but emphasized more on culture within the relationship between these two entities to have common objectives. In other words, while downplaying some elements of the AHSC organizational form, the Nuffield Trust emphasized others that could be generalized and easily transferred into England. For example, The Nuffield Trust highlighted mission statements of AHSCs in the U.S., which could be adopted by universities and associated NHS hospitals, who wished to become University Clinical Centre:

> In the US the development of mission statements has been an important process in the ownership and establishment of joint working. A mission statement is developed through active engagement with staff and regularly reviewed. The phrase mission management in the U.S. reflects a move from apple pie statements to ones that are measurable and can guide a joint approach (Nuffield Trust, 2000: 16).

By downplaying some elements of the organizational form and emphasizing others, the actor transformed the AHSC organizational form to be more compatible and fit with the new institutional context.

3) Bundling with field elements

Another essential action in the translation process of the organizational form into the new field is constructing the organizational form in the format that is understandable, useful, and acceptable to actors in the field. This can be done through bundling the organizational form with existing beliefs, practices and context in the field. By filtering the features of the organizational form through downplaying some features and emphasizing others as described above, the Nuffield Trust combined these filtered elements of the organizational form with existing elements of the field's such as practices and approaches of joint working that some universities and associated NHS hospitals already had in place.

The Nuffield Trust noted a number of best practices from selected university/NHS partners in the UK, which could be examples of what they viewed as 'good' joint working practices and arrangements and could be used to construct University Clinical Centre:

> There are some very good examples of collaboration in the management of research, through collaborative committees or joint offices for R&D [in the UK]. The Medical School has a real say in the allocation of funds and the Trust benefits from focused and dynamic research that is fed back into service. Where collaboration has been achieved so have effective systems of financial allocation…In Dundee, as part of the Tayside Consortium, the Trust attempts to recruit research-active clinicians. Additionally the Chief Scientist in the Scottish office annually issues guidelines to the NHS which assist in the objective of joint research. This approach offers the Trust and the University the opportunity to develop an overt plan, under the direction of the head of the research consortium, for the allocation of research monies (Nuffield Trust working group, 2000: 18).

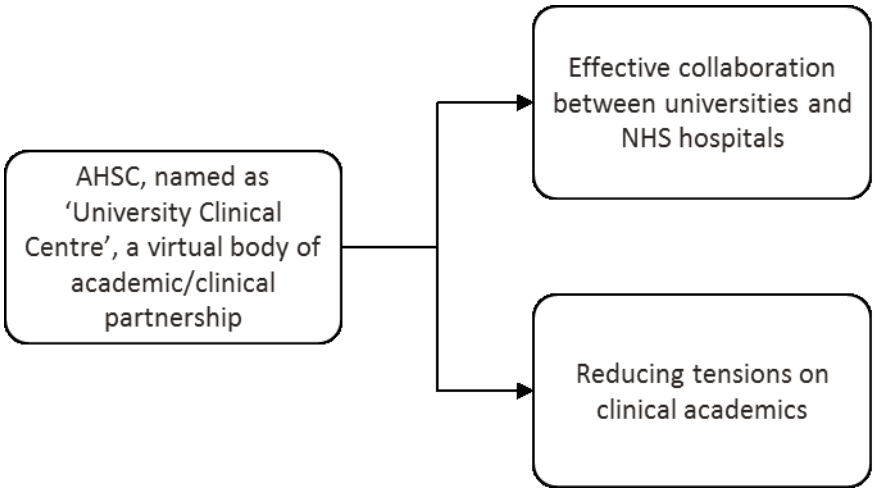
In addition, to construct the AHSC organizational form in the version that is understandable and useful to the field, the Nuffield Trust reconceptualized constituents of the American AHSC with organizational actors in the British healthcare field. In the U.S., organizations that are listed as members of the Association of Academic Health Centers (AAHC) are AHSCs. The definition of the AHSC organizational form provided by the AAHC refers to organizations that consist of a medical school, health profession school(s), and an owned or affiliated relationship with hospitals, health system, or organized healthcare delivery (Wartman, 2007). This results in 125 American AHSCs. In England, since no such organizations existed, the Nuffield Trust referred to the members of the UK University Hospitals Forum as counterparts. The members of this Forum included 23 medical schools with associated relationship with 28 hospitals across England (Davies, 2002). The Nuffield Trust argued that the definition of the UK counterparts of the American AHSC's members was used to advance understanding regarding the AHSC organizational form.

Once the new organizational form found its place in the new context, it needs material and/or symbolic modifications to adapt to the new context and gain wide acceptance. The actors select, add, subtract, and transform some features of the organizational form to make it suitable

for their context. These features e.g., specific meaning, practices, functions, constituents, and values could be removed as they might conflict with some institutional elements of the new context. Some features might be emphasized, while others might be softened in order to render the organizational form suitable, useful, and legitimate for the new context. The organizational form was constructed as generalizable and flexible, however, detailed enough to present its distinctiveness from existing organizational forms and practices in the new institutional context.

Figure 4-4 illustrates the outcome of the translation of the AHSC organizational form in the activation phase in the simple format of means-end frame. The key actor translated the organizational form by matching between the solution and existing problems, and naming and defining the organizational form in the way that it became understandable and acceptable to local actors.

Figure 4-4: The translated frame of the AHSC organizational form in England in 1998 – 2004



The Nuffield Trust actively promoted the adoption of the AHSC organizational form in the British context. Their activities included studies of various AHSCs in the U.S., publications that compared the American AHSCs and the NHS/university relationship in the UK, and

organizations of events for policy makers and leaders of hospitals and universities to share their views regarding the AHSC organizational form.

In the activation phase, the key actor (the Nuffield Trust) consolidated a lot of ideas – material and symbolic elements of the AHSC organizational form, best practices in the UK, existing threats and problems in the field, and possible resistance to the organizational form – and interpreted these elements in the way the organizational form could be generalized, understandable, useful, and acceptable to the field's audience. However, the AHSC organizational form was not adopted in the activation phase. One reason for unsuccessful translation can be attributed to how the Nuffield Trust theorized the AHSC organizational form as a solution. This will be explained in details in the next chapter.

Another likely reason for unsuccessful translation in the first phase could be because of diverse interests of other actors and the dominant value of equity in the field. In other words, the translation of the AHSC organizational form still did not respond to the interest of other actors and, in particular, the central actor (the government) at that time – they did not know why AHSC mattered to them or to the British healthcare. Furthermore, in the activation phase, there was resistance from other sub communities in the NHS such as district hospitals to the AHSC organizational form. Strong views were expressed against the special status such as University Clinical Centres or AHSC that could potentially create hierarchies among hospitals. There was fear that hospitals in general might receive less funding than their peers with special relationship with medical schools. Although the Nuffield Trust tried to modify the original organizational form into a version that was seemingly more suitable, it still did not convince the rest of the stakeholders in the field. One Nuffield Trust researcher summarized obstacles to the adoption of the AHSC organizational form, as follows:

> Ultimately, differences in perception of academic health organisations may rest in large part upon difference in national values…Americans celebrate success and excellence, especially in the fields of academic and scientific endeavour. They have a high level of faith in science and technology to solve problems and value choice and diversity but have little concern for equity. Americans also distrust government, and prefer leadership to come from non-governmental organisations. In contrast, the British appear far more concerned with equity, given to higher expectations of government and less fixated with

> choice. [AHSCs] reflect the society in which they exist and the extent to which properties of leadership and a distinctive identity are conferred upon them is first and foremost the result of social processes (Davies, 2002: 40).

The AHSC frame – an organizational form to support the integration of the tripartite mission to enhance healthcare – can be generalized for adoption. But the obstacles to the adoption was other socially-constructed elements of the American AHSC such as the value of individual rights, success, and being excellence, which collided with the valued principle of equity and anti-elitism in the British healthcare. Here the equity does not only mean equal treatment for patients, but also refer to equity among healthcare providers. In other words, teaching hospital, non-teaching hospitals, other health professional organizations are all equal and thus no healthcare providers should be treated with specialty.

Phase 2: Dormancy

In 2004 – 2006, the translation of the AHSC organizational form was in a dormant state, characterized by very little discourse in the form of publications or public accounts regarding the issues of the joint management and the adoption of the AHSC organizational form, no interest or support from the central actor like the government, and no key contributions of resources and activities made to promote the AHSC organizational form in the field.

AHSC was a controversial topic as the organizational form carried some interpretations conflicting with the political context and some beliefs in the field. Therefore, although the key actor (the Nuffield Trust) worked to adapt the AHSC organizational form to the new field, the translation was still not successful. Specifically the AHSC organizational form in England was looked on with indifference by the government, who was the central and most highly legitimate actor, and was opposed by some other healthcare providers who might have less involvement with provisions of medical education and research:

> It has been observed that the concept of the academic health centre has virtually no currency in the UK and, given this, the absence of policy with this specific focus is not surprising. The interface between the health service and higher education has been a subject of ongoing, if intermittent, debate since 1948. In recent years a number of challenges have arisen which work across this interface. Yet the shift to acceptance that an

> institutional focus for policy is necessary to achieve an integrated response to these challenges has never occurred (Davies, 2002: 9).

However, the efforts of the Nuffield Trust to translate the AHSC organizational form in England were not in vain. Although the government and the large part of the NHS were not interested in the adoption of the AHSC organizational form at that time, some universities and NHS teaching hospitals were interested and kept the organizational form alive. This is partly because of the way the researchers at the Nuffield Trust detached the organizational form from the specific U.S. context and developed the abstraction that accompanied the travel of the AHSC organizational form. In order to promote the organizational form within the field, these researchers had worked from 1997 to 2004 to present AHSC as the solution to a number of problems arising across the interface between universities and the NHS, and objectified the translation of the AHSC organizational form into a certain number of publications. Rather than paying specific focus on medical education and research, these Nuffield Trust researchers developed the relationship among research, education, and clinical care that had stronger linkage to healthcare and the NHS as a whole. These efforts kept the AHSC alive and continued its translation in the field. As a consequence, the work of the Nuffield Trust actually supported the translation of the AHSC organizational form to endure and continue within the field. One leader of the designated British AHSCs referred back to the role of the Nuffield Trust in my interview:

> We had various attempts to tackle the problem of implementing AHSC in the past. In 2002 we got somebody from the Nuffield Trust to produce a piece of research, a book on historic academic medical science centres (interview, senior management, AHSC 2).

Lack of interest in the adoption of AHSC also reflected in the interview with a former staff of the Nuffield Trust, who mainly involved in research project on AHSC in 2001 – 2004. He described the situation during the dormancy phase, as follows:

> When I came back from the U.S. and I had to give a presentation at the Nuffield Trust on what I did. They got a respondent in, who was leading strategy in the Department of Health at that time. So I went to my presentation. He said that this is a topic that it needs time and strategy and never in the agenda for years. So nobody is looking because it is of no interest of British policy makers. I did some bits on consultancy subsequently so there

> was this kind of rumbling discussion kept alive by a group of chief execs [of NHS teaching hospitals] and heads of medical schools. And I was also working on consultancy which had helped keep it alive. So and then somehow out of all of that, I don't know how it happened, Imperial College kind of emerged, with Ara Darzi's tie (interview, former staff, Nuffield Trust).

In 2006 the translation of the AHSC organizational form was reactivated, thanks to the role of Imperial College and Professor Ara Darzi. Therefore, another interesting question is under what circumstances and how AHSC moved from the dormant state to the reactivated state.

Phase 3: Reactivation

In 2006 – 2009 two key events arose that allowed change to occur and also enabled the two key actors (Imperial College and Professor Darzi), who had an interest in the AHSC organizational form, to once again bring it back to the mainstream attention of the stakeholders. The first key event was the collapse of the Paddington Health Campus, invested through private finance initiative or widely known as the PFI scheme. The Blair government set up the project of the Paddington Health Campus to establish what they called "a super hospital" in the newly developed Paddington area. However, the cost of development exceeded the budget and kept increasing. The project was finally cancelled, which badly affected Imperial College whose facilities of the medical school were part of the project.

During the same time the government had recently introduced a new type of organization of healthcare providers, namely the NHS foundation trust. Compared to NHS hospitals, NHS foundation trusts enjoyed more freedom in terms of managerial and financial aspects. They have more authority to manage themselves. It is a part of the policy to decentralize the NHS. By law, the form of the NHS Foundation Trust can also be run and managed by non-hospital organizations. With the shock from the collapse of the Paddington project and the opportunity from the new form of NHS Foundation Trust, Imperial College and its associated hospitals – Hammersmith and St Mary's – consulted and agreed to integrate their governance and structure. Hammersmith Hospital merged with St Mary's Hospital to become Imperial College Healthcare NHS Trust, which has been the largest NHS Trust in England until today. This new merger integrated with the medical school, and the whole structure was led by Imperial College.

Following this integration, Imperial College and the two hospitals announced the creation of the UK's first AHSC.

The second event was the change in the leadership of the NHS London in 2006. The new leader of the NHS London determined to reform the capital's healthcare to be modernized, world-class, and to meet patients' needs. Professor Darzi, who was the head of the clinical academic department of Imperial College and the associated NHS hospital, was asked by the NHS London to review healthcare and propose strategy. Professor Darzi published a powerful report: *Healthcare for London: A Framework for Action* in 2007, in which one recommendation was the creation of a number of AHSCs in London. He was then elevated by the Brown government to The House of Lords and began to act as a consultant to the Prime Minister on the healthcare issue. While he worked as a health minister, he continued advocating the adoption of the AHSC organizational form across England.

The key actors (Imperial College and Professor Darzi) continued highlighting the frame of the AHSC organizational form constructed in the first phase: AHSC was a solution to tensions and complexities of NHS/university relationship and to generate effective collaboration between the two entities, and added other elements that were more up-to-date. In the reactivation phase, two aggregate dimensions prevailed: (a) strategy for gaining support and mobilizing forces, and (b) legitimation of the AHSC organizational form.

Aggregate dimension: Strategy for gaining support and mobilizing forces

In the reactivation phase, the actors (Imperial College and Professor Darzi) engaged in the dimension of strategy for gaining support and mobilizing forces to promote the AHSC organizational form to be visible, powerful, and compelling; and achieve legitimacy for the adoption of the AHSC organizational form. Based on my analysis, there were three second-order themes for this dimension: 4) aligning with dominant discourse, 5) engaging key stakeholders and 6) mobilizing symbolic resources.

4) Aligning with dominant discourse

The transformation of the reaction to the AHSC organizational form from a solution that was considered useful but not suitable, to a very essential and imperative organizational form,

had much to do with the role of strategic actors to gain resources and support from the key stakeholders (in this case, the government and other sub-communities of the NHS apart from teaching hospitals). In this present case, Imperial College and Professor Darzi aligned the AHSC organizational form with contemporary elements within the field that could provide energy to facilitate and accelerate the adoption of the organizational form. These elements were dominant discourse such as political agenda and trends that were currently of interest of the stakeholders.

When Imperial College and Professor Darzi translated the AHSC organizational form, they drew on a range of political discourses concurrently available in the field, as part of their strategy to facilitate the adoption of the organizational form. Specifically, they referred to the dominant political agenda and trends in the field of healthcare – translational research and innovation.

In 2006, Sir David Cooksey was requested by the Chancellor of the Exchequer to review the arrangements of the public funding for health research in the UK. This review is published in 2006, known as the Cooksey report. The Cooksey report acknowledged that the health research had made contributions to the nation's healthcare and economy. However, there were neither overarching strategies for prioritizing types of research nor directions. The Cooksey report emphasized the importance of translational research for the British healthcare and economy. Translational research in the context of healthcare refers to "the process of taking the findings from basic or clinical research and using them to produce innovation in healthcare settings" (Cooksey, 2006: 15). However, the report showed that there were two gaps in translational research in the British healthcare. It suggested that closing translational gaps needed strong collaboration between universities and NHS organizations.

Meanwhile, the Blair government set forth a 10-year framework on science and innovation (2004 – 2014) to improve the nation's health and create the nation's wealth in England (UK Government, 2004). It highlighted research and innovation as key to achieve international competitiveness, and therefore growth and wealth of the country. In the healthcare sector, this framework also embedded research and innovation as part of the culture and ethos of the NHS (National Institute for Health Research, 2009). Furthermore the role of research in the

NHS was emphasized as instrumental to move the NHS to the forefront in the global healthcare and market, and this gave rise to the importance of the university sector in helping deliver this.

In line with this policy (in promoting research, innovation, and international competitiveness) and the Cooksey report's recommendations on closing translational gaps, the government established a new health research funding body, 'National Institute for Health Research' (NIHR). NIHR is a national research facility, which provides the framework to position, manage, and maintain research issues including directions, staff, and infrastructure in the NHS in England (Department of Health, 2006). The aim of the NIHR is to enable the NHS to be innovative and conduct leading-edge research with world-class organizations such as universities, with focus on the need of patients and publics (Department of Health, 2006: 9). In summary, the goal was to promote innovation and translational research with expected outcomes that were linked to both healthcare for patients and the country's international competitiveness to drive economy and growth.

Both Imperial College and Professor Darzi connected the AHSC organizational form to these political agenda and mindset by reframing it as means to achieve these desired ends. Through this connection, the meaning and functions of AHSC became associated with innovation, translational research, world-class status in healthcare, and international competitiveness. This is illustrated by the quotation from my interview with Professor Darzi as shown below.

> When I was doing the London report, there was quite a big mindset or trend in looking more at translational research. And you can't do translational research without a very strong partnership or ownership of clinical practices (interview, Professor Darzi, 2009).

This is consistent with Boxenbaum and Gond's (2006) work on micro strategies of contextualization. "Social movements and new trends carry positive energy that benefits practices associated with them" (Boxenbaum & Gond, 2006: 18). In their examination of individual transfers of the American business practice of social responsible investment (SRI) to France and Quebec, they found that one strategy that the individuals used was 'stowing' – the action that individuals align a foreign practice with a social movement or trends to use it as a mobilizing force and facilitate the transfer. By aligning with the dominant discourses in the field,

the actors increased legitimacy for the AHSC organizational form. The AHSC organizational form became perceived as means that would help the NHS achieve innovation and translational research, and as a symbolic organization to compete internationally. This frame of the AHSC organizational form reflected in my interview with a senior staff at Department of Health:

> The motivation [for setting up the AHSCs] I think is born of a historic desire, which we can argue, play in the last 20 years of effective joint working between the universities and the leading teaching hospitals around integrating their tripartite mission; combined with a growing realization bearing in mind the great AHSCs in other countries of the benefits; combined with the growing imperative in this country around realizing the benefits of translational research – Sir David Cooksey's report, which is critical here looking at how we bridge translational gaps in terms of the UK science. AHSC is very clear and obvious routes in terms of international competitiveness (interview, senior staff, Department of Health).

By aligning with the dominant discourse in the field at the time, the AHSC organizational form gained support from the central actor and thus forces to become powerful, useful, and legitimate in the eye of stakeholders. The framing of the AHSC organizational form connected with the dominant discourse, becoming more relevant to the field. The AHSC organizational form was considered as means to achieve innovation, translational research, and international competitiveness.

5) Engaging key stakeholders

Another critical factor for the adoption of the AHSC organizational form was also the degree to which the stakeholders, particularly those previously against AHSC as the government and sub-communities of the NHS in general, were in favor of the establishment of the AHSC organizational form. Imperial College and Professor Darzi created arenas, in which they engaged all stakeholders to enroll them into their vision, and negotiate over framing and meaning aspects of the organizational form. This was to shape and construct the organizational form in response to various needs and interests of stakeholders and to gain support from them for the adoption of the new organizational form.

To gain wide acceptance and support, Imperial College conducted a consultation process regarding the establishment of the AHSC organizational form with all the stakeholders, while Professor Darzi engaged the field audiences through his two reviews of healthcare of London and healthcare across England.

Imperial College and the two hospitals announced public consultation on the creation of the UK's first AHSC. This public consultation involved multiple groups of stakeholders: patients, NHS partners and healthcare providers in the local community, staff, students, academics and researchers, and local health authorities. It described what the new integration of Imperial College and the two hospitals in the form of the AHSC organizational form meant to the field of the healthcare and what benefits AHSC would bring to them:

> The consultation period will run from 1 May to 31 July 2007. During this period we will be asking everyone with an interest, including staff, patients, students, researchers, partner organisations and the public, for their views [on the creation of the UK's first AHSC] (extracts from Imperial College AHSC's consultation document, 2007).

Imperial College submitted the stakeholders' views in response to the consultation process to the Department of Health so that the Department of Health took them into account to make a decision whether to allow the creation of an AHSC. Throughout the consultation process, Imperial College emphasized that being an AHSC would provide world-class research, education, and healthcare for students, employees, patients, local community, and the country. On 1st October 2007, the government approved the creation of the AHSC by Imperial College and associated hospitals.

Likewise, Professor Darzi made two reviews of the healthcare in 2007 and in 2008: *Healthcare for London: A Framework for Action*, and *High Quality Care for All: NHS Next Stage Review Final Report* respectively, which involved the biggest consultation process in the history of the British healthcare – 60,000 NHS staff, clinicians, patients, the government and its agencies (NHS Choices, 2011). He addressed the key stakeholders regarding the case for change to improve the quality of healthcare to be world-class, and within this framework of change, included the AHSC organizational form as one means to achieve it. His report was based on the

notion that London is one of the greatest capitals in the world, and therefore people should receive the best healthcare:

> In 2006, Ara Darzi was asked by David Nicholson who was then the Chief of the London SHA, and soon after became the Chief Executive of the NHS, to form a group of clinicians to look at London's healthcare on the basis that here we have a capital city, one of the richest cities in the world, with levels of health outcome which is as poor as anywhere in this country and actually on the level, in some parts, of Mumbai (interview, senior management, AHSC2).

His reports were highly influential. The Financial Times acclaimed it as "the world's most ambitious attempt to raise the quality and effectiveness of an entire nation's healthcare" (Timmins, 2008). Through this review, Professor Darzi mapped the AHSC organizational form on the British healthcare landscape as a driver of innovation in the NHS. The AHSC organizational form was not only directly linked with NHS teaching hospitals, but also networked with local and general hospitals in the community to provide ground-breaking research for the best healthcare (Darzi, 2007). In addition, Professor Darzi's consultation process and reviews showed that the AHSC organizational form was beneficial to patients, communities, and the country. His report was embraced by the NHS London and the government. Subsequently, Professor Darzi was promoted to be the House of Lord to give advice on the healthcare issues. As a result, the establishment of the AHSC organizational form was included in the political agenda.

By engaging the stakeholders into negotiation, framing and construction of the organizational form, the key actors shaped the framing of the AHSC organizational form in response to the interest of the stakeholders. This helped gain support and increase usefulness and propriety of the organizational form in the field. The AHSC organizational form was considered as means to achieve effective collaboration between universities and the NHS for better research, education, and clinical care, and also innovation in the NHS.

6) Mobilizing symbolic resources

Another theme of actions in which the key actor, particularly Professor Darzi, engaged was mobilizing symbolic resources. These symbolic resources included setting criteria and

organizing the designation process of AHSC with high-credential selection panel. These symbolic resources related to the image and identity of the AHSC organizational form in the British healthcare. By mobilizing symbolic resources, Professor Darzi made the AHSC organizational form attractive, powerful, and normatively legitimate in the field, which accelerated and facilitated the adoption of the AHSC organizational form.

In his London report, Professor Darzi translated the AHSC organizational form into criteria, which were specific to the British context. The criteria included 1) integrated governance (ranging from full merger to federated partners or delegated authorities), 2) internationally-recognized excellence in research and clinical practice, 3) clear integrated funding streams for research and teaching, 4) integrated leadership and career paths, 5) joint programs which combine research and clinical work, 5) commercial expertise to market research and benefits the country's economy (Darzi, 2007: 105). Professor Darzi stated "we propose six criteria for determining if a university/hospital partnership is really an AHSC…This would ensure that the AHSC label did not become a term like 'university hospital' and 'teaching hospital', which are both used loosely and liberally" (Darzi, 2007: 104). By setting these criteria, Professor Darzi created status and distinctiveness of an AHSC in relation to the field of the British healthcare.

Then when he became the House of Lord, Professor Darzi advised the government to organize the AHSC designation process. Organizations that had already called themselves as AHSC such as Imperial College also needed to reapply through this designation process. The government established an international selection panel, in which representatives of AHSCs from many countries (e.g., the U.S., the Netherlands, Canada, and Australia) were invited to judge the candidates. The government and the selection panel built on the criteria proposed by Professor Darzi to identify the university-NHS partnerships that could best represent England's AHSCs. In 2009, the government announced the five successfully accredited AHSCs.

Interestingly, there was no funding for being accredited as an AHSC. Still, there were 15 applicants for the AHSC designation. Many said in their interviews that the competition organized by the government catalyzed the adoption of the AHSC organizational form. The following quotation from an interview with one of the five designated British AHSCs illustrated

how actors perceived the designation process as a trigger for their attention to the adoption of AHSCs in England:

> As soon as you announce a competition, of course, everybody's competitive juices get flowing. I think there were 15 applications and 7 short-listed. The thing that was very assuring was that the panel that was selected to adjudicate had pretty unimpeachable credentials. Not only because they made the right decision by accrediting us, but they were genuinely very good people (interview, senior management, AHSC 3).

Another interview with one of the five successfully-designated AHSCs also stated similarly:

> It's very amusing because there's no money in it. And we could have called ourselves an AHSC anyway. But because there is a competition and because we are competitive, we couldn't resist competing (interview with senior management, AHSC 2).

It is noteworthy that the designation process and the criteria of being an AHSC were themselves the translations of the AHSC organizational form. Note that other countries that adopt the AHSC organizational form such as the U.S. and the Netherlands had no competition process as in England. The American AHSCs emerge from the system of market competition, whereby AHSCs are created by organizational partners (universities and healthcare providers) with capacity to integrate. In the Netherlands, the government directly designated AHSCs with no competition. The accreditation process of the AHSC organizational form like in England was perceived to grant higher status and prestige to successfully accredited organizations. There were expectations that being accredited as an AHSC would attract funding from both the government and outside the field, investment, talent, and recognition. In other words, organizations that were accredited as AHSCs would have more opportunities to attract all of these economic outcomes than non-AHSC organizations.

The actor used symbolic resources, including the criteria and the designation process and the involvement of highly-legitimate people such as the international selection panel with high credentials, to make the AHSC organizational form distinctive and powerful. Attached to these

symbolic and normative resources, the AHSC organizational form gained forces to become more visible and normatively legitimate in the field.

By mobilizing symbolic resources including criteria, highly-legitimate designation process, the key actors gained momentum to convince stakeholders, as well as promote and legitimate the adoption of the AHSC organizational form in England. This also affected the means-ends frame of the AHSC organizational form: the AHSC organizational form is attached to the meaning of distinctive, prestige, world-class and international. As attention to the AHSC organizational form increased, more organizational actors jumped on the bandwagon, desiring to become an AHSC, even though there was no money or funding attached to this organizational form.

Overarching dimension: Legitimation

Another aggregate dimension, in which Imperial College and Professor Darzi engaged, in the reactivation phase is legitimation. These key actors attached legitimate elements in the field to amplify the legitimacy of the AHSC organizational form. The aim was to construct the AHSC organizational form that made sense to the field's audience, and useful and suitable in the field. Based on my analysis, there were two second-order themes: 7) aligning with existing regime and values, and 8) aligning with highly-legitimate persons.

7) Aligning with existing regime and values

To amplify legitimacy of the adoption of the AHSC organizational form, Imperial College and Professor Darzi aligned the AHSC organizational forms with legitimate elements in the field. The field elements included the new organizational form (NHS Foundation Trust), introduced by the government in 2004, and the field's dominant values.

One issue of resistance against AHSC in the first phase of translation was the perception of the AHSC organizational form as one-organization model under a single management that could be led by a university. This resistance was formed due to concerns that creating the AHSC organizational form might bring radical change to the field (a university might run a hospital), and fear of elitism or special treatment of university-NHS hospital linkage that could affect the unfair allocation of funding to other healthcare organizations. When the new healthcare

organization, NHS Foundation Trust, was introduced by the government in 2004, Imperial College leaders took the opportunity and coped with the resistance by grounding the creation of the AHSC organizational form on the form of NHS Foundation Trust. As described previously, NHS Foundation Trust was a new type of healthcare organizations, which allows non-healthcare organizations to manage hospitals. By selecting the new type of organization as a sense-making vehicle, the AHSC organizational form overcame the initial resistance, and the role of universities in managing hospitals became legitimate.

Furthermore, Imperial College and Professor Darzi aligned the AHSC organizational form with the field's dominant values. The key values and principles that the NHS has held since its inception are equality and fairness, which is translated into the repeated saying – "free at the point of use and available to everyone based on need, not ability to pay" (Department of Health, 2010), or "the NHS is about fairness for everyone in our society" (Department of Health, 2010: 7). To translate the AHSC so that it would be legitimate, the actors framed the AHSC organizational form in the way that although it is a distinctive organizational form that might have a special status, it will improve the quality of the healthcare that is rooted in the valued principle of equality and fairness. In other words, people in England would be treated equally with world-class and excellent healthcare services delivered from latest medical discoveries:

> For the first time in this country we seek to truly integrate biomedical research and healthcare provision to provide the best healthcare in the world, free at the point of delivery (Imperial College AHSC, 2008: 3).

Another example is when Imperial College conducted the consultation process regarding the creation of the UK's first AHSC, they also took into account the issues of equality into the process. The following quotation is from Imperial College's meeting minutes during the consultation period:

> The consultation paper on the proposal to create an AHSC through the merger of St Mary's and Hammersmith Hospitals Trusts and Imperial College, together with a draft response, were discussed. It was noted that health inequality and equal access were both issues which the AHSC would have to address. It was agreed that a paragraph should be added to the Trust's response welcoming the opportunity to engage in debating the issues

> and that the response should be widely circulated to interested parties (extracts from Imperial College's meeting minutes, dated 25 July 2007).

By aligning with existing regime and the dominant values, the actors augmented legitimacy of the organizational form as the relevant and proper solution. The frame of the AHSC organizational form was thus connected with the field's desirable ends – best healthcare for everyone.

8) Aligning with highly-legitimate persons

In addition, Imperial College and Professor Darzi amplified legitimacy of AHSC in England by developing relationships with highly-legitimate actors. For example, when Professor Darzi was appointed to the House of Lord by the Prime Minister (then Gordon Brown), as part of the scheme "Government of all talents", he had contacts with important figures in the government, the Department of Health, and the NHS. Professor Darzi leveraged these contacts to legitimize the implementation of the AHSC organizational form in England. The government agreed to include the establishment of the AHSC organizational form in their political agenda, and acknowledge the role of AHSC in improving healthcare:

> England's health secretary, Alan Johnson, announced on 9 March that five centres have been awarded academic health science status. Mr Johnson said, "I congratulate the successful candidates, who have demonstrated their enthusiasm and commitment to the vision of bringing together world class research, teaching, and patient care to improve health in local communities as well as internationally through their global reach…In times of economic uncertainty it is even more important that we continue to support this country's knowledge industries to ensure that we benefit from the competitive edge which they provide" (British Medical Journal, 2009).

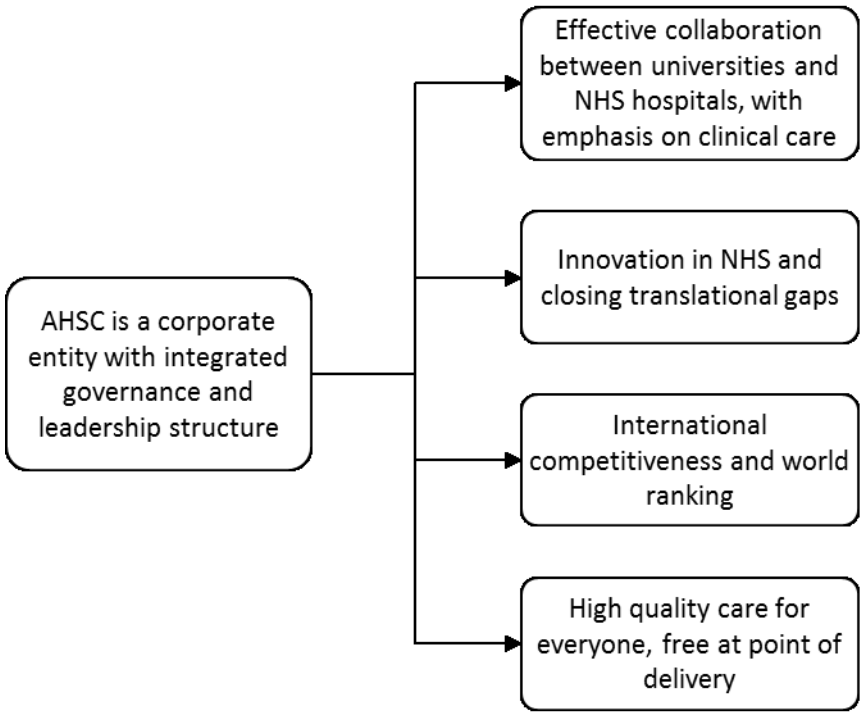
At the same time, the leader of Imperial College AHSC established a high degree of legitimacy with the NHS and the media. The leader of Imperial College AHSC, which was titled as Chief Executive/Principal was awarded Innovator of the Year in the 2009 NHS Leadership Awards for pioneering the creation of the UK's first AHSC. He was also ranked the top 30 most powerful people in NHS management policy and practice in England by Health Service Journal, in which he was the only chief executive in the list. Although this ranking and award winning

happened just after the designation process of AHSC, these elements augmented legitimacy of the AHSC organizational form in England by emphasizing the linkage between the AHSC organizational form and the image of success.

To successfully translate the AHSC organizational form, the key actors connected with important figures from multiple communities within the field. Although this action did not directly affect the means-ends frame of the AHSC organizational form, it increased legitimacy of the AHSC organizational form as desirable, viable, and appropriate in the British healthcare.

During the period between 2006 and 2009, the key actors integrated the AHSC organizational form with multiple elements within the field, and hence shaped the means-ends frame of the AHSC organizational form. Apart from means to achieve effective collaboration between universities and the NHS, the AHSC organizational form also connected with selective political discourses on innovation and translational research, the dominant values of equality and fairness, and some symbolic elements, including being world-ranking and international competitiveness (see Figure 4-5).

Figure 4-5: The translated frame of AHSC in England in 2006 – 2009



In addition, the findings add another insight regarding the time dimension in the translation process. The transformation of the organizational form through translation does not only occur across institutional contexts, but also over time. This is in line with other theoretical and empirical research (e.g., Czarniawska & Joerges, 1996; Maguire & Hardy, 2009; Zilber, 2006). Table 4-3 presents another illustrative evidence of transformation over time by comparing the 2001 and 2007 definitions of the AHSC organizational form, extracted from the Nuffield Trust's and Professor Darzi's reports respectively.

Table 4-3: Comparison of the definitions of the AHSC available in 2001 and 2007

Source	Definitions
Nuffield Trust's report, 2001	"[University Clinical Centre] seeks to capture the unique contribution of university teaching hospitals, medical schools and other academic departments, for example Nursing, working in a partnership that embraces all providers of medical teaching and research. A University Clinical 'Centre' is a virtual body, and its composition, beyond the core membership of university hospitals and medical schools is flexible and will develop over time. The term 'centre' does not, in this context, relate to a centralised body nor necessarily imply physical co-location" (5-6).
Professor Darzi's report	"[AHSCs] are corporate entities with integrated governance and leadership structures that have assumed the role of strategically and operationally managing both healthcare and relevant academic resources. Their purpose is to exploit the potential for exemplary care and innovation through integration of the clinical, research and education functions. AHSCs are able to attract the best talent internationally by providing a high-quality clinical environment where research can be carried out" (104).

This table provides evidence that the construction and framing of the AHSC organizational form changed considerably through the translation over time. The first definition focused on organizational members and emphasized functional aspects of AHSC to bring joint

working between universities and NHS hospitals. The second definition, on the contrary, focused more on outcomes for healthcare, patients and the country.

The case study shows the role of actors and the creation of meaning in the translation process. It also allows comparison between the translations of the same organizational form that failed at one time, and succeeded later. The next question is why so? And what made the AHSC organizational form to move from the dormancy to the reactivation that finally led to the successful translation. This will be explained in subsequent chapters.

4.3.4. Summary

The finding illustrates how a foreign organizational form is translated to fit the new receiving context, with focus on the role of actors and the creation of meaning. This case study reveals the whole process of translation of organizational forms – the activation phase at the time of its introduction into the field, the dormancy phase, and the reactivation phase that led to the establishment of the organizational form. It illustrates multiple actors engaging in the process, how they translated, adapted, and modified the organizational form into the new context, and how these actions affected the meaning of the AHSC organizational form over time.

I grouped various actions into three aggregate dimensions – (a) contextual design of a solution, (b) strategy for gaining support and mobilizing forces, and (c) legitimation of the organizational form. First, the dimension of contextual design of a solution shows that actors framed the organizational form as a solution to the field's problems, downplayed some contextually specific elements and emphasized others, and bundled these filtered elements with field elements. This group of action aimed to increase relevance, usefulness, and suitability of the organizational form in relation to the new context. The dimension of strategy for gaining support and mobilizing forces shows that actors adjusted the organizational form in alignment with trends, social movements, and normative and symbolic resources. By doing so, actors did not only gain support for the adoption of the organizational form, but also accelerated the process. The dimension of legitimation shows that actors located the abstract organizational form within existing understanding and actions that constitute the institutional environment, and amplified legitimacy for the new organizational form.

Addition, subtraction, and transformation can be expected to occur throughout the translation process. However, this statement is still too broad. To render implications for future research in translation and for practitioners, more detailed actions or strategies used in the translation process are needed. Contributing to this deficiency, the finding in this chapter unpacked the detailed translation process from a single case study. It confirms the notion that the translation process is shaped and accelerated by the context, the role of the actors, and the temporal factor.

Chapter 5.

FINDINGS: THEORIZATION

5.1. Introduction

In this chapter, I investigated the theorization process of the foreign organizational form in the field of the British healthcare from 1997 to 2009. I based my analysis on the notion that the processes of translation and theorization are complementary, and together formulate more nuanced understanding of the translation process of the foreign organizational form.

Strang and Meyer (1993) defined theorization as "the self-conscious development and specification of abstract categories and the formulation of patterned relationships such as chains of cause and effect" (492). Greenwood, Suddaby, and Hinings (2002) further clarify that theorization is the process whereby innovations such as new organizational forms or practices are justified, and made available in simplified form for wider adoption. Based on Tolbert and Zucker's (1996) work, Greenwood and his colleagues summarized that theorization involves two components: specification of problems or organizational failings, and justification of possible solutions. For innovations or solutions to achieve legitimacy and be widely adopted, they need to be abstracted and presented compellingly, by embedding it within prevailing normative prescriptions, thereby giving them moral legitimacy; and/or providing it with functional superiority or pragmatic legitimacy (Greenwood et al., 2002: see also Suchman, 1995; Tolbert & Zucker, 1996). Scholars (Fligstein, 1997; Greenwood et al., 2002) acknowledge that strategies of theorization in one setting might be different in others. This depends on types of fields (mature, in crisis, or emerging), and the extent of schisms within an organizational community. However, little research examines strategies that constitute theorization, and how these strategies vary in different contexts.

The study in this chapter examines theorization in mature and highly-institutionalized field. Mature fields have certain features, normally characterized by extant institutionalized rules or norms that construct perception of legitimacy and a coherent discourse, clearly defined institutional structure and dominant actors, concentration of resources associated with dominant actors, and stable inter-organizational relationship. The empirical case on which I based this study was the adoption of the AHSC organizational form in the British healthcare. The British healthcare is a mature field, composed of multiple groups of actors i.e., the NHS and its sub communities of healthcare providers, academic communities such as research institutions and university medical schools, the government and its agencies, patients, and industry. The dominant actor in the field is the government, who sets up healthcare policies, has authorities over the NHS, and controls allocation of most financial resources in the field. Another leading actor is the NHS, which consists of several sub communities of healthcare providers. Despite subject to direction of the government, the NHS is the major player in the field and sets up norms of professionalism. With multiple groups of actors and thus multiple interests, the field is more complex than the setting of one organizational community in which Greenwood et al examined the process of theorization.

The key actors under my study of theorization were the Nuffield Trust, Imperial College, and Professor Darzi, who engaged in motivating change and the adoption of the AHSC organizational form in the British healthcare from 1998 to 2009. Interestingly, change was initiated from these individual organizational actors in the field, rather than from the dominant actor as the government or the NHS itself. One of my interviewees expressed the same curiosity:

> Well, a very interesting process. It was interesting among examples actually of a policy initiative that was very much not just initially driven from the bottom up and has been sustained from the bottom up by people like [the leaders of Imperial College AHSC] themselves. You know, normally in this country health policy, as we see classically at the moment, is top down (interview, senior management, AHSC 4).

These key actors with background of think tank and academic communities did not have coercive power that can force other field members to accommodate their interest. Therefore this is an interesting case for studying the process of theorization of the foreign organizational form,

which is initiated and successful from within mature fields. How do actors who are not in dominating positions or communities discursively motivate the adoption of a new and foreign organizational form? In this study, I investigated the role of the Nuffield Trust, Imperial College, and Professor Darzi in theorizing the foreign organizational form to win legitimacy in the field. These actors collectively constructed theorizing accounts and promoted them vigorously over time. In Stang and Meyer's words, "models must make the transition from theoretical formulation to social movement to institutional imperative" (1993: 495). In England whether or not the AHSC organizational form will turn into an institution is yet to be seen. However, from the standpoints of field constituents like universities, NHS, the government and its agencies, AHSC has been accepted as a novel organizational form that serves the purpose of strong partnership between NHS healthcare providers and universities to unleash the integration of research, education, and clinical practices or widely known as the tripartite mission, with the ultimate focus on improving patient care.

My finding shows that theorization involves three elements: 1) framing problems, 2) theorizing the organizational form, and 3) theorizing adopters. In Greenwood and his colleagues' empirical study on theorization, they did not mention the third element – theorizing adopters. However, in the context of the adoption of foreign organizational forms in the mature field with diverse groups of actors, this element is also important. The actors theorized explanations for why this particular foreign organizational form makes sense as a solution to the range of problems and to various stakeholders in the field.

5.2. Method and analysis

In the first stage, I went back to read through my chronological order of key events and activities and my narrative of the case of the AHSC organizational form. My approach, following Greenwood et al (2002), was to focus on excerpts or 'text segments' that discussed the adoption of the AHSC organizational form. "A text segment consists of two to three sentences that contain one or more key phrases. The length of the segment is determined by the need to include sufficient context to provide understanding of how the phrase or phrases is or are being used" (Greenwood et al., 2002: 66). I then arranged the selected text segments by actors who constructed them and by phase. For example, I arranged the group of text segments constructed

by the Nuffield Trust in the activation phase separately from the text segments constructed by Imperial College and Professor Darzi in the reactivation phase. Then each text segment was open-coded to identify arguments used by the key actors in different phases.

In the second stage, I grouped these arguments into themes with the questions in mind: how the actors formed arguments to motivate the adoption of the AHSC organizational form, and whether and how these arguments appealed to key stakeholders, including universities, the NHS in generaland its sub communities, and the government. This was to understand what strategies the actors used to promote the adoption of the organizational form. At this stage of analysis, I grouped the arguments into second-order themes to reflect various strategies.

In the final stage, I grouped these themes into aggregate dimensions, guided by the extant literature of theorization (Strang & Meyer, 1993; Greenwood et al., 2002). The aggregate dimensions include 1) framing problems, 2) theorizing the organizational form, and 3) theorizing adopters. Figure 5-1 shows the data structure of theorization process in the activation phase, highlighting first-order categories, second-order themes, and aggregate dimensions. Table 5-1 shows supporting evidence for the coding. Figure 5-2 and Table 5-2 show the data structure and supporting evidence of coding (respectively) of theorization in the reactivation phase.

5.2.1. The change

The change examined in this thesis was the transformation of the collaboration arrangements between universities and the NHS in the field of the British healthcare. From 1981 to 2009, there have been efforts to change from the separated structure and culture between these two entities, to the form of partnership that directs the two entities towards shared goals.

Since the establishment of the NHS in 1948, the jurisdictional boundaries between the university and the NHS sectors in England have been distinct. Owing to the overlapping activities in education, research, and clinical care, universities and their NHS partners depended on cross-representation in management, day-to-day communication among leaders, and some financial tools such as knock-for-knock to manage the relationship (Davies, 2010). Universities are independent, partially funded by the government and statutory research councils such as HEFCE. The NHS organizations, on the contrary, are dependent on the tax system, and subject

to the direction of the government. Although activities of these two entities overlapped, their priorities were set differently. Universities focus on improving their rankings through conducting research, particularly in the area of basic science, and getting publications in medical journals, teaching quality and students' satisfaction; whereas the NHS organizations deal with daily operation in management, financial sustainability, and focus more on clinical research. In summary universities and NHS teaching hospitals have been structured as independent entities, but in effect they are interdependent in delivering research, education, and clinical care (see Figure 3-2).

The AHSC organizational form was first proposed as a solution in 1997, and had been promoted by think tanks, individuals and organizational actors. The key actors, as identified in this thesis, include the Nuffield Trust in the activation phase (2001 – 2004), and Imperial College and Professor Darzi in the reactivation phase (2006 – 2009). Finally, in 2008, the government officially supported the establishment of a number of AHSCs in England, thereby organizing the 5-month competition process for designating universities and NHS partners as an AHSC. In 2009, the government announced the five successful AHSCs. Among the five AHSCs, there are two emerging governance models – the fully-integrated model and the partnership model. Figure 3-3 and Figure 3-4 illustrate these emerging models in England.

5.3. Finding

The debate over the change in universities and associated NHS hospitals from separated to integrated structure and the propriety of the AHSC organizational form ran over two decades. The two phases of translation – activation and reactivation – show different accounts of arguments and strategies to promote change and the adoption of the AHSC organizational form.

Activation phase (1997 – 2004)

The issue of joint working between universities and NHS hospitals appeared first in late 1980s, with the formation of the SGUMDER to discuss the impact of the NHS reform on the provisions of medical education. The SGUMDER concluded that "liaison and consultation are not enough for effective collaboration. Both parties [should] recognize their unity of purpose and combine in a joint enterprise to achieve it." Since then, the problems of the NHS/university

relationship became realized, and attempts were made to find mechanisms for the joint working. The Ten Key Principles were recommended by the SGUMDER as the rules of engagement between the NHS and the higher education sector at all levels – governmental, regional, and organizational levels (Langlands, 2003). In the meantime, the field also experienced a decrease in the number of clinical academics, which was claimed as the consequence of the structural and cultural separation between universities and NHS teaching hospitals (House of Lords Science and Technology Committee, 1999; Richards, 1997).

The match between the issues of the joint working and clinical academic career in crisis, and the move to the creation of the AHSC organizational form (the solution) first appeared in the 1997 report by an independent task force on clinical academic careers (also known as the Richards report). The Richards report suggested more work be done to explore the AHSC organizational form existing in North America and Europe. It is interesting as an early expression of how AHSC came to be theorized in the UK. The early attempt of theorization was built on the recognized problems in the field. The justification of the AHSC organizational form was based on functional suitability, given the current situations of clinical academic career, and competing priorities between universities and associated NHS hospitals. The Richards report's recommendations were widely discussed and responded by other key stakeholders, specifically the SGUMDER, the NHS authorities and the CHMS. However, it was agreed among these actors in response to the Richards report that such "radical" solution – the creation of the AHSC organizational form – be avoided, but acknowledged change was necessary. As described in the previous chapter, this was when the Nuffield Trust came to be involved by invitation.

In the previous chapter, I present that the Nuffield Trust translated the AHSC organizational form by framing it as a solution to the recognized problem, and, through the actions of filtering elements of the original organizational form, combining some features of the foreign organizational form with some field elements. In this chapter, I investigated the theorization process performed by the Nuffield. Figure 5-1 shows the data structure of theorization by the Nuffield Trust, which I grouped into three broad categories: framing problems, theorizing the organizational form, and theorizing adopters. Table 5-1 provides evidence for my analysis.

Framing problems

In framing problems, the Nuffield Trust engaged in two strategies: identifying problems, and framing existing arrangements and local solution as ineffectual. Note that the first strategy of identifying problems involves articulating the need for change and defining problems with linkage to impacts on particular groups of actors.

Across data sources including the Nuffield Trust's reports and documents dated in 2001 – 2004 and interviews, I examined how the Nuffield Trust framed the need for change and problems, and whom they targeted. Three arguments can be noticed from the data. First, it was for the first time that change was framed as progression. The Nuffield Trust traced back to the work in 1981, published by Sir Fred Dainton with the Nuffield Trust (then the Nuffield Provincial Hospitals Trust), as if it was the vision of how universities and NHS teaching hospitals were already predicted to be. Since then, several attempts have been made to find the way to manage this interface between universities and the NHS:

> Since Dainton's reflections, a body of work on the NHS/university interface has emerged and evolved from technical liaison arrangements to a much stronger recognition of organisational interdependence and the need for a culture of partnership (Smith, 2001: 27).

This is different from other concurrent reports such as the SGUMDER's or the JMAC's, as these reports framed changes as necessary due to the NHS reform and emerging problems, not as inevitable progression.

Secondly, the Nuffield Trust emphasized that universities and NHS teaching hospitals were interdependent, and thus this relationship required effective joint working mechanisms. Such relationship was for the first time framed as unique, more complex than previously acknowledged, and different from any relationships in the field of the British healthcare. To my knowledge, it was also the first time the relationship between universities and NHS teaching hospitals were conceptualized as "tripartite mission," which was the common term in the U.S., referring to the integration of research, education, and clinical care of the American version of the AHSC organizational form. This is interesting because although the Nuffield Trust labeled the organizational form with the new name (University/Academic Clinical Centre) instead of adopting the original name AHSC, they used the symbolic and meaning of the AHSC

organizational form – integration and tripartite mission – to frame the problem and the solution. And this helped support the case that the Nuffield Trust was trying to make about the uniqueness and interdependence of the university/NHS hospital relationship.

However, this unique relationship was not recognized by the government, the NHS authorities, other NHS sub-communities, and even some university/NHS partners themselves. The Nuffield Trust claimed that the tensions and complexities that universities and NHS teaching hospitals were currently facing stemmed from the lack of effective joint working mechanisms. These tensions and complexities could not be alleviated or managed under existing mechanisms i.e., cross-representation and liaison. And these tensions were exacerbated by the recently transformed political context of healthcare. Therefore, the third argument was linked to the transformed political context, including the government's budget constraints in public sectors, the NHS reform, and the establishment of the RAE. The Nuffield Trust claimed that these political changes worsened the situation of universities and NHS teaching hospitals, and thus it reached a moment for change:

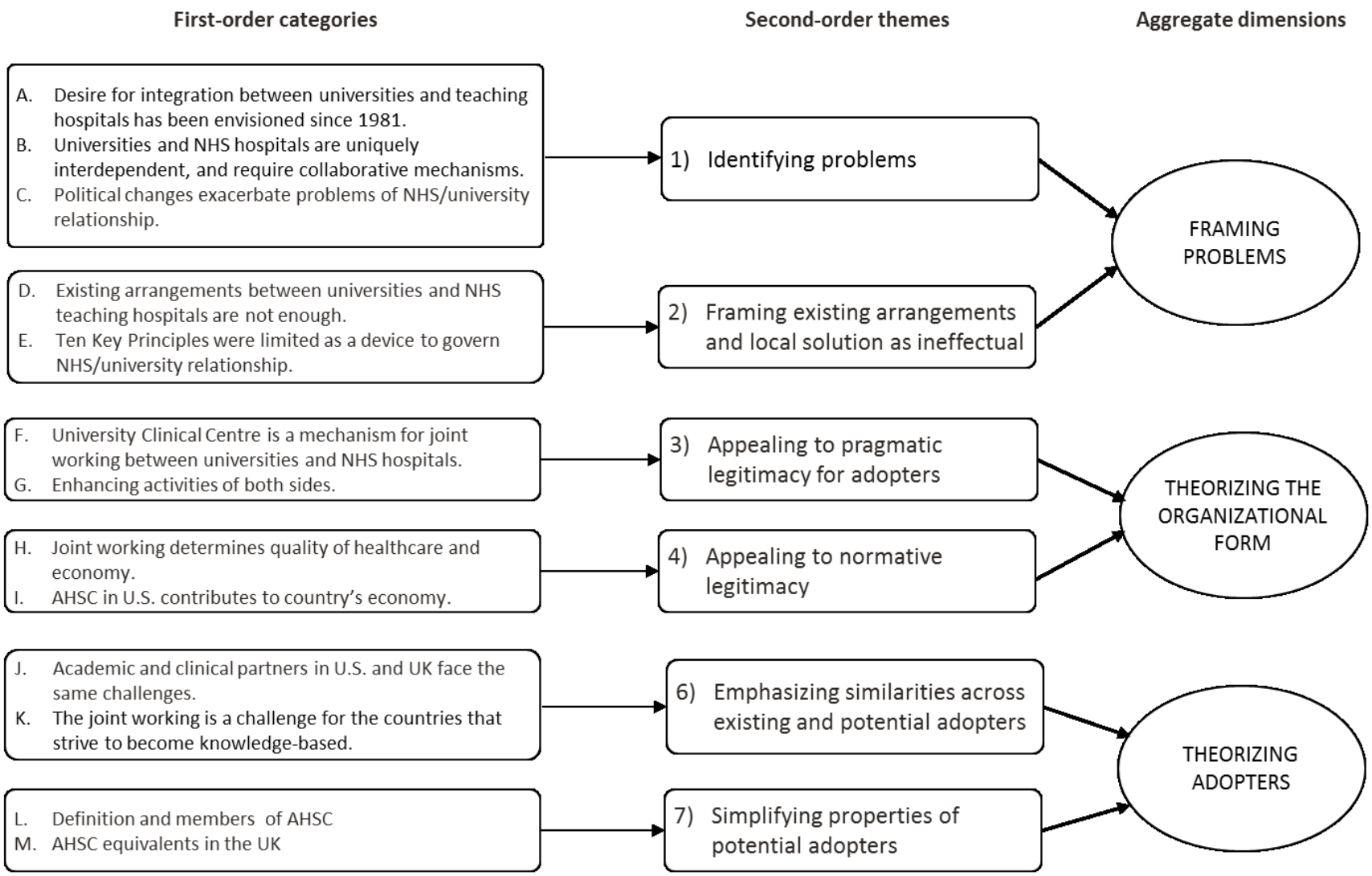
> The unique contribution made by medical schools and university teaching hospitals is in their dual and interdependent mission. Changes in the external environment have created incentives for organisations to pursue strategies that point in different directions…The NHS is predominantly focused on service. Whereas in universities, the RAE, for example, has had a destabilizing effect on NHS/university relations. At present, there are few incentives to align research, education and clinical service strategies. The RAE has shifted the emphasis between research and service and left the impression that the two missions are in conflict (Nuffield Trust Working Group, 2000: 9).

Another strategy of framing problems in which the Nuffield Trust engaged was framing existing arrangements and local solutions as ineffectual. As described above, the Nuffield Trust reframed existing arrangements as inadequate and ineffective given the impact of political transformations on the NHS/university relationship. Furthermore, the Nuffield Trust viewed that the local solution – the Ten Key Principles – were not detailed enough to guide collaboration in practice. The Nuffield Trust argued that the view of the collaboration from the Ten Key Principles was too narrow, as it was mainly concerned with provisions of medical education and too focused on coherence at the policy level. They argued that the relationship between

universities and NHS teaching hospitals was actually reciprocal – the NHS hospitals committed to medical education and research, and universities also had important part in providing clinical services. They emphasized this relationship was unique, and thus required novel mechanisms for joint working. Attacking the local solution, the Nuffield Trust strengthened the need for change and problems. This strategy aimed to appeal to relevant actors to seek new solutions with functional superiority:

> The working group found that the Ten Key Principles are limited as a device to govern the NHS/academic interface. They lack a modern strategic context and are neither sufficiently broad nor detailed enough to address all the aspects of the shared agenda (Nuffield Trust Working Group, 2000: 5).

Figure 5-1: Data structure – Activation phase



It can be noticed here that the Nuffield Trust focused more on the problems inherent in the structure and practices of collaboration than the outcomes i.e., quality of patient care. They paid attention to the issues of effectiveness and management of the interface. This reflects in the terms and phases they commonly used throughout their reports such as "management of the paradox," "management of the interface," "collaboration arrangements," "harness partnership," "effective collaboration," "joint arrangements," "joint entities," etc. The way the Nuffield Trust theorized the problems primarily appealed to change for pragmatic reasons. And these pragmatic reasons mainly appealed to only some communities in the field – universities and NHS teaching hospitals.

Theorizing the organizational form

In theorizing the organizational form, the Nuffield Trust engaged in two strategies: 1) appealing to pragmatic legitimacy for adopters, and 2) appealing to normative legitimacy.

The Nuffield Trust theorized the adoption of the AHSC organizational form in the way that appealed to potential adopters – universities and associated NHS hospitals. They theorized the organizational form, under the name of University Clinical Centre, as the solution to the identified problems, and related this account of the problems and the solution to pragmatic outcomes. The pragmatic outcomes included more efficiency in working together between universities and NHS hospitals, and effective communication both internally and externally with other organizational communities:

> Recognising this joint purpose, a University Clinical Centre provides the organisational vehicle to speak with one voice, without prejudice to matters which are the prerogative of each corporate organisation (Smith, 2001: 10).

To complement their arguments regarding the pragmatic outcomes, the Nuffield Trust pointed to the benefits that both sides would receive to enhance their activities. The Nuffield Trust developed chains of causes and effects between functions of universities and teaching hospitals. They argued that research, education, and clinical care actually complemented as causes and effects. Basically, high quality education was possible in the place where there was high quality clinical care. Likewise, research and innovation could only occur in the place where existing knowledge was challenged by new knowledge and its application. In the same vein,

good outcomes of education and research could generate high quality patient care. The Nuffield Trust developed the pragmatic relationship between universities and NHS teaching hospitals.

To enable change, it was important for the AHSC organizational form to align with normative elements such as moral, norms, and beliefs, held within the field. The Nuffield Trust attached the need for change and the creation of the AHSC organizational form to the quality of the healthcare and the country's economy. The Nuffield Trust justified the AHSC organizational form by aligning it with normative legitimacy to gain support from the stakeholders. At the same time the Nuffield Trust also referred to success stories of AHSCs in the U.S., which made significant contributions to the U.S. economy. This action linked the adoption of the AHSC organizational form to the good of the country or what Suchman called normative legitimacy:

> Academic Clinical 'Centres' make an important contribution to regional and national economies. Centres are major employers, and investment in academic clinical centres produce innovations that generate wealth and make a positive contribution to UK pic. In America, the Association of American Medical Colleges (AAMC) estimates that centres contribute $186 billion directly and indirectly to the American economy (Nuffield Trust working group, 2000: 6).

It can be noticed that in the first phase the key actor paid attention to framing the relationship between universities and NHS teaching hospitals as a special relationship that needed unique collaboration arrangements rather than structural and cultural separation of arrangements. This unique relationship was conceptualized as tripartite mission, which is a phrase commonly attached to the American version of the AHSC organizational form. Yet the Nuffield Trust focused more on the problem of structures and arrangements rather than clinical outcomes. The justification of the AHSC organizational form thus primarily appealed to functional suitability and superiority to serve this unique relationship rather than normative legitimacy (i.e. to improve healthcare). In addition, the problem framing and justifications also mainly appealed to small groups of actors (universities and NHS teaching hospitals), rather than the NHS, the government, or the country as a whole. Overall, the actor framed problems and justified the organizational form (the solution), as mainly appealing to pragmatic legitimacy for adopters, while interests of other organizational communities were less emphasized in the

theoretical model of the new organizational form. This might be partial explanation for the question why the AHSC organizational form was not adopted or justified in this phase.

Theorizing adopters

Apart from framing problems and justifying solutions, another important element of theorizations that are often overlooked in most empirical studies is theorizing adopters. Theorizations of adopters are important particularly in the case of the adoption of foreign organizational forms. It adds up explanations of how new organizational forms became abstracted and justified. In most studies of mimicry, new organizational forms or practices are widely diffused when they become more objectified, and because of more available information regarding success stories associated with such organizational forms and practices. Theorization scholars suggest that mimicry is partly generated from self-identifications of actors with others that they share some similarities. Translation scholars suggest that most imitation comes from comparison with successful others. The common theme here is that the adopters view themselves as more or less similar to the adopted, justifying a reason for adoption. Because of these perceived similarities, if they respond in the same way, they will achieve the same outcomes. Theorizing adopters involves defining populations or some cultural categories in which adoption of the given organizational form is imaginable and sensible (Strang & Meyer, 1993).

In theorizing adopters, the Nuffield Trust engaged in two strategies: 1) emphasizing underlying similarities across existing and potential adopters, and 2) specifying characteristics of potential adopters within the field.

The Nuffield Trust theorized the UK and the U.S. as in the same populations – they both were the countries with the same category of economy (knowledge-based economy), and both countries had the same aspiration to be world-class in the domain of healthcare. Because of these similarities, they both thus faced the same challenging environment in the healthcare. By theorizing adopters with emphasis on identified similarities, the Nuffield Trust justified the adoption of the AHSC organizational form in the British healthcare:

> Academic medical institutions in the US and the UK do the same kind of work, and are increasingly subject to common forces that transcend national boundaries…Leading academic medical centers in both countries aspire to be world-class in each of these

> domains. This requires similar resources, organized similarly, regardless of geographic location… regardless of how a given healthcare system is governed and financed, effective education of health professionals cannot occur without close partnerships between medical schools and operating healthcare facilities (Blumenthal, 2000: 14).

The second strategy of theorizing adopters involved simplifying attributes of potential adopters within the field. Apart from highlighting dimensions or forms of similarities across high-level abstraction of entities as countries, the Nuffield Trust distilled properties of potential and appropriate adopters to contribute to a better understanding of the foreign organizational form within the field. I believe this is an important strategy of theorization of the foreign organizational form. The U.S. and the UK healthcare fields are based on significantly different structures and logics. What makes sense in one setting, might not be readily understandable in others. By simplifying attributes of potential adopters within the field, the actor contributes to better understanding of the foreign organizational form, and emphasizes that the adoption of the organizational form is possible and sensible. For example, since there were no AHSC organizations at that time in the UK, the Nuffield Trust defined and simplified possible types of organizational members of AHSC that could be understable in England:

> [University Clinical Centre] describes a joint venture between university teaching hospital, medical school, and other related academic departments combining to manage the common mission (Smith, 2001: 10).

Another example is the Nuffield Trust's comparative studies between the American AHSC and the relationship between universities and the NHS in the UK. The Nuffield Trust referred to organizational members of the American AHSCs and interpreted them into simplified format that universities and NHS hospitals could make sense of and saw similarities between them. In the U.S., organizations that are listed as members of the Association of Academic Health Centers (AAHC) are AHSCs. In the UK, as such organizations did not exist and most organizational actors had no direct contact with the American AHSCs, the Nuffield Trust referred to the members of the UK University Hospitals Forum as counterparts. The Nuffield Trust argued that the definition of the UK counterparts of the American AHSC's members was used to advance understanding regarding the AHSC organizational form.

In sum, the theorization in the activation phase was performed by a think tank (the Nuffield Trust). The theorization contained three tasks: framing problems, theorizing the organizational form, and theorizing adopters. The theorization of problems, solutions, and adopters were logically linked, and primarily appealed to pragmatic legitimacy for adopters.

Table 5-1: Selected evidence for my coding analysis in the activation phase

First-order categories		Representative data
A. Desire for integration between universities and teaching hospitals has been envisioned since 1981.	1)	"[Sir Fred] Dainton [composing the 1981 report Reflections on The Universities and The National Health Service] considered the interface between universities and the NHS to be 'the place where the future confronts the present'…Since Dainton's reflections a body of work on the NHS/university interface has emerged" (Nuffield Trust working group, 2000: 4).
B. Universities and NHS hospitals are uniquely interdependent, and require collaborative mechanisms.	2)	"Management of [university medical schools and associated NHS hospitals] is complex, the tensions inherent in this environment rarely exist in other contexts…The close proximity of a university hospital and its medical school imposes managerial challenges that are different in character from those experiences by other NHS providers" (Nuffield Trust working group, 2000: 11-12).
	3)	"It is argued in this monograph that specialist centres have a particular role in university/clinical partnership. It is a role that is not widely appreciated or necessarily promoted by the organisations themselves" (Smith, 2001: 24).
C. Political changes exacerbate problems of NHS/university relationship.	4)	"[it has been] noted, for some prophetically, that the NHS reforms - the introduction of a purchaser/provider split and competition between trusts to win service contracts from providers - had the potential to squeeze out the academic mission from NHS providers" (Smith, 2001: 31).
D. Existing arrangements between universities and NHS teaching hospitals are not enough.	5)	"[Our reports] support the emphasis in SGUMDER's Second Report (1990) that 'liaison and consultation are not enough for effective collaboration. Both parties [should] recognise their unity of purpose and combine in a joint enterprise to achieve it.' There are, however, some inherent tensions between the competing priorities of service provision, education and research; these result from

First-order categories		Representative data
		university teaching hospitals being both independent and yet interdependent in pursuing a common mission" (Smith, 2001: 9).
E.	Ten Key Principles were limited as a device to govern NHS/university relationship.	6) "There is a need for a new framework for NHS/university relations; it is needed to provide a modern strategic context and greater flexibility to enable a variety of partners to address all aspects of the partnership. The context of NHS/university relations has become increasingly complex and has outgrown the current framework [the Ten Key Principles]" (Smith, 2001: 20).
F.	University Clinical Centre is a mechanism for joint working between universities and NHS hospitals.	7) "Recognising this joint purpose, a University Clinical Centre provides the organisational vehicle to speak with one voice, without prejudice to matters which are the prerogative of each corporate organisation" (Smith, 2001: 10).
G.	Enhancing activities of both sides	8) "If the ability of university hospitals to provide quality service diminishes, this will inevitably harm the educational and research mission. Likewise, deterioration in the ability of academics to sustain leadership in education and research will inevitably undercut the quality and range of patient service that can be provided" (Nuffield Trust working group, 2000: 12).
H.	Joint working determines quality of healthcare and economy.	9) "A strong relationship between university hospitals, medical schools and other related academic departments is a key factor in determining the future quality of the nation's health" (Nuffield Trust working group, 2000: 6). 10) "Co-operation makes an important contribution to regional and national economies. [University Clinical] Centres are major employers, and investment in university clinical centres produce innovations that generate wealth and make a positive contribution to UK" (Nuffield Trust working

First-order categories	Representative data
	group, 2000: 12).
I. AHSC in the U.S. contributes to the country's economy	11) "In America, the Association of American Medical Colleges (AAMC) estimates that [academic clinical] centres contribute $186 billion directly and indirectly to the American economy" (Nuffield Trust working group, 2000: 6).
J. Academic and clinical partners in U.S. and UK face the same challenges.	12) "Academic medical institutions in the US and the UK do the same kind of work, and are increasingly subject to common forces that transcend national boundaries…Leading academic medical centers in both countries aspire to be world-class in each of these domains. This requires similar resources, organized similarly, regardless of geographic location… regardless of how a given healthcare system is governed and financed, effective education of health professionals cannot occur without close partnerships between medical schools and operating healthcare facilities" (Blumenthal, 2000: 14). 13) "A comparative analysis of the recent histories of two leading academic centres in the UK and USA found striking parallels, this despite the profound differences in national healthcare systems, suggesting the influence of forces which transcend national boundaries" (Davies, 2002: 5).
K. The joint working is a challenge for the countries that strive to become knowledge-based.	14) "Establishing strategic links between research, education and health service provision (the tripartite mission) is a major challenge for a health service that strives to become a knowledge-based, learning organization, and for universities to meet the changing demands of clinical education and research" (Nuffield Trust working group, 2000: 4).
L. Definition and members of	15) "[University Clinical Centre] describes a joint venture between university teaching hospital, medical

	First-order categories		Representative data
	AHSC		school, and other related academic departments combining to manage the common mission" (Smith, 2001: 10).
M.	AHSC equivalents in the UK	16)	"In the USA because of organisational diversity and in the UK because of the lack of currency of the AHC concept. For the USA, AAHC definitions have been used. These define AHCs with reference to ownership of a teaching hospital or system by a medical school, or by reference to faculty dominance of teaching hospital staffing. In some cases, this may result in one centre combining a medical school with a number of teaching hospitals or systems… In the UK, the principal clinical partners of the 23 medical schools have largely self-identified themselves by participation in the UK University Hospitals Forum. Membership of this forum is defined not merely on the basis of being a university teaching hospital, but using tests of research intensity, links to external research funders and significant academic influence over the hospital. At present, 28 hospitals are represented (Davies, 2002: 13).

Reactivation phase (2006 – 2009)

In the reactivation phase, the key actors were Imperial College and Professor Darzi. I examined the theorization process performed by these two actors from 2006 to 2009. Figure 5-2 shows the data structure of theorization by Imperial College and Professor Darzi, which I grouped into three broad categories: framing problems, theorizing the organizational form, and theorizing adopters. Table 5-2 shows evidence for my analysis.

Framing problems

In framing problems, Imperial College and Professor Darzi engaged in two strategies: 1) identifying problems, and 2) drawing on beliefs of field constituencies to amplify the problems. The first strategy is similar to one of the Nuffield Trust's strategies in framing problems. The second strategy is specific to the reactivation phase, and arguably an important strategy to compel field audiences to focus their attention to the problems.

The debate over the adoption of the AHSC organizational form started again in 2006, when Imperial College and its associated NHS hospitals decided to create the UK's first AHSC. The key event that motivated Imperial College and the hospitals to consider the adoption of the AHSC organizational form was the collapse of the Paddington Health Campus project. It was part of the government's mega project, invested through the Private Finance Initiative (PFI) scheme, to redevelop the Paddington area. The project was cancelled because the expense considerably exceeded the budget. This event had an impact on Imperial College, as one of its medical school premises was part of the project. The quotation below, from the interview with the senior management of Imperial College AHSC, described the situation at that time:

> The specific motivation was that the NHS had undertaken a large PFI proposal in Paddington, which involved the university with a 70 million pound research building and that proposal, that planning took seven years and at the end of the day they decided not to do it. So the university had been in a position whereas it effectively had its faculty of medicine completely blocked from any development, any capital investment effectively anywhere on an NHS project. So it was a very pragmatic reason to do it [the adoption of AHSC] (interview, senior management, Imperial College AHSC).

Figure 5-2: Data structure – reactivation phase

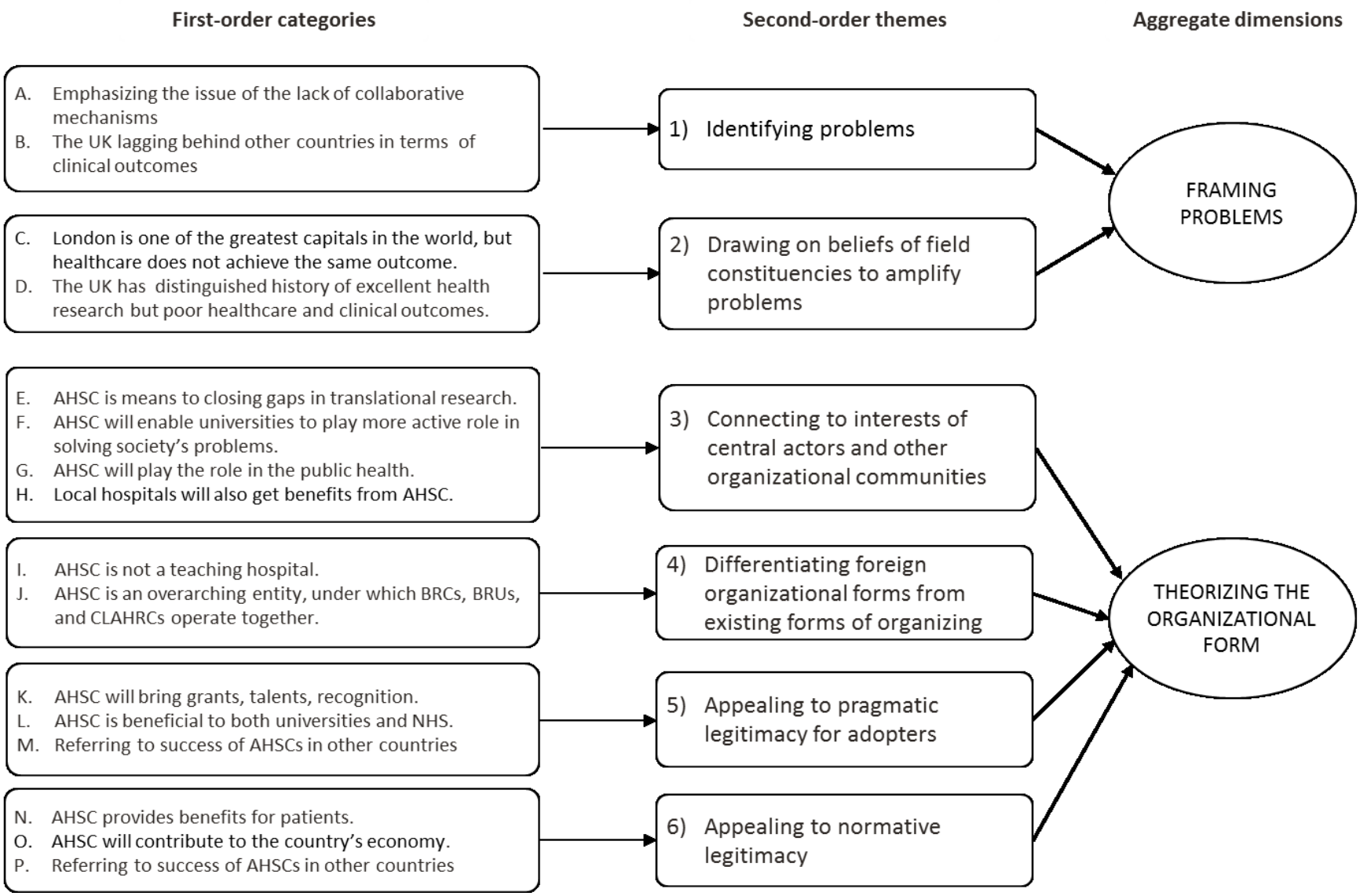
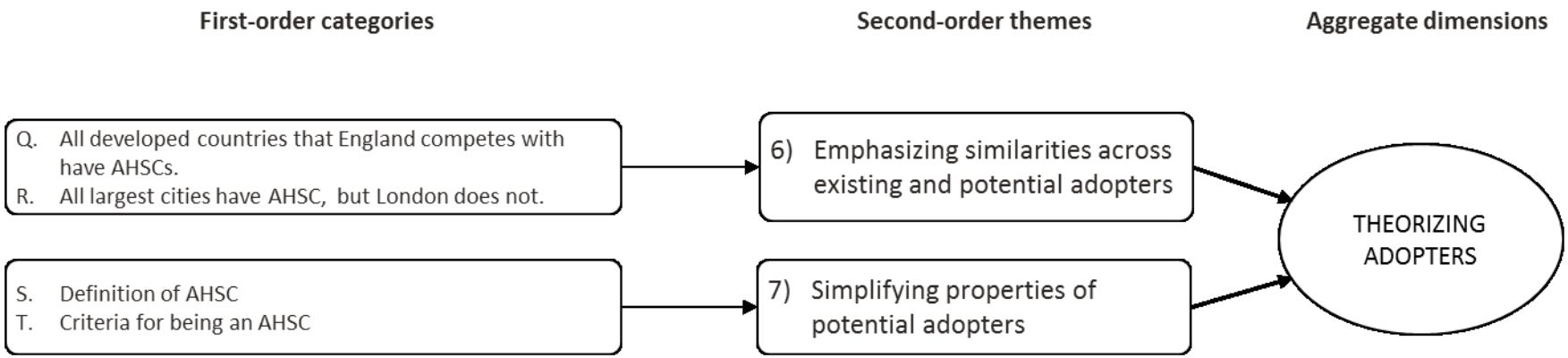


Figure 5-2: Data structure – reactivation phase (continued)



Imperial College used the disruptive event of the Paddington Health Campus to rationalize the adoption of the AHSC organizational form with the associated hospitals (Hammersmith Hospital and St Mary's Hospital). Interestingly, the theorizing accounts that could be identified from the public data of Imperial College AHSC – i.e., their consultation reports with stakeholders regarding the creation of the UK's first AHSC, and their interviews given in news and magazine – were based on different accounts of justifications. Specifically, the actual motivation was not much mentioned. Instead, they framed change and movement to the creation of the AHSC organizational form by raising concerns over poor clinical outcomes and the underperformance of the NHS. The Imperial College leader claimed that the reason why the NHS could not deliver satisfactory clinical outcomes because of the lack of effective joint working with universities. With focus on patients and clinical outcomes, Imperial College articulated the case for change, which was likely to appeal to the wide spectrum of the stakeholders (rather than just universities and NHS partners as the Nuffield Trust emphasized in the activation phase). He began by highlighting the urgent need for change:

> The National Health Service has been failing the public for years because of the historical divide between university medical schools and hospitals…The system is broken. Although universities' biomedical research is world class…institutions are pushed away by a "Stalinist" NHS. The consequence is that while we are second only to the US in biomedicine and have four of the top universities in the world in this area, we are way down the table when it comes to clinical outcomes (interview, Imperial College AHSC leader, Times Higher Education, 2008).

Imperial College claimed that the structural separation between universities and NHS hospitals were a reason for the unsatisfactory performance of the NHS – not able to meet patients' satisfaction and relatively poor clinical outcomes in the country and the global league.

In the meantime, there was change in the leadership of the NHS London in 2006. The new leader had a vision of better quality healthcare for Londoners, thereby requesting Professor Darzi, who was then the head of clinical academic department of Imperial College, to review the London healthcare and provide strategies. Professor Darzi formed a team and subsequently published the 2007 report: *Healthcare for London: A Framework for Action*. His review is based

on the case for change that London was one of the greatest capitals in the world, but this greatness did not reflect in the healthcare. There were still poor clinical outcomes and inequalities in the healthcare:

> London is a world-class city and Londoners deserve a world-class healthcare system. But, though there are many areas of real excellence in London, of which we should be proud, world-class care is not currently what every Londoner can expect. There are stark inequalities in health outcomes across London, and the quality and safety of patient care is not always as good as it could, and should be (an extract from the report: A Framework For Action, 2007).

In this report, one recommendation to improve the healthcare in London was to establish a number of AHSCs to promote London as a capital of excellence in healthcare. He was then designated by the Brown government to the House of Lord, and acted as an adviser for the Prime Minister regarding the healthcare issues. While he worked for the government, he continued advocating the creation of the AHSC organizational form across England. During his ministerial appointment, he published another report in 2008: *High Quality Care for All, NHS Next Stage Review Final Report*, in which he continued supporting the creation of the AHSC organizational form. He claimed failure to change would be detrimental to not only the healthcare, but also the country as a whole.

Examining multiple data sources in relation to Imperial College and Professor Darzi, I notice that, overall in the reactivation phase, the core means-ends account was repeated (the change to joint management and the adoption of the AHSC organizational form). However, there were some modifications in focus and targets of the problems. Both Imperial College AHSC and Professor Darzi placed primarily focus on the problems inherent in the common interests of the field – clinical outcomes and improved health of patients and populations; in contrast to the first phase, in which the key actor focused on the problems inherent in the structure and practices of collaboration between universities and associated NHS teaching hospitals.

Change in the reactivation phase was more dramatically attached to professional values and national benefits. Problem framing became more dramatic and aimed at a wider range of stakeholders – not only some specific groups of universities and NHS partners, but the NHS in

general, the government, patients, and the country. The key actors put more emphasis on the language that appealed to the interest and value of the healthcare (quality of patient care) and to the good of the country (economy and international recognition), rather than the language of functional superiority for managing collaboration arrangements. Basically, if the arrangements between universities and NHS hospitals did not change to a more integrated structure, the NHS would neither be able to deliver quality clinical outcomes for patients, nor to attract foreign investment in health industries. And consequently the country (the main investor of the national healthcare system) would lag behind others in respects of both healthcare and economy. This proposal for change appealed to normative claims, and targeting the NHS, people in the country, and the government. Therefore, it can be noticed that in the reactivation phase more emphasis was placed on normative alignment (patients, clinical outcomes, the good of the country) than in the activation phase. In addition, in the reactivation phase, theorizing accounts focused on a wide range of stakeholders (universities, NHS in general, the government, patients), rather than specific groups of universities and NHS teaching hospitals.

Another strategy in framing problems in which Imperial College and Professor Darzi engaged was drawing on beliefs of field constituencies to dramatize and amplify problems in order to gain wide attention. For example, both Imperial College and Professor Darzi attached the issue of the joint working between universities and NHS to the national prides. They both drew on the UK's history of great medical discoveries that have had until now significant impact on the healthcare such as Alexander Fleming's discovery of penicillin. They raised Alexander Fleming's discovery as an example in which research and clinical practice was well integrated and consequently led to great impact on the mankind. By doing so, the actors did not only dramatize the need for change, but also formed a normative link between research and clinical outcomes. In other words, it made the case of change to integration between university medical schools and NHS hospitals even stronger:

> Many of the great medical breakthroughs have occurred in London. Alexander Fleming discovered penicillin at St Mary's Hospital and John Snow identified cholera as a water-borne disease in Soho…London's future record in health research must match this distinguished past (Darzi, 2007: 25).

Interestingly, the accounts of change and the adoption of AHSC organizational form is no longer associated to the Ten Key Principles. In fact, the Ten Key Principles have no longer mentioned since 2004. It is possible that these principles, once regarded as the rule of engagement between the NHS and the higher education sector, became taken-for-granted – that common and shared objectives of joint management are acknowledged between the Department of Health and the Department for Education, but nothing has ever happened in practices at organizational level. Or since these principles were invented in the Conservative government (1979 – 1997), they gained less attention after the new election to the new Labour government (1997 - 2007). In the reactivation phase, the AHSC organizational form was no longer supplementary or used as guidance along with existing collaboration mechanisms, but the only solution that England should adopt.

Theorizing the organizational form

In theorizing the organizational form, Imperial College and Professor Darzi engaged in four strategies: 1) connecting to interests of the central actor and other organizational communities; 2) differentiating the new organizational form from existing forms of organizing in the field; 3) appealing to pragmatic legitimacy for adopters; and 4) appealing to normative legitimacy.

To justify the adoption of the AHSC organizational form, the key actors drew on interests of the central actor and various organizational communities, and linked these interest to the AHSC organizational form meaningfully. One of the most evident examples is the account in which Imperial College and Professor Darzi linked the AHSC organizational form to the political imperative – gaps in translational research. In 2006, the government announced consolidation of funding for health research from diverse government agencies into a single fund. Following this agenda, Sir David Cooksey reviewed the arrangements for the public funding for health research in the UK and found that the UK health research has made great contributions to the nation's healthcare and economy. However, the review also found that the UK might not gain full economic and health benefits from public investment in health research. The problem was because there were two gaps in the translation of health research: translating from basic science into new products and treatment, and translating these new products and treatment into clinical

practice (Cooksey, 2006). It suggested that closing translational gaps required strong collaboration between academics and clinicians. The review's recommendations were accepted by the Treasury in December 2006.

Both Imperial College and Professor Darzi leveraged these statements in the Cooksey report to reframe and dramatize the need for change and the adoption of the AHSC organizational form. At this stage, both actors framed that the structural/cultural separation between universities and NHS partners was the obstacle to closing the translational gaps, and that the AHSC organizational form was the solution:

> At the governmental level, the Cooksey review identified two gaps in translational research…As a consequence, the Government and leading charities have pledged substantial and increasing levels of funding to improve translational research in the UK…Yet this injection of funding will achieve nothing if we do not change the way organisations work on the ground…A solution to this problem was unveiled in October, 2007, with the creation of the UK's first Academic Health Science Centre, after the merger of Hammersmith and St Mary's NHS (National Health Service) Trusts and their integration with Imperial College London (an extract from Imperial College AHSC leader's article, 2009).

This theorization by justifying the AHSC organizational form as the solution to closing gaps in translational research helped gain attention from the government and the NHS. This arguably dramatized the justification and accelerated the adoption of the AHSC organizational form in England. In the Chancellor's 2006 pre-budget statement, Gordon Brown (then the Chancellor of the Exchequer in the Labour government) acknowledged the findings and recommendations of the Cooksey report, and also accepted Imperial College and its NHS partners' proposal to create the UK's first AHSC (Imperial College news release, 2007). The recognition of the relationship between translational gaps and the AHSC organizational form (the solution) also reflected in an interview of Sir Ian Kennedy, who was a highly-legitimate person in the British healthcare, and also designated by the Department of Health as the chair of the international panel for selection of the British AHSCs:

> It's hard to overstate the importance of translational research and the impact that this can have on the care of patients. I have a particular interest in the benefits that Academic Health Science Centre designation can bring to patients across the NHS (Medical News Today, 2008).

In addition to attract attention and gain wide support in the field, Imperial College and Professor Darzi linked the AHSC organizational form to interests of various organizational communities such as NHS organizations in public health, local hospitals, society, and the country to justify the role of the AHSC organizational form. For example, Imperial College explained the role of the AHSC organizational form in improving the work in public health:

> The Academic Health Science Centres means we can go beyond the boundaries of our hospitals and into the wider community. Such a concept offers an unparalleled opportunity for research and improvements in public health. At Imperial, one of our new Clinical Programme Groups, Preventative and Interventional Public Health, will introduce and evaluate public health interventions in a local population of 3 million people (Smith, 2009: 1058).

The next strategy that Imperial College and Professor Darzi used to theorize the organizational form was differentiating the AHSC from similar forms of organizing existing in the field. An evident example is when the AHSC organizational form needed to be justified against existing models of collaboration that were created by the UK government in 2006. Following the Cooksey report on the new funding arrangements and the recommendations regarding translational research, the government established a new governmental agency NIHR in 2006, to take charge of managing the new funding arrangements. With aims to close translational gaps, the NIHR set up new schemes by funding universities and NHS partners who could together best conduct high-quality translational research. Those selected would receive grants from NIHR, and establish virtual organizational partners to conduct translational research together. The types of funding include Biomedical Research Center (BRC) and Biomedical Research Unit (BRU) for closing the first translational gap, and Collaboration for Leadership in Applied Health Research and Care (CLARHC) for closing the second translational gap. As the purpose of these new bodies was to bring together universities and NHS hospitals to work on

translational research, some viewed that establishing the AHSC organizational form might not be necessary. In addition, being BRU, BRC, or CLARHC, organizational partners would also receive government funding for working together, while being an AHSC has no money given. In response to such circumstance, the key actors theorized by differentiating the new organizational form from these seemingly similar models, and at the same time meaningfully connecting the new and existing ones in alignment with the dominant goal and value held in the field.

Imperial College and Professor Darzi emphasized that BRC, BRU, and CLAHRC could be only projects, but the AHSC organizational form involved integrated governance structures between universities and NHS organizations, where the leadership and directions were clearly articulated to both parties, and where research, education, and clinical practice were truly integrated. They argued that conducting translational research required strong collaboration between universities and NHS healthcare organizations with clearly defined governance structure and leadership. Therefore BRC, BRU, and CLAHRC could perform better under an overarching body of the AHSC. Below is the illustrative quotation from the interview with Professor Darzi, when he was asked regarding the relationship between the NIHR's bodies and the AHSC organizational form:

> BRC/BRU and CLAHRC are only about money. AHSC would be an overarching institution under which all these could be integrated (interview, Professor Darzi, 2009).

Contrasting the new organizational form with existing models and developing relationships between them, the actors contribute to more understanding of the new organizational form.

Additionally, for the AHSC organizational form to achieve legitimacy, it needed to be framed as appealing to pragmatic legitimacy for adopters and normative legitimacy for stakeholders in the field. To adopters as university and associated NHS hospitals, the AHSC organizational form was theorized as the organizational form that could attract more grants and funding from the government in the future:

> AHSC will be centres of excellence, capable of competing internationally, and making them highly attractive targets for research funding, clinical trials, and recruiting the best researchers and clinicians (Lancet, 2008: 508).

To patients, the government and the NHS in general, the AHSC organizational form was justified as the organizational form that would generate better healthcare and help boost the country's economy:

> We need to streamline and speed up the process by which we take medical advances to patients. Their health is our primary concern, but they are not the only beneficiaries. Biomedical research can also play a crucial part in helping our ailing economy back to health. Unless we make proper use of this biomedical research base, we will lose our edge over our global competitors (extracts of the leader of Imperial College AHSC's interview in the Times Higher Education, 2008).

In addition, the key actors sought both pragmatic and normative legitimacy for the adoption of the AHSC organizational form by referring to success of exemplary AHSCs in the U.S. and other countries. The actors connected the creation of the AHSC organizational form to not only pragmatic benefits for adopters as universities and associated NHS hospitals, but also the good of the country. Referring to renowned organizations such as the Johns Hopkins, Massachusetts General Hospital, and Duke University Health Systems, the key actors justified the AHSC organizational form by linking its adoption with expected pragmatic and normative outcomes. These top academic health organizations are described as world-class and successful figures in terms of both health research and provisions:

> Other large developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Science Centres (AHSCs), combining world-class research with leading-edge clinical services and education and training. For instance, Toronto has Sunnybrook Health Science Centre and Boston has Massachusetts General Hospital (Darzi, 2007: 25).

Theorizing the new organizational form by relating it to interests of other actors, connecting with functions of existing forms of organizing, appealing to pragmatic legitimacy for

adopters, and appealing to normative alignment, Imperial College and Professor Darzi gained wide support in the field and thus increased legitimacy for the AHSC organizational form.

Theorizing adopters

Imperial College and Professor Darzi engaged in two strategies of theorizing adopter: 1) emphasizing similarities between existing and potential adopters, and 2) simplifying properties of potential adopters in the field.

To facilitate the adoption of the AHSC organizational form in the UK, Imperial College and Professor Darzi highlighted some forms of similarities across all the countries that have AHSC, which somehow defined the set of population in which the adoption of the AHSC organizational form was "imaginable and sensible" (Strang & Meyer, 1993). Both actors referred to the countries such as the U.S., France, and China, which are all the countries that have ones of the biggest economies in the world, and those with whom England has competed in many aspects including the quality of healthcare. Consequently, regardless of the national healthcare systems, the AHSC organizational form can be and should be created in England. As the leader of Imperial College stated, "there is no reason why a country which is the fifth biggest economy in the world does not have healthcare system like somewhere else" (Imperial College AHSC leader's interview, 2009). The key actors referred to these developed countries with the establishment of AHSCs and linked to their seemingly success stories i.e., economic growth and leading healthcare systems. They predicted that if England adopted the AHSC organizational form, she would also gain the similar outcomes:

> Everyone does it. America does it. Holland does it. France does it. Germany does it. Every single leading economy, which we compete with. Japanese do it. Chinese do it. We are the only ones who have come to this very late (Imperial College AHSC leader's interview, 2009).

In addition, my analysis of the case revealed that Imperial College and Professor Darzi engaged in another strategy of theorizing adopters – simplifying attributes of potential and appropriate adopters within the field. My analysis suggests that the capacity to theorize adopters by distilling properties of the organizational form and simplifying them into attributes of potential adopters represents an important strategy of theorization of the foreign organizational

form in the mature organizational field. Specifically, Professor Darzi simplified attributes of potential adopters, which also helped not only universities and associated NHS teaching hospitals, but also other actors in the field to have a better understanding of the organizational form. Also, it contributed to understanding of the actors about what kinds of adopters in which adoption is "imaginable and sensible." Therefore it received little resistance from those, who might think that AHSC was no difference from existing arrangements such as BRCs, BRUs, and CLAHRCs, and those who might perceive that AHSC was not different from what universities and NHS organizations in England have been doing.

For example, Professor Darzi proposed six criteria for being an AHSC in his 2007 report Healthcare for London: A Framework for Action: 1) integrated governance (ranging from full merger to federated partners or delegated authorities), 2) internationally-recognized excellence in research and clinical practice (with the ability to be a leader in the UK), 3) clear integrated funding streams for research and teaching, 4) integrated leadership and career paths, 5) joint programs which combine research and clinical work, 5) commercial expertise to market research and benefits the country's economy (Darzi, 2007: 105). He emphasized that these criteria suggest that the UK did not have any AHSCs.

By simplifying properties of potential adopters, the actors contribute to a better understanding of what the organizational form means in the local context. It links the fit between the attributes of the new organizational form and the attributes of potential adopters. The key actors construct shared theory of the AHSC organizational form within the field.

I therefore suggest that theorizing the adopters by emphasizing similarities across adopters and simplifying the properties of adopters to help multiple actors gain more understanding of the organizational form is an important strategy of theorization in the mature field with multiple groups of actors.

In sum, the theorization in the reactivation phase was performed by an individual and an organizational actor (Professor Darzi and Imperial College). Similar to the activation phase, the theorization contained three tasks: framing problems, theorizing the organizational form, and theorizing adopters. However, strategies in some tasks of theorization were changed. Problem framing was more dramatized and changed as impacting the common interests of the field (i.e.,

improved healthcare outcomes). The organizational form was linked to various interests of multiple actors in the field, and justified against existing forms of organizing. Overall, theorization in the reactivation phase primarily appealed to normative legitimacy, and targeted a wide spectrum of members of the field.

Table 5-2: Selected evidence for my coding analysis in the re-activation phase

	First-order categories		Representative data
A.	Emphasizing the issue of the lack of collaborative mechanisms	1)	The leader of Imperial College gave an interview with Health Service Journal about the problem in the healthcare: "It had been clear for about 25 years that the structure in the UK wasn't working. The academic sector was delivering in terms of discoveries, [but] the service side was not delivering in terms of outcomes. Service people were only interested in targets and financial difficulties. Universities wanted nothing to do with improving outcomes" (extracts from Health service journal, 2009).
B.	The UK lagging behind other countries in terms of clinical outcomes	2)	"The National Health Service has been failing the public for years because of the historical divide between university medical schools and hospitals…The system is broken. Although universities' biomedical research is world class…institutions are pushed away by a "Stalinist" NHS. The consequence is that while we are second only to the US in biomedicine and have four of the top universities in the world in this area, we are way down the table when it comes to clinical outcomes" (published interview with Imperial College AHSC leader, Times Higher Education, 2008).
		3)	"The UK as a whole risks lagging behind its international competitors. The UK now spends half as much on research as a proportion of GDP compared with the United States. At the same time, the number of commercial drug trials taking place in India and Russia is growing exponentially, whilst trial numbers in the UK remain fairly static" (Darzi, 2007: 24).
C.	London is one of the greatest capitals in the world, but healthcare does not achieve the same outcome.	4)	"London is one of the greatest cities in the world. Inhabited for over two thousand years, it has a rich historical and architectural heritage. It is a city renowned for its vibrant artistic and creative output, as well as for being a hub of innovation and invention. It is a financial powerhouse, rivalled only by New York… However, we know at present that whilst there is excellence in healthcare in London, that excellence is not uniform. There are stark inequalities in health outcomes and the quality and safety of

	First-order categories		Representative data
			patient care is not as good as it could, and should, be" (Darzi, 2007: 2).
D.	The UK has distinguished history of excellent health research but poor healthcare and clinical outcomes.	5)	"The UK has discovered and developed so many of the basic tools used in modern medicine—from penicillin, to the structure of DNA, and to recent advances in genetics and cell and molecular biology—but as a nation we are slow to put these innovations into practice" (an extract from Imperial College AHSC leader's article, 2009).
		6)	"Many of the great medical breakthroughs have occurred in London. Alexander Fleming discovered penicillin at St Mary's Hospital and John Snow identified cholera as a water-borne disease in Soho…London's future record in health research must match this distinguished past" (Darzi, 2007: 25).
E.	AHSC is means to closing gaps in translational research.	7)	"At the governmental level, the Cooksey review identified two gaps in translational research…As a consequence, the Government and leading charities have pledged substantial and increasing levels of funding to improve translational research in the UK…Yet this injection of funding will achieve nothing if we do not change the way organisations work on the ground…A solution to this problem was unveiled in October, 2007, with the creation of the UK's first Academic Health Science Centre, after the merger of Hammersmith and St Mary's NHS (National Health Service) Trusts and their integration with Imperial College London" (an extract from Imperial College AHSC leader's article, 2009).
		8)	"For too long, university-based research in the UK has failed to translate into improved clinical practice. Health minister Ara Darzi has recognised that the situation must change by integrating research, clinical care, and education through close collaboration between universities and hospitals. Darzi envisages that this collaboration could take the form of Academic Health Science Centres (AHSCs), which have proved successful in the USA, Canada, and Sweden" (Lancet, 2008: 508).

	First-order categories		Representative data
F.	AHSC will enable universities to play more active role in solving society's problems.	9)	"The model for Academic Health Science Centres also brings into sharp focus the social contract between universities and society. Many universities have traditionally prided themselves on their autonomy, arguing that they better serve society by a degree of separation. However, it makes sense to have a more active role when they have the skills and competencies to solve society's problems" (Smith, 2009: 1058).
G.	AHSC will play the role in the public health.	10)	"The concept of Academic Health Science Centres means we can go beyond the boundaries of our hospitals and into the wider community. Such a concept offers an unparalleled opportunity for research and improvements in public health. At Imperial, one of our new Clinical Programme Groups, Preventative and Interventional Public Health, will introduce and evaluate public health interventions in a local population of 3 million people" (Smith, 2009: 1058).
H.	Local hospitals will also get benefits from AHSC.	11)	"The development of AHSCs does not, and must not, mean that all research is concentrated in major acute and specialist hospitals. We expect that both polyclinics and local hospitals will be linked with AHSCs or even be part of them… many local hospitals will be networked with AHSCs so that they can benefit from the latest research developments and AHSCs can coordinate research and trials within local hospitals" (Darzi, 2007: 105).
I.	AHSC is not a teaching hospital.	12)	"[The criteria] would ensure that the AHSC label did not become a term like "university hospital" and "teaching hospital," which are both used loosely and liberally" (Healthcare for London report, 2007: 105).
J.	AHSC is an overarching entity, under which BRCs, BRUs, and CLAHRCs	13)	"The Department of Health has awarded Biomedical Research Centre (BRC) status to the joint application by Hammersmith and St Mary's, in partnership with Imperial College. This is worth £19.5 million funding per annum. This creates a building block on which the ambitious AHSC programme

	First-order categories	Representative data
	operate together.	can be built, but will still leave major financial pressures on the partners that we believe are better handled through an AHSC" (Imperial College's leaflet – pre consultation, 2007).
		14) "BRC/BRU and CLAHRC are about money. AHSC would be an overarching institution under which all these could be integrated" (interview, Professor Darzi, 2009).
		15) "BRCs could develop into AHSCs" (Darzi, 2007: 105).
K.	AHSC would bring grants, talents, and recognition	16) "The new centre will be a magnet for investment and attract new companies and jobs" (Guardian, 2007).
		17) "AHSC will be centres of excellence, capable of competing internationally, and making them highly attractive targets for research funding, clinical trials, and recruiting the best researchers and clinicians" (Lancet, 2008: 508).
L.	AHSC is beneficial to both universities and NHS.	18) "I suppose the sum was supposed to be greater than the parts because the NHS will say we are translating and introducing the best clinical care based on our fantastic five-star academic partner. And the university will say we are actually running some of the biggest trials based on our very strong clinical partner. But that probably has happened one way rather than two ways." (interview, Professor Darzi, 2009).
		19) "The NHS can be the best in the world, but it must support the development of the integrated approach [of AHSC] to achieve that goal" (Imperial College AHSC, 2008: 5).
M.	Referring to success of AHSCs in other countries	20) "The fusion of care, research and teaching mirrors that of powerful academic health centres in the US, such as those at Stanford, Harvard, and the John Hopkins Hospital in Baltimore, the top-ranked US hospital for 17 years running" (Financial Times, 2007).
N.	AHSC provided benefits for	21) "The AHSC's vision is that the quality of life of our patients and populations will be vastly improved

	First-order categories	Representative data
	patients.	by taking the discoveries that we make and translating them into advances — new therapies and techniques – and by promoting their application in the NHS and around the world, in as fast a time frame as is possible" (Imperial College AHSC, 2008: 5).
		22) "How will the development of AHSCs benefit patients? The experience of the US shows that AHSCs provide excellent patient care. Thirteen out of the top fifteen hospitals for digestive disorders and rheumatology are AHSCs which focus on a range of clinical areas. Five of the top fifteen hospitals for cancer care are specialist cancer AHSCs" (Darzi, 2007: 105).
		23) "AHSCs aim to improve patient care speeding up the translational benefits of research - taking it from bench to bedside and back again" (Department of Health, 2008).
O.	AHSC will contribute to the country's economy.	24) "[Patients'] health is our primary concern, but they are not the only beneficiaries. Biomedical research can also play a crucial part in helping our ailing economy back to health. Unless we make proper use of this biomedical research base, we will lose our edge over our global competitors" (extracts of the leader of Imperial College AHSC's interview in the Times Higher Education, 2008).
		25) "AHSCs will also generate economic growth through spin-offs and industry investment" (Department of Health, 2008).
P.	Referring to success of AHSCs in other countries	26) "How will the development of AHSCs benefit patients? The experience of the US shows that AHSCs provide excellent patient care. Thirteen out of the top fifteen hospitals for digestive disorders and rheumatology are AHSCs which focus on a range of clinical areas. Five of the top fifteen hospitals for cancer care are specialist cancer AHSCs" (Darzi, 2007: 105).
Q.	All developed countries that England competed with have	27) "Everyone does it. America does it. Holland does it. France does it. Germany does it. Every single leading economy, which we compete with. Japanese do it. Chinese do it. We are the only ones who

	First-order categories	Representative data
	AHSCs.	have come to this very late" (Imperial College AHSC leader's interview, 2009).
		28) "Other large developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Science Centres (AHSCs), combining world-class research with leading-edge clinical services and education and training" (Darzi, 2007: 25).
R.	All largest cities have AHSC, but London does not.	29) "Other large developed cities have ensured the promotion of clinical excellence and the translation of research into practice by establishing one or more Academic Health Science Centres (AHSCs), combining world-class research with leading-edge clinical services and education and training. For instance, Toronto has Sunnybrook Health Science Centre and Boston has Massachusetts General Hospital" (Darzi, 2007: 25).
S.	Definition of AHSC	30) "AHSCs are corporate entities with integrated governance and leadership structures that have assumed the role of strategically and operationally managing both healthcare and relevant academic resources. Their purpose is to exploit the potential for exemplary care and innovation through the integration of the clinical, research and education functions. AHSCs are able to attract the best talent internationally by providing a high-quality clinical environment where research can be carried out" (Darzi, 2007: 104).
T.	Criteria for being an AHSC	31) Professor Darzi proposed six criteria for being an AHSC in his 2007 report Healthcare for London: A Framework for Action: 1) integrated governance (ranging from full merger to federated partners or delegated authorities), 2) internationally-recognized excellence in research and clinical practice (with the ability to be a leader in the UK), 3) clear integrated funding streams for research and teaching, 4) integrated leadership and career paths, 5) joint programs which combine research and clinical work, 5) commercial expertise to market research and benefits the country's economy (Darzi, 2007: 105).

5.4. Summary

In this chapter, I examined theorization as a part of translation processes of foreign organizational forms. As shown in the previous chapters, the translation process based on the present case study consisted of three phases: activation, dormancy, and reactivation. I analyzed theorization in the activation and reactivation phases to present theorization of the foreign organizational form over time. In each phase of the translation, I found that the actors employed a variety of strategies in the theorization process of the foreign organizational form, which can be synthesized into three main components: framing problems, theorizing the organizational form, and theorizing adopters. In the activation phase, the key actor (the Nuffield Trust) employed two strategies in framing problems: (1) identifying problems, and (2) framing existing arrangements and local solution as ineffectual. They used two strategies in theorizing the organizational forms: (1) appealing to pragmatic legitimacy for adopters, and (2) appealing to normative legitimacy for stakeholders. And the actor employed two strategies in theorizing adopters in the activation phase: (1) emphasizing similarities across existing and potential adopters, and (2) simplifying properties of potential adopters.

In the reactivation phase, the strategies underlying the theorization process, performed by Imperial College and Professor Darzi, were fairly different from those in the activation phase. Two strategies underlying framing problems in the reactivation phase were (1) identifying problems, and (2) drawing on beliefs of field constituents to amplify problems. Four strategies forming theorizing the organizational forms were (1) connecting to interests of central actors and other organizational communities, (2) differentiating foreign organizational forms from existing forms of organizing, (3) appealing to pragmatic legitimacy for adopters, and (4) appealing to normative legitimacy for stakeholders. Lastly, theorizing adopters in the reactivation phase include two strategies, which were similar to those in the activation phase: (1) emphasizing similarities across existing and potential adopters, and 2) simplifying properties of potential adopters. Together these components and process of theorization show how individual and organizational actors, who notwithstanding do not possess dominant positions in mature fields, could discursively motivate change and the adoption of new organizational forms. Previous studies of theorization have focused on how actors as institutional entrepreneurs (Maguire et al.,

2004; Perkmann & Spicer, 2007; Tracey et al., 2011) theorize new organizational forms. This study shows that theorization is not a temporal act that happens one time. But it requires sustained repetition so that meaning and comprehensibility of new organizational forms come to be shared (Greenwood et al., 2002). Future research could examine in more details by focusing on the relationship between differences in theorizing over time and material fluctuations or power structure and political process within the field.

This study contributes to the literature of theorization. First, it provides more nuanced view of theorization by highlighting various strategies. Furthermore, it shows that theorization involves three tasks: framing problems, theorizing the organizational form, and theorizing adopters. Extant research focuses on the first two tasks in analyzing theorization, and neglects the dimension of adopters. Theorizing adopter is an important component of the process, as it contributes to understanding of why the organizational form can be adopted in different contexts, and who in the new context can be potential and appropriate adopters.

Second, it contributes to understanding of theorization in mature fields. In their study of change and the adoption of a new organizational form in mature and professional fields, Greenwood and his colleagues suggest that the strategy in theorization to legitimize new organizational form is to align the new form with normative legitimacy. My finding resonates with previous research and extends significantly. Specifically, it suggests that: for the foreign organizational form to achieve legitimacy and widely adopted in the mature field, it needs to be not only embedded within normative prescriptions, but also links to pragmatic legitimacy to appeal to potential adopters, relates to interests of various groups of stakeholders, and causally connects with existing organizational forms and practices with the field. This is interesting because the actors in this case study formed the relationship between new and existing organizational forms, rather than replacing them. Therefore, the foreign organizational form causally relates to not only particular outcomes, but also to interests of field constituents, functions of existing models and forms of organizing, and to potential adopters. In this way, the new organizational form is interlocked into institutionally structured configurations of actors and cognitive map of the field.

Chapter 6.

FINDINGS: A GARBAGE CAN MODEL OF TRANSLATION PROCESSES

6.1. Introduction

In this chapter, I develop a garbage can model of translation. Based on my case study, I observed that the whole process of the translation of the AHSC organizational form – from the first-time appearance to the creation – consists of four interesting features: 1) the organizational form framed as the solution to an array of problems, 2) the existence of the solution even before some problems, 3) multiple actors contributing to adoption of the organizational form, and 4) triggering events and timing that provided an opportunity for the creation of the AHSC organizational form to be not only appropriate but also imperative. I found that these features were similar to elements of the garbage can model. Based on this observation, I thus draw on the ideas of the garbage can model to develop a novel view of what translation is and how it works.

My findings have so far revealed one pattern of the translation process as unfolding over three phases: activation, dormancy, and reactivation. In each phase, I presented strategies in which the key actors engaged in the translation process of the foreign organizational form. It implies the deliberate and planned process through intention and efforts of the actors. However, based on my empirical observations, my data shows translation is not a planned process (at least not always). It is also riddled with uncertainty, complexity, and randomness. My data supports an alternative garbage can model of translation.

This chapter consists of three parts: 1) background and conceptualization of the garbage can model, 2) the finding of a garbage can model of translation processes, and 3) conclusion and theoretical ramifications.

6.2. Background and conceptualization of the garbage can model

Cohen, March, and Olsen (1972) introduced the garbage can model to organizational studies, which was among the first theoretical models that "introduce a strong cognitive dimension of the study of internal process" (Perrow, 2000: 473). They proposed a conceptualization of decision-making context within an organization, which is in contrast to the classical model of decision-making that "solutions are chosen for their optimally efficient resolution of preexisting problems" (Lipson, 2007: 82). In the garbage can model, problems and solutions are viewed as streams. The model posits that problems, solutions, decision-makers, and choice opportunity are independent. Hence, the process does not always begin from problems, then solutions, as Cohen and his colleagues observed "decision-making is thought of as a process for solving problems, [but] that is often not what happens" (Cohen et al., 1972: 16).

In some decision-making context, they argue that solutions may seek problems, both problems and solutions may await opportunities for decisions, and energy of people in the decision nexus is likely to be distributed according to the overall load and arrival time of the various streams rather than by any objective criteria determining the relative importance of a particular issue (Hoffman & Jennings, 2011; Levitt & Nass, 1989). Thus, choices are made, based on an intermeshing of elements – "the mix of problems that have access to the organization, the mix of solutions looking for problems, and the outside demands on the decision makers" (Cohen et al., 1972: 16). By conceptualizing the phenomenon this way, random outcomes can be expected. The connections between decisions and outcomes are determined by temporal factors rather than causal connections between decisions and outcomes (Levitt & Nass, 1989).

In the decision-making context of an organization, where the independence of problems, solutions, decision-makers, and choice opportunity could be found, Cohen and his colleagues metaphorically term it as a garbage can. Choice opportunity is a can label. Decision-makers dump problems and solutions into the garbage can according to its label. Cohen and his colleagues called organizations that have the garbage can features as "organized anarchies", and identified the characteristics of such organizations, including problematic preferences, unclear technology, and fluid participation. Problematic preferences mean ambiguity in problems and

goals. The nature of problems may not be well understood, and the actors may be uncertain what they want to achieve. Unclear technology refers to unclear connections in procedures, process, or systems to reach a decision. Fluid participation refers to unpredictability of entrances or exits of participants in the decision-making context.

One can observe some similarities between the garbage can model and institutional theory. Both highlight that the change that occurs does not always come from rational or calculative thinking. However, while the garbage can model calls attention to the strategic effect of timing and implies random outcomes at organizational level, institutional theory extends this notion to inter-organizational level (Perrow, 2000: 473). Institutional theory focuses on forces that shape attention and identity, influence behaviors and actions that lead to the outcome of homogeneity across organizational fields. Hence, I view that the idea of the garbage can model provides a new perspective to studies of translation.

The garbage can model has been modified to fit many settings. In his study of US national policy agenda, Kingdon (2002) modified the four elements of the garbage can model (problems, solutions, participants, and choice opportunities), to three elements (problems, policies, and politics). According to Kingdon's work, policies are solutions, and politics refer to both participants and choice opportunities. Kingdon also added another two elements: policy window and policy entrepreneurs. In examining the case of the BP oil spill, Hoffman and Jennings (2011) used the elements of the garbage can model: (1) the timing of events, and (2) the actors matching problems and solutions or institutional entrepreneurs, to understand the process of institutional change. In this study, I identify two elements in developing a garbage can model of the translation process: (1) temporal dimension, or to be more specific, field conditions that facilitate the translation of the organizational form, and (2) conditions of strategic actors engaging in the translation process.

Conceptualization in this way provides a novel view of the translation process. The translation process is partly not a planned and purposeful process, as extant research assumes. But the process and outcomes of translation are determined by temporal factors rather than causal connections between deliberate actions and successful translation.

6.3. Findings – A garbage can model of the translation process

In this section, I describe the British healthcare field as the garbage can. Subsequently, I develop a garbage can model of the translation process of the AHSC organizational form, which encompasses the impact of field conditions and the conditions of the strategic actors at the time of translation.

6.3.1. The garbage can model

I applied the garbage can model to the field-level analysis. Although the original concept of the model is developed to characterize some decision-making activities at organizational level, previous research applied this concept to study institutionalization and change at the field level (see for example Hoffman & Jennings, 2011). In this case study, I equate the British healthcare field as the garbage can.

The British healthcare can be characterized to fit with the properties of garbage can – multiple and fluid participants in the decision nexus, multiple stakeholders and preferences, and uncertainty due to change in political context. The uncertainty in the field reflects in one of my interviewees, when he was asked regarding the future of the AHSC organizational form in England:

> One thing you learn in anything which is politically controlled is the policy changes. Whether they will have another competition for AHSCs, I don't know. Whether they will decide to continue to designate, I don't know. Whether it matters whether they do or they don't, I don't know (interview, senior management, AHSC 2).

In this case, the British health policy is viewed as the label of the garbage can. The AHSC is the solution that had been attached to multiple problems: 1) concerns over standards of medical education and research, 2) clinical academic career in crisis, 3) lack of joint working mechanisms between universities and NHS, 4) gaps in translational research and innovation in the NHS, and 5) high quality healthcare. The connections between these problems and the AHSC solution changed over time. Given the uncertainty, ambiguity, and involvement of multiple actors and preferences (i.e., the government, the NHS communities and authorities, universities

and academic organizations, patients), the outcome of the translation of the AHSC and the timing for the implementation of the solution is "driven as much by the who, when, and where of political positioning in the decision nexus as by the what of the technical problem" (Hoffman & Jennings, 2011: 106). In other words, the adoption of the AHSC organizational form is as much driven by temporal factors as causal connections between problems and solutions.

Next, I describe the two elements, including field conditions, and conditions of strategic actors, which constitute the garbage can model of translation processes.

Field conditions

I refer field conditions to attention patterns of field constituents. The process by which people attend to particular issues is socially and culturally constructed and shaped by the group, organization, and organizational field of which they are a part (Hoffman & Jennings, 2011; March & Olsen, 1989; Thornton & Ocasio, 2008). Czarniawska (2009) explained this process by drawing on the notion of attention. There is a limit to the number of issues that people can notice and react to (Cohen et al., 1972; Czarniawska, 2009). Czarniawska (2009) referred to Down's (1972) work, which presented the notion of issue-attention cycles, "in which [issues] suddenly leap into prominent, remain the center of attention for a short time, and gradually fade away" (Czarniawska, 2009: 427). Politics and mass media can be such arenas for the focus of attention of people in the field (Czarniawska & Joerges, 1996). Thus, problems and/or solutions represented as being coupled with the issues in the focus of attention have higher chance of being legitimized (Czarniawska & Joerges, 1996).

In the present case, the British healthcare is a highly regulative and normative setting, in which the government is the central actor who sets directions and controls most financial resources in the field. Therefore, the government's focus and political agenda arguably influences attention of field constituents and sets the tone of the context in the field.

Conditions of strategic actors in the translation process

Attention of field constituents that are shaped by the political context such as in this present case at some time allow brief window of opportunity for problems or solutions to have higher chance to gain visibility and attention. The mood and attention of the field, however, do

not automatically lead to the field acceptance of the new organizational form, but actors do (DiMaggio, 1988). The success of framing and translating, the visibility in the field, and coupling of problems and solutions depend on the role of actors. In Chapter 4 and 5, I showed deliberate actions and strategies underpinning the translation of the organizational form in each phase. The configurations of strategies had distinctive consequences for the translation of the AHSC organizational form and its matching with various problems. In this section, I provide additional dimensions of the actors, including motivation that triggered the actors to distribute energy to promote the adoption of the AHSC organizational form, and their capacity at a given time to achieve so.

Figure 6-1 depicts the garbage can model of the translation process, based on the case study of the AHSC. The model consists of three phases. In each phase, I describe the field conditions that were influenced by political context, conditions of strategic actors who engaged in the translation of the AHSC organizational form through strategies of translating and theorizing, and the problem-solution matching of the AHSC as illustrative outcomes of the translation in each phase.

6.3.2. Activation phase

Field conditions: In the activation phase, two policies were dominant in the context: the internal market policy first introduced by the Thatcher government and the subsequent modernization policy of the NHS introduced by the Blair government. As described in Chapter 4, the UK government during Magaret Thatcher's premiership implemented the internal market policy, which stemmed from the need to constrain public expenditure, and was maintained throughout the subsequent Major government. After the new Labor became the government, the healthcare policy significantly promoted the quality of healthcare services with the focus on enhancing efficiency of the NHS such as waiting-time reduction and cost management (see the New NHS agenda, 1998). The issues of medical education and research have also been included in the government's health agenda. There were important activities related to academic issues during this time. For example, the government led the formation of the SGUMDER to evaluate the impact of the NHS reform on medical education and research in 1990s. The R&D program of the NHS was first launched in 1991 (Hanney, Kuruvilla, Soper, & Mays, 2010). However, the

issues of medical education and research had been less prioritized than the issue of health services. In short, the topical focus of the British healthcare in the activation phase was efficiency and modernization of healthcare delivery rather than the medical education and research issues.

Conditions of strategic actors: The key actor in the activation phase was the Nuffield Trust, the UK think tank for healthcare policies. Basing on the case study, I explained the conditions of the Nuffield Trust at the time through their opportunity, motivation, and capacity to transpose and promote the AHSC organizational form.

Consider the situation of the Nuffield Trust in the activation phase. Following the SGUMDER's formation to assess the impact of the NHS reform of medical education and research, the Nuffield Trust was given an opportunity by the government and its agencies to host forums for the relevant stakeholders to discuss about the collaboration mechanisms between universities and NHS organizations, and propose solutions. The Nuffield Trust was thus given an opportunity to access into the arena of discussing, framing problems, and proposing solutions.

At the same time, the Nuffield Trust came to expose to the AHSC organizational form through their relationship with the Commonwealth Fund, also a think tank in healthcare policies, in the U.S. The Nuffield Trust and the Commonwealth Fund collaborated in convening several symposia to bring together policy makers, health researchers and practitioners from both the UK and the U.S. for exchange of information and views regarding the healthcare issues (Commonwealth Fund, 2013b; Nuffield Trust, 2013). The Commonwealth Fund at that time focused on the issues of AHSCs, thereby establishing a task force on AHSC (existing between 1996 and 2003) to address environmental challenges to AHSCs in the U.S. (Commonwealth Fund, 2013a). In addition, the Commonwealth Fund supported the Harkness Fellowship program, which provided funding for the Nuffield Trust researchers to study AHSCs in the U.S. (Davies, 2002). It is thus not surprising that the Nuffield Trust, when requested by the government and health authorities to host the discourse on joint management and find a new solution, suggested the adoption of the AHSC organizational form. Through this direct contact with the Commonwealth Fund the Nuffield Trust had capacity to transpose the AHSC into the UK.

In the activation phase, AHSC was constructed as the solution to three problems: 1) concerns over medical education and research, 2) a decrease in the number of clinical academics, and 3) lack of collaboration between universities and the NHS (the emphasis given on the latter). The Nuffield Trust used various strategies in translating and theorizing the AHSC organizational form so that it achieved acceptance and legitimacy in the field. In the Chapter 4, I presented my analysis of translation strategies that the Nuffield Trust used to adapt the new organizational form to the new context, which I grouped into an aggregate dimension – contextual design of solution. In the Chapter 5, I presented the strategies of theorization the Nuffield Trust used to frame problems and justify the new organizational form.

Although the Nuffield Trust worked to translate the AHSC to fit with the British context and theorized this new organizational form primarily based on functional superiority (as opposed to existing arrangements between universities and the NHS and to the local solution such as the Ten Key Principles), the translation of the AHSC organizational form into established organizations failed in the first phase. The reason for the unsuccessful translation was mainly because it was not of interest of the policy makers. Below is the extract from the Nuffield Trust's report demonstrating this point:

> It has been observed that the concept of the academic health centre has virtually no currency in the UK and, given this, the absence of policy with this specific focus is not surprising. The interface between the health service and higher education has been a subject of ongoing, if intermittent, debate since 1948. In recent years a number of challenges have arisen which work across this interface. Yet the shift to acceptance that an institutional focus for policy is necessary to achieve an integrated response to these challenges has never occurred (Davies, 2002: 9).

Another example is from the interview with the former researcher of the Nuffield Trust. He was granted the Harkness Fellowship to study several AHSCs in the U.S. and made a presentation regarding the adoption of the AHSC organizational form back in England:

> When I came back from the U.S. and I had to give a presentation at the Nuffield Trust on what I did. They got a respondent in, who was leading strategy in the Department of Health at that time. So I went to my presentation. He said that this is a topic that it needs

> time and strategy and never came into the agenda for years. So nobody is looking because it is of no interest of British policy makers (interview, former staff, Nuffield Trust).

The Nuffield Trust had access into the field's discussions of change, in which they had an opportunity to frame problems and propose solutions. And because of their relationship with the Commonwealth Fund, the organization had motivation and capacity to transpose the AHSC into England. With the simultaneous presence of problems, exposure to the solution, and field-level discussion of change as opportunity, the Nuffield Trust coupled these elements, constructed the British version of the AHSC organizational form, and logically framed the problems and the solution. With all this opportunity and capacity, it seemed that the Nuffield Trust should have been able to successfully promote the adoption of the AHSC organizational form. However, their efforts failed, as the field was receptive to neither the issues of research and education, nor the importance of formalized collaboration between the two entities. As a result, the translation entered the period of dormancy. Nevertheless, their efforts to promote the adoption of the AHSC organizational form were not in vain. The framing of the AHSC organizational form as means to effective collaboration between universities and NHS organizations survived over time, waiting for window of opportunity or powerful problems to be coupled with so that it could rise to attention.

6.3.3. Dormancy phase

The dormancy phase was during the period of transition from the second term of the Blair government to the third term (during the period between 2004 and 2006). The government still continued their healthcare agenda to enhance efficiency of the healthcare services and the NHS sector. Nothing significant changed in terms of healthcare policies and directions.

The AHSC organizational form became a topic that was talked about among some specific groups of actors such as deans of medical schools and chief execs of NHS teaching hospitals. To quote one of my interviewees, it was "a rumbling issue" among some actors in the field, but never came into interest of key stakeholders like the government or the NHS in general. In this phase, there were low resources and actions contributed to promote the adoption of the AHSC organizational form. There was neither actors who actively engaged in translation, nor

interest from key stakeholders to continue discussion about the topic. The translation of what AHSC was or meant to the British context subtly continued among some specific groups of actors. Therefore, the discourse of the AHSC was at peripheral of the field. Where the documents could be found, the AHSC organizational form was linked to the need for joint management and collaboration between universities and NHS hospitals (Davies & Smith, 2004; Smith, 2005). The translation of the AHSC was in the dormant state until the emergence of new advocates for the organizational form – Imperial College and Professor Darzi – getting involved in the translation process:

> There was this kind of rumbling discussion kept alive by a group of chief execs [of NHS teaching hospitals] and heads of medical schools. And I was also working on consultancy which had helped keep it alive. So and then somehow out of all of that, I don't know how it happened, Imperial College kind of emerged, with Ara Darzi's tie (interview, former staff, Nuffield Trust).

6.3.4. Reactivation phase

Field conditions: The reactivation phase saw the shift in the political environment to pay more attention to research and innovation in the NHS, as well as the acknowledgement of the role of universities in helping the NHS deliver world-class research and innovation. As already described in the previous chapters, in 2006 the Chancellor of the Exchequer invited Sir David Cooksey to review the arrangements for the public funding for health research in the UK. The Cooksey report pointed out that the UK health research has made great contributions to healthcare and economy, and suggested the government focusing more on translational research. The Cooksey report, however, found that there were two gaps in translational research pathway, and these gaps could be closed by strong collaboration between universities and NHS organizations.

At the same time, the government set forth a 10-year framework on science and innovation (2004 – 2014) to improve the nation's health and create the nation's wealth (UK Government, 2004). Following the Cooksey report's recommendations and the 10-year framework investment, the government established NIHR in 2006 – a new funding body to be in charge of positioning, managing, and maintaining research issues including directions, staff, and

infrastructure in the NHS in England (Department of Health, 2006). Arguably, the field became more receptive to research and innovation and the role of universities to help the NHS deliver it.

Conditions of strategic actors: The key actors in the reactivation phase were Imperial College and Professor Darzi. Basing on the case study, I explained the situation of these two key actors at the time through their motivation to adopt the AHSC organizational form in England, and their capacities to promote it across the field.

The adoption of the AHSC organizational form was reactivated, thanks to the role of Imperial College and Professor Darzi. The motivation of Imperial College was born from a disruptive event that triggered Imperial College to promote change and hasten the process of the translation. Imperial College was triggered by the collapse of PFI scheme, and hence determined to create a new organization that gave the College more authority to have more control and coordination with the associated NHS hospitals:

> The specific motivation was that the NHS had undertaken a large PFI proposal in Paddington, which involved the university with a 70 million pound research building and that proposal, that planning took seven years and at the end of the day they decided not to do it. So the university had been in a position whereas it effectively had its faculty of medicine completely blocked from any development, any capital investment effectively anywhere on an NHS project. So it was a very pragmatic reason to do it [the adoption of AHSC] (interview, senior management, Imperial College AHSC).

Interestingly, when Imperial College theorized the adoption of the AHSC organizational form to the field's audience, Imperial College constructed the AHSC as the solution to the emerging problems that were of interest of stakeholders at the time (i.e., translational research and innovation), whereas the real motivation from the disruptive event was not at all referred to.

Professor Darzi had personal motivation from his own experience, when he was the head of a clinical department at Imperial College, as he stated in his interview:

> It was a personal one actually, to be fair, because of the way I ran this department. When I first worked [at Imperial College] as a lecturer, there was a clear dividing line between the academic department of surgeon which is called the ASU (Academic Surgery Unit) and the GSU (General Surgery Unit). That contained two or three people who were appointed

> by the NHS. And the ASU contained 2 or 3 people who were appointed by the university… So it really took me back into the university's lack of regard to what the NHS is and the NHS's lack of regard to what the university does. Where I strongly believe that the sum could be greater than its parts… So when I became a minister, I announced essentially we should have a number of Academic Health Science Centres (interview, Professor Darzi, 2009).

In 2006, Professor Darzi was requested by the NHS London to review the capital's healthcare and provide strategies how to improve it. With this opportunity, Professor Darzi suggested the establishment of the AHSC organizational form as one solution.

Both actors revealed what motivated them to distribute their energy to promote the AHSC organizational form. There is no evidence why they attended to the AHSC organizational form in particular, instead of other organizational forms, practices, or ideas. This might be partially explained by the legacy of the Nuffield Trust that helped the AHSC organizational form remain in the field. However, this issue is out of scope of this research, but would be interesting for future work.

In addition to the motivation, another element is the capacity that empowers the actors to achieve so. Professor Darzi, in particular, had capacity that came from his social position that granted him legitimacy to connect with stakeholders across the field. After his review of healthcare in London, Professor Darzi was designated as a health minister and to the House of Lord, providing advice regarding health issues directly to the government. His social status at the time as the minister granted the AHSC organizational form social salience (Fiske & Taylor, 1991), which increased the field's attention to the particular issue. Professor Darzi were also skillful in sorting and manipulating meaning and symbolic to promote the AHSC organizational form to gain supports from multiple stakeholders.

Imperial College also had a capacity to connect across organizational communities in the field and promote the AHSC organizational form. Their capacity came from a coalition of organizational actors who are legitimate in different groups of stakeholders. Imperial College did not only promote the AHSC organizational form alone or only through the discursive process. But the university collaborated with the two historically renowned and prestige hospitals in

England – Hammersmith Hospital and St Mary's Hospital – together forming the first AHSC in the country. By doing so, they formed an influential coalition that was deemed legitimate in both university community and NHS community. Consequently, they had capacity to promote the AHSC organizational form and gain support from key stakeholders.

In the reactivation phase, AHSC was constructed as means to three ends: 1) joint management between universities and NHS, 2) closing gaps in translational research and innovation in the NHS, and 3) high quality healthcare. Interestingly, the previous two issues appearing in the activation phase (concerns over medical education and research, and clinical academic career in crisis) were no longer emphasized in this phase. Imperial College and Professor Darzi employed various strategies in translating and theorizing the organizational form. In Chapter 4, I presented the strategies of translation in which the actors engaged, which I grouped into two aggregate dimensions: strategies for gaining support and mobilizing forces, and legitimation. In chapter 5, I presented how Imperial College and Professor Darzi theorized problems, the organizational form as the solution, and adopters in order to appeal and make sense to key stakeholders.

Imperial College and Professor Darzi were obviously not the first actors who introduced the AHSC organizational form into England. They were not researchers who directly conducted studies of AHSCs in the U.S., whereas the Nuffield Trust did. What was interesting was the time Imperial College and Professor Darzi chose to promote the AHSC organizational form, as Professor Darzi stated in the interview:

> When I was doing the London report, there was quite a big mindset or trend in looking more at translational research. And you can't do translational research without a very strong partnership or ownership of clinical practices. (interview, Professor Darzi, 2009).

It was the time when the field was receptive to the issues of research and innovation, allowing window of opportunity for strategic actors like Imperial College and Professor Darzi to promote the adoption of the AHSC organizational form. When the AHSC organizational form was presented as means to closing gaps in translational research and driving innovation in the NHS, it became more visible and gained attention from the stakeholders. The AHSC organizational form was thus the product of the elevated attention to the benefits of translational

research and innovations in the healthcare. This highlights the role of timing in the translation process.

Both Imperial College and Professor Darzi engaged in efforts and activities to translate the AHSC to be suitable and relevant to the context, while strategically theorizing the AHSC organizational form by matching with powerful problems at the time so that the AHSC gained the momentum and support in the field. The actors translated and theorized the AHSC organizational form that fitted the context, in which the field was receptive to the idea and key stakeholders and sponsors were "willing to respond to the call" (Czarniawska, 2009). Hence, the outcome was successful translation – AHSC became visible, compelling, legitimate, and eventually got adopted. The outcome of the translation process of the AHSC thus occurred partly by deliberate actions of focal actors, and partly by temporal factors that allowed the combination of problems and the solution to be convincing and powerful in the field.

6.3.5. Transition between phases

In this subsection, I identified sets of conditions that were associated with the movement from one phase to another: 1) energy of dominant actors, 2) existence of strategic actors, and 3) the status of problems.

Transition from the activation phase to the dormancy phase

I found that three conditions were associated with the movement from the activation phase to the dormancy phase: dominant actors' energy to other issues, strategic actor's energy distributed to multiple issues, and the existence of not powerful problems. The government distributed their focus and energy to issues of healthcare, and paid less attention to academic issues such as research and education. The Nuffield Trust presented the AHSC as the solution to the problematic relationship between universities and NHS hospitals, and to integrate research, education, and clinical services. The framing of the AHSC did not align with interests of the central actor, while the central actor also put their energy to other issues with which they were more concerned at the time. Therefore, the translation of the AHSC organizational form became stagnant and entered the dormancy phase.

The second condition was the strategic actor's energy distributed to multiple issues at the same time. Although the Nuffield Trust played a leading role in promoting the adoption of the AHSC organizational form at that time, the think tank also paid attention to other health-related domains. They were not only interested in the issues of university/NHS relationship, but also studied and published a wide range of healthcare domains such as evaluation of the NHS's performance; integrated care delivery across primary, secondary, and tertiary care; quality of healthcare, social care and public health. Arguably, the energy of the Nuffield Trust was distributed extensively to a lot of issues around healthcare, rather than channeling it to advocate solely the adoption of the AHSC organizational form.

The third condition was the status of the problems with which the AHSC was coupled. The problems of university/NHS relationship or integration of academic and clinical activities were not adequately powerful to attract attention in the field. These problems interested only some specific organizational communities rather than the field in general. As a consequence, the case for adoption of the AHSC was less convincing to stakeholders. However, because there was still interest in the AHSC albeit within small groups of actors, the translation of the AHSC did not disappear, but still continued at peripheral of the field. These conditions led the translation of the AHSC organizational form to the period of dormancy, waiting for an opportunity or powerful problems to be coupled with.

Translation from the dormancy phase to the reactivation phase

I found that three conditions were associated with the movement from the dormancy phase to the reactivation phase: dominant actors' energy distributed back to the relevant issues to the organizational form, existence of strategic actors with energy and capacity to promote the new organizational form, and emergence of powerful problems. In this phase, the government turned to the issues of research and education, because they needed to revise public spending in the medical and healthcare area. Also, there were influential reports such as the Cooksey report and Best Research for Best Health, which highly-legitimate persons in the field published on behalf of the government, suggesting that health research made great contributions to the country's economy and healthcare. These reports also supported the idea of formalizing and strengthening collaboration between universities and the NHS. With these strong discourses and

rhetoric, the government shifted their attention to research and education, and distributed their energy accordingly to promote collaboration between universities and NHS organizations. One evidence was the establishment of NIHR to direct and promote health research based on collaboration between universities and the NHS.

Although attention of the dominant and central actor was now shifted in the way that facilitated the adoption of the AHSC, it could not automatically lead to the establishment of the AHSC organizational forms. Another condition therefore was the existence of strategic actors with energy and capacity to reactivate the translation of the AHSC organizational form. Imperial College and Professor Darzi had motivation to promote the adoption of the AHSC. The motivation of Imperial College was triggered by the collapse of PFI scheme, which led them to desire more control over associated NHS hospitals. Professor Darzi's motivation was born from his personal experience. With these motives behind, both actors focused their energy at the time to promote the establishment of the AHSC organization in the UK. Since both Imperial College and Professor Darzi were in the position that they were considered legitimate to organizational communities across the field, they also had capacity to attract attention of field constituents and reactivate the translation of the AHSC. The existence of these strategic actors with energy and capacity to promote the AHSC reactivated and catalyzed the translation process of the AHSC organizational form.

The third condition was emergence of powerful problems. Important problems are more likely to be solved than unimportant ones (Cohen et al., 1972). These problems were the lack of innovation in the NHS, and gaps in translational research, which stemmed from the influential reports published at the time. These problems were considered important, not only because they were framed by highly-legitimate persons in the British healthcare, but they were also considered important and imperative by the government. In the 2006 pre-budget statement, the government acknowledged the problems of gaps in translational research and the lack of innovation, and consequently announced allocation of budget to solve these issues (Imperial College news release, 2007). And as a consequence attention of other members of the field ensued. If there were no powerful problems that the AHSC could be coupled with, the dormancy period might last longer and the process of translation might not be reactivated. By relating the AHSC

organizational form to these powerful problems, field constituents paid more attention to the AHSC, and therefore the translation of the AHSC were reactivated.

6.4. Conclusion and theoretical ramifications

My objective in this chapter was to develop a garbage can model of translation processes through the case study of the AHSC organizational form. Based on the present case study, the garbage can model is developed in each phase of the translation – activation, dormancy, and reactivation. In each phase, the model encompasses the combination of two elements: field conditions that are determined by attention of key stakeholders, and conditions of actors engaging in translation. In the activation phase, strategic actors had motivation, opportunity, and capacity to translate the organizational form into the new context. However, the translation did not succeed and went into the dormancy phase, as field conditions were not receptive to the organizational forms. The conditions associated with the transition from the activation phase to the dormancy phase were dominant actors' energy to other issues, strategic actor's energy distributed to multiple issues, and the existence of not powerful problems.

In the dormancy phase, the field conditions were still no receptive, since attention of field constituents was directed to other issues. There was no existence of actors, actively engaging in the translation. Low resources and contributions were made to promote the adoption of the new organizational form. The conditions that triggered the movement from the dormancy phase to the reactivation phase were dominant actors' energy distributed back to the relevant issues to the organizational form, existence of strategic actors with energy and capacity to promote the new organizational form, and emergence of powerful problems.

In the reactivation phase, field conditions facilitated the new organizational form. There were strategic actors with motivation, opportunity, and capacity to motivate the adoption of the new organizational form. With the combination of receptive field conditions, strategic actors with motivation and capacity to translate, theorize, and connect across organizational communities within the field, successful translation occurred. And these combinations influenced the meaning of the organizational form in the new context. This finding has ramifications for

institutional theory of translation and makes three contributions and new insights into studies of translation processes.

Extant research presents translation as planned processes in which actors expend in deliberate actions and strategic intent to achieve successful translation in new institutional contexts. It implies that the outcome of translation – meaning transformation to a local version and adoption of the organizational form – is the product of deliberate and purposeful actions. The finding based on the present case provides new insights into the translation process: that the translation process and outcomes depend on not only deliberate actions and intentionality, but also societal and temporal conditions within the field. In other words, the translation process also involves the aspect of coincidental process, in which translators happen to have an opportunity and capacity to do so at the right time and therefore successfully work to translate the organizational form. If there are only actors with strategic intent in translation but the field at the time is not receptive, translation processes might not continue – let alone successful translation. Likewise, if field conditions facilitate translation but no existence of actors with intention, translation could fail too.

In this case study, the British healthcare field was receptive to the issues of research and collaboration between universities and NHS hospitals at the particular point in time. This shift in the field context provided window of opportunity for the AHSC organizational form. If the translation was undergone a few years later, the establishment of AHSCs in the UK might still not happen and the frame of AHSC might also be something different. And because the strategic actors – Imperial College and Professor Darzi – happened to have motivation and capacity to promote change and the organizational form at this time, the AHSC organizational form was eventually adopted. Boxenbaum (2006) also acknowledged that the role of field conditions in translation processes in her study of translation of diversity management, and proposed that this area merits additional attention in future research. However, it has not been widely explored and thus little understanding of how translation actually works. Therefore, my finding, in contrast to extant studies, suggests that translation is actually embedded in complex institutional structure, random participation of translators, and complex symbolic elements. My finding suggests that translation process and outcomes are influenced by both deliberate actions and the strategic effect of timing.

The ideas of the garbage can model on conditions of actors (who act as translators) and field conditions are novel contributions to institutional thinking of translation. Translator conditions contribute to new dimensions of the translation process. The conditions of translators include motivation, opportunity, and capacity that they have at a particular time, which enable them to distribute their energy to promote the new organizational form. These conditions of translators are not much referred to in studies of translation. Usually, translators are broadly defined as interested actors in new organizational forms or practices in the field, and they could be policy-makers, researchers, consultants, or organizational actors. Existing studies focus on strategies of translators rather than conditions or situations that activate them to engage in (or even be distracted away from) translation. The garbage can model provides the new notion that these conditions around translators also matter in understanding the translation process. It suggests why this particular actors act as translators but not others in the field, and how these conditions shape their interpretations and strategies in translating new organizational forms. For example, the Nuffield Trust translated the AHSC and presented it as the solution to identified problems because they had contact with the Commonwealth Fund. Or because Professor Darzi had personal experience and preexisting interest in the AHSC, he promoted it as the solution to field problems once he had an opportunity given by NHS London. These conditions determine distribution of energy of translators to particular issues, and thus there is enough energy for translation to the extent of successful outcomes. Their efforts to devote to particular domains and their involvement vary from one time to another. Therefore the translation process is uncertain and changing. The outcome of translation therefore is not due to purposefulness, but is the combination of field conditions and the arrival of translators with energy distributed to motivating the organizational form.

Future research can go in more detail by examining available energy of actors at the particular point in time. This can be done by mapping issues that interested actors have to deal with at the time of translation, and examine amount of energy the actors allocate to each issue. This can also link to social positions of the actors within the field at the time. People possessing high social positions might have less energy available to particular issues than people in lower social positions in the hierarchies, due to higher demands in institutional fields. However, when people in high social positions distribute relatively high energy to promoting the organizational

form, translation may have more chance to be successful. In this case study, actors at both positions are present. Perhaps because there is the combination of these two actors, energy was enough to promote the AHSC organizational form. However, it might not be the same, if only one of them did the translation. Future word could do more investigation, by conducting comparative case studies.

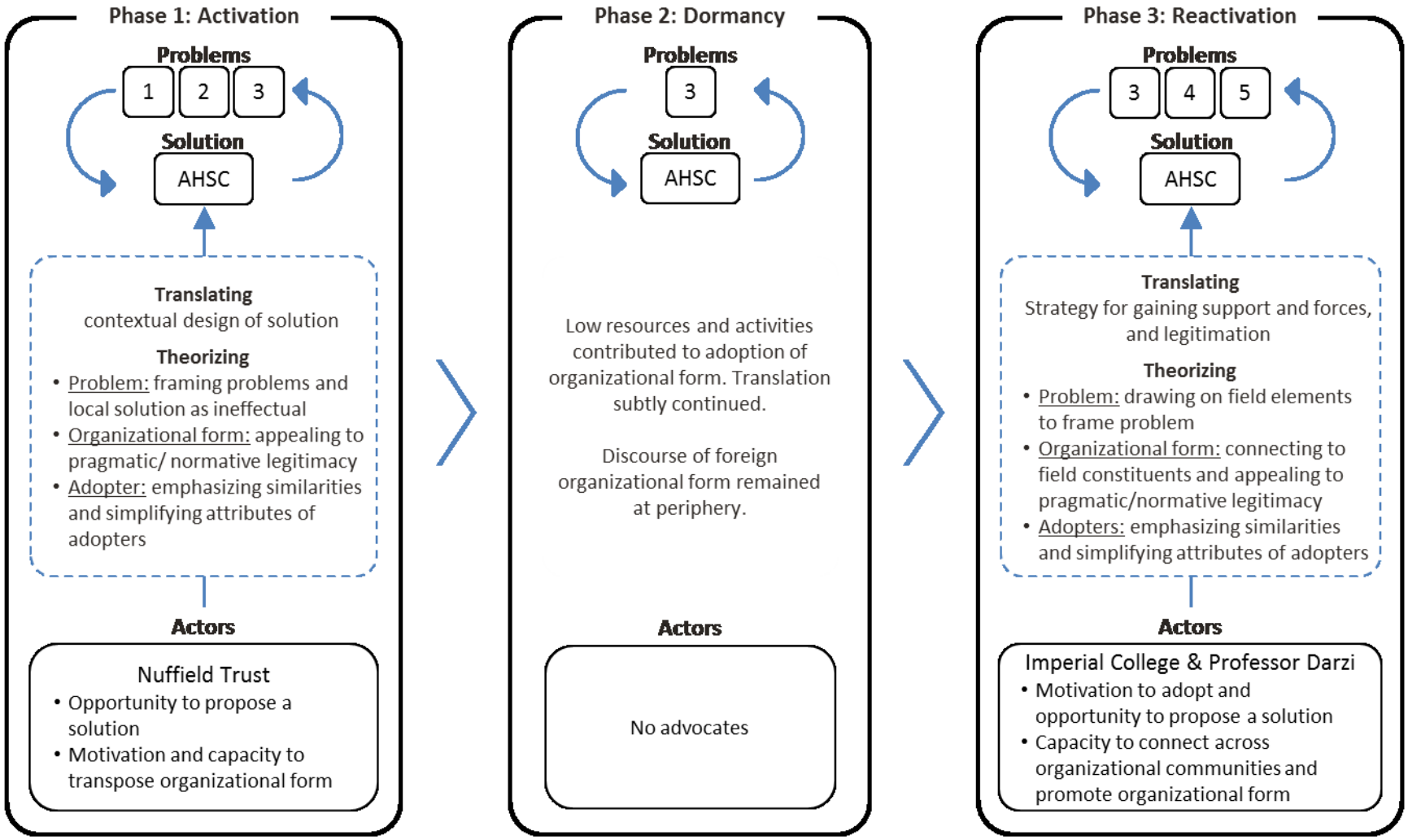
Insights from the garbage can model also illuminate the temporal dimension in the translation process. Extant studies acknowledge the temporal dimension in the translation process in the way that meaning and material aspects of organizational forms change through translation over time (Zilber, 2006). But we still have little understanding of how it influences, and what exactly influences. One particular relevant element of the garbage can model is the availability of energy within the field that disproportionately devote to different domains. I propose that this energy distribution can be understood as the attention pattern within the field. In a mature field such as in this case study, attention in the field is arguably shaped by behavior of central and dominant actors. The government is the highly-legitimate actor in the British healthcare with authority and control over allocations of resources to each organizational community. Therefore, the government's health policies and directions shape the field's attention to particular domains. Consequently, energy of multiple groups of actors in the field is directed to the issues that are of interest of the government. Therefore, the temporal dimension in the translation process is not only about change patterns, but it also provides window of opportunity for the organizational form (despite sometimes briefly). The outcome of translation or the meaning transformation of the organizational form therefore is not because of purposefulness, but because of the simultaneous existence and combination of these elements.

It is noted that translation involves negotiation between various parties and reshaping of what is finally transmitted. The finding shows that the end product of translation is not entirely the product of purposeful and deliberate action. Rather, it is the combination of strategic actors who distribute energy to promote the organizational form, field conditions that facilitate the organizational form, and presence of powerful problems that the organizational form can be coupled with.

I do not propose that a garbage can model does occur in every translation process. In some cases, it can be assumed that deliberate actions significantly lead to successful translation, even though field conditions were not receptive. Future work could look into types and characteristics of fields that could encounter a garbage can outcome of the translation process. The translation in this case study occurs in mature fields with diverse groups of actors. Therefore, I assume that such types of fields are likely to have a garbage can model of translation more than mature fields with less diversity of organizational communities such as in Greenwood et al's (2002) case study of professional communities of accountants.

Translation acknowledges that meaning of organizational forms underwent change across contexts and over time. The garbage can model calls attention to the strategic effect of timing through the distribution of energy by translators and the impact of field conditions at the time of translation. We know that actors select and filter the elements of the organizational form, and mobilize symbolic resources or institutional elements to increase legitimacy of the organizational form in the new context. The garbage can shape understanding that different elements in the field to be picked up are available at different time. So it depends on the temporal dimension and the condition of actors who happen to focus on the organizational form and have capacity and skills to mobilize local elements and filter the new organizational form to be compatible with the new context. The finding testifies to the complex institutional structures, dynamics of meaning systems that influence the translation process, the outcome and what is finally transmitted.

Figure 6-1: A garbage can model of translation processes



Problem labels:
1) medical education and research
2) clinical academic career
3) effective collaboration between universities and NHS
4) translational research and translation
5) high quality healthcare

Chapter 7.

DISCUSSION AND CONCLUSION

7.1. Research contribution

This thesis investigates the role of actors and the creation of meaning in the translation process of foreign organizational forms through a single case study of the creation of the AHSC organizational form in the field of the British healthcare. It addresses three research questions: 1) how is a foreign organizational form translated across institutional contexts, and over time becomes legitimate in a new institutional context? 2) What tasks of theorizations are required in legitimating the foreign organizational form? What is the role of theorization in the translation process? 3) What accounts for successful translation? I answer these three questions by drawing on three theoretical concepts, including neo-institutional translation, theorization, and garbage can model. This thesis contributes to two literatures: translation and theorization.

7.1.1. Translation

I examine the work of actors and the creation of meaning in the translation process through the qualitative case study. My finding in Chapter 4 revealed one pattern of the translation process as unfolding over three phases: activation, dormancy, and reactivation. It identified various actions constituting the translation process, which are grouped into three aggregate dimensions: (1) contextual design of a solution, and (2) strategy for gaining support and mobilizing forces, and (3) legitimation of the organizational form. The three overarching dimensions played out in different phases. The first dimension was the key action in the activation phase, while the second and third dimensions were key actions in the reactivation phase.

My finding makes two contributions to research on translation. First, it provides more nuanced view of translation. It highlights not only meaning modifications, but also actions and strategies underlying the translation process. Translation research focuses on changes that organizational forms undergo when they are adopted in new institutional contexts. Most translation studies show broad mechanisms by illustrating how translation is shaped and influenced by several factors at organizational and field levels. With the exception of Boxenbaum's (2006) work, we still have little insight into how actors in new contexts mobilize field elements, and work to translate new and sometimes foreign organizational forms; and how organizational forms become compelling to the extent that they are adopted. This thesis contributes to this deficiency, by examining the interaction between actions, actors, and creation of meaning that results in successful translation of a foreign organizational form.

The case study shows only one example of a successful translation. The phases and actions may not be generalizable to every translation process. However, the finding resonates with previous research. Specifically, it confirms that translation involves combining a foreign organizational form with a legitimate local element to gain acceptance in the field (Boxenbaum, 2006; Hargadon & Douglas, 2001). These legitimate local elements could be existing understanding, actions, regimes, or practices that constitute or are part of institutional environment. The third dimension – legitimation – presents how actors aligned the foreign organizational form with legitimate elements in the field. In the case study, these legitimate elements included existing regimes and principles, and highly-legitimate persons. This action contributed to comprehensibility and increased legitimacy of the foreign organizational form in the new institutional context.

The first and second dimensions: (1) contextual design of a solution, and (2) strategies for gaining support and mobilizing forces, have gained little attention in previous studies of translation. Translation research posits that organizational forms or practices, when travelling into new contexts, undergo modifications. The first dimension showed in more detail how actors worked to select, downplay, and emphasize some features of the foreign organizational form so that it made sense to actors in the new institutional context. However, the modification of meaning is not enough. Translation also requires actions to make organizational forms powerful, and to gain supports from stakeholders. The second dimension showed how actors worked to

gain support and mobilizing forces by aligning the organizational form with dominant political discourse in the field, engaging key stakeholders into translators' vision, and mobilizing symbolic resources to convince specific organizational communities to join forces.

The second contribution is that I present the entire trajectory of the translation process of organizational forms from its first appearance in the field to its adoption. Most studies focus on the translation at one point in time, rather than looking at historicity in the process. Normally the studies start from a group of actors interested in ideas or organizational forms, and translated ideas or organizational forms into new contexts. This results in studies that focus on single groups of actors engaging in translation rather than collective actions of multiple actors in the field. My study of the translation process extends existing studies by examining from the first appearance of the organizational form to the creation, taking into account involvement of multiple actors over time, as well as existing arrangements and local solutions that were present during the translation of the foreign organizational form. "New fashions are said to replace old ones, but the role of the old in the spread of the new is hardly discussed" (Frenkel, 2005: 149). Had I focused my data collection exclusively on Imperial College and Professor Darzi, I would have missed out the formation of problems long before the introduction of the AHSC and the role of the Nuffield Trust that constructed the initial framing of the AHSC in the British healthcare. I therefore argue that to analyze the detailed translation process requires a longitudinal study that shows temporal order and sequence of events, leading to successful translation.

Through examining actions and strategies underlying translation, it seems that translation is a planned and purposeful process. However, based on my empirical observations, I found that translation is not a planned process that causally connects between deliberate actions and successful translation. Rather, a translation process is a garbage can. In Chapter 6, I developed a garbage can model of translation processes, which provides new thinking of translation. The translation process is a coincidental and non-rational process. For successful translation, it requires not only strategic actions, but also depends on field receptivity and arrival of actors who are activated to engage in translation through motivation, opportunity, and capacity at the particular point in time. The finding in Chapter 6 provides a novel insight into translation, and calls for attention to the strategic effect of timing on the translation process.

Translation scholars (Czarniawska & Joerges, 1996; Rovik, 1998) contend that, for ideas to become powerful and legitimate, it depends on how they are packaged, formulated, and timed. I believe this statement is theoretically explained and empirically illustrated in this thesis.

7.1.2. Theorization

My finding in Chapter 5 makes two contributions to current understanding of theorizations. First, it provides more nuanced view of theorization by highlighting strategies and actions that can be synthesized into three components, including framing problems, theorizing the organizational form, and theorizing adopters. Together, these three components lead to the legitimation of the new and foreign organizational form. This is different from extant studies of theorization, which focus only on framing problems and justifying new organizational forms (Greenwood et al., 2002; Tolbert & Zucker, 1996). My finding suggests that to understand theoretical models that actors construct to motivate the adoption of new organizational forms or practices we should take into account not only logical relationships between problems and solutions, but also relationships between the problem-solution account and the element of adopters. My finding shows that the nature of problem, properties of the organizational form as the solution, and attributes of adopters are all linked and constructed into theoretical models that motivate change and the adoption of the new organizational form. For future research, one could ask how actors promote the new organizational form to potential adopters and stakeholders. Or another question could be how the actors with capacity and interest in the new organizational form - institutional entrepreneurs – promote themselves as appropriate adopters as a part of attempts to gain support from stakeholders and ensure continuity of the theorizing account in the field. Like Greenwood et al.'s (2002) suggestion, my findings confirm that theorization is not a temporary act, but an extended, on-going, process that requires sustained repetition to draw out shared understanding of the problem and meaning of the organizational form.

Second, my finding is consistent with and extends understanding of theorization in mature fields. The characteristics of mature fields are extant institutionalized rules and norms that construct perception of legitimacy and a coherent discourse, clearly-defined inter-organizational structures and power hierarchies, and concentration of resources associated with dominant actors. Therefore, for new organizational forms or practices to be widely accepted and

adopted in mature fields, scholars propose that actors employ symbolic resources in the field – the dominant norms and coherent discourse – to frame problems and justify solutions (Greenwood et al., 2002). However, fields are also composed of multiple communities of organizations. Despite working towards the mutual interest that hold fields together, organizational communities are guided by different logics and thus have certain differences in perception of legitimacy. Therefore for new organizational forms to achieve legitimacy in mature fields, my finding suggests that theorization involves not only alignment with normative and pragmatic legitimacy, but also conforming to interests and different perception of legitimacy of various stakeholders, and connecting with existing organizational forms and practices. Moral and pragmatic legitimacy are still primary concerns. However, they are not only ways of achieving legitimacy for the new organizational form. The resources that the actors can use in the field to frame problems and justify the new organizational form are thus not only existing institutionalized norms but also power of dominant actors. If the actor can access that power, by aligning the new organizational form with interests and the issues of focal attention of these powerful actors, they have high chance to successfully justify the new organizational form.

In addition, we know that there is high resistance to change in the mature field. Therefore, theorization of the new organizational form should be in the way that adds value to members of the field and existing forms of organizing.

Greenwood et al (2002) called for attention to studies of theorization so as to help generalizability of theorization. This study contributes to the literature of theorization, specifically to understanding of the theorization process in mature organizational fields.

7.1.3. Translation, theorization, and the garbage can model

In this section, I draw on my findings to describe the relationship between translation and theorization that forms the dynamic process of translation. Then I discuss this dynamic process in relation to the notion of the garbage can model.

My analysis highlights that translation is a micro mechanism. Actors in light of their particularities and present circumstances in which they are embedded (i.e., personal preferences, identities, experiences with the organizational form, and social positions) act to adapt the

organizational form to their own institutional context. The adaptation of the organizational form is done through actors' selection of elements of the organizational form and combination with some selected elements of the field (be it symbols, meaning, technologies, objects, and human). Based on the present case, these actions can be grouped into three dimensions associated with particular objectives that resulted in modifications of the organizational form to fit the new context: contextual design of a solution, strategy for gaining support and mobilizing forces, and legitimation of the organizational form. Theorization is a macro mechanism, in which actors act to promote change and confer legitimacy to the organizational form. Actors construct theorizing accounts regarding the organizational form in the way that makes sense to stakeholders and that the adoption is suitable in the field. To do that, theorizing accounts encompass the need for change, identification of problems, linkage to the benefits and outcomes of adopting the new organizational form, and socially constructed similarities between the original and the new receiving fields to facilitate the transfer of the organizational form. Theorization is thus the act to generalize translations into rhetoric and simplified accounts so that the organizational form can diffuse within the institutional field and then in turn potentially across fields.

The findings suggest that translation and theorization do not occur in a sequential manner, but rather are simultaneous and interact to each other throughout the process from the introduction of the organizational form to its adoption. The actors' translating and theorizing actions are directed by the actors' intentionality. In the first phase, the Nuffield Trust's intention was to solve the field problems (i.e., the issues of medical education and research and clinical academic career) with the new organizational form, which was constructed in the complementary way with existing collaboration arrangements between the NHS and universities. It was pragmatic motivations that led the Nuffield Trust to engage in contextual design of the organization by filtering the features of the organizational form and bundling with field elements. The Nuffield Trust's theorization was also primarily based on functional suitability of the AHSC in complementing existing collaboration arrangements. In the reactivation, Imperial College and Professor Darzi were also pragmatically inspired. However, these two actors desired to promote and implement change in existing forms and practices to the AHSC organizational form. These intentions affected and shaped the actors' actions and strategies. For example, Imperial College and Professor Darzi, when engaging in translating, expended a lot of efforts in actions such as

aligning the organizational form with dominant discourse or interests of stakeholders, with intentions to gain wide supports for change and achieve legitimacy for the organizational form. Their theorizations were performed in the way that primarily aligned with normative and moral legitimacy. The normative and moral legitimacy, as Greenwood et al (2002) noted, is very important in a professional field such as healthcare. For change to occur and new managerial forms or practices to achieve legitimacy in this type of fields, they need to be embedded within normative prescriptions. Therefore, I made an observation that the level of intentionality to have substantial impacts on the field determines actors' actions and strategies of translating and theorizing.

Based on the case study, I posit that strategic actions (both translating and theorizing) play the important role in the translation process. However, these strategic actions alone do not answer why some translations succeed and others fail. My finding of the three phases of the translation process even shows that translations failed in the first attempt and then disappeared from the main discourse before being reactivated and successful. The garbage can model accounts for this outcome, and identifies the conditions that determine success of translation.

In Chapter 6, I show that the translation process is actually not a planned and purposeful process that causally connects between deliberate actions and successful translation. Rather, it operates according to the principles inherent to the garbage can model. My developed garbage can model, based on the present case, accounted for how the translation process operated and why it was successful. In addition to strategic actions, the process also depends on another two elements: (1) field conditions, shaped by the dominant actor's attention, and (2) existence of strategic actors who were activated to engage in translation through motivation, opportunity, and capacity. The garbage can model suggested that these two elements are independent. Once they are simultaneously present – field receptivity to the organizational form and strategic actors distributing energy to promote it, translations can be successful.

The garbage can model directs attention to the significance of conditions around translators. It suggests why this particular actors act as key actors in the translation process but not others, and how these conditions – motivation, opportunity, and capacity at the particular point in time – affect their expectations and intentions to have impacts on the field, which in turn

shape how actors translate and theorize the new organizational form. This notion resonates with the translation perspective that the present circumstances in which translators are embedded (i.e., identities, social positions) influence how translators edit and adapt the organizational form. However, the garbage can model extends this understanding to acknowledge the significance of timing (e.g., political or market contexts, the arrival of problems, the arrival of solutions, choice opportunity), and distribution of energy according to these timing effects. In the translation literature, actors have traditionally been viewed as purposefully acting to adapt the organizational form and develop strategies to implement it in the field. The garbage can model however shows that actors must be able to review their expectations and intentions, dependent on their situation and the mood of the field at the time of translation (Leca, Battilana, & Boxenbaum, 2008). As in this case, the actors, activated through motivation, opportunity, and capacities at the time, noticed what the field's attention and the organizational form had in common, using it as an opportunity and strategically translate and theorize the organizational form. And because the field was readily receptive, other communities within the field were willing to participate in the process in which the organizational form finally got adopted. The conditions that facilitate successful translation therefore are the temporal factors – field receptivity and existence of one or more actors with capacity and motivation to engage in translating and theorizing the new organizational form. The garbage can model reconceptualizes translation as a non-rational and coincidental process. With this conceptualization, we can gain better understanding of how translation actually works, and obtain a broader and more realistic understanding of the translation process of organizational forms.

Translating and theorizing are actions, in which translators engage in order to adapt the foreign organizational form to the receiving field and provide (practical and moral) reasons for the organizational form to be adopted. The garbage can model explains under what conditions translators and their strategic actions would lead to successful outcomes – the achieved legitimacy and adoption of the organizational form.

7.2. Limitations

This research is based on a single case study. Therefore, its findings may not be generalizable. The three phases of the translation process (activation, dormancy, and

reactivation) are specific to the case. However, the three phases are in line with previous observations. In his theoretical paper on virus-inspired theory, Røvik (2011) observed that adopted ideas sometimes remain in organizations for a long period, alternating between active and inactive states. His observation was based on other longitudinal studies of management ideas, which also noticed the same pattern. After introducing into organizations or fields, some ideas or organizational forms undergo a temporal suspension before they are adopted or enacted into practice. To generalize the three phases, more work needs to be done by examining the characteristics of the circulating ideas or organizational forms and types of receiving fields to develop typologies and conditions in which this pattern of translation could occur. Likewise, the actions and strategies of translating and theorizing, underlying the translation process, should have significant generalizability. However, this still needs to be verified in future studies.

Although the thesis provides the detailed process of translation, the research is largely based on archival data and actors' reflections on their past actions. To compensate this deficiency, I collected multiple sources of secondary data such as various reports from government and professional associations, survey and questionnaires, interviews given in media, books, and news and magazine accounts, to ensure triangulation and internal validity of my study. I believe that I have collected the complete set of data pertinent to the translation of the AHSC organizational form in England.

The interview data itself also has limitation in conducting studies of translation. Interviews are limited to interviewees' experience and interpretations. The information that interviewees reveal is limited to what they think as relevant and are willing to share with researchers. To compensate these limitations, I conducted interviews with a wide range of informants, including senior management and staff of each of the five AHSCs, senior staff of Department of Health, former researchers of the Nuffield Trust, and health experts in England. As I conducted the case study by tracing back over a decade, retrospective interviews also posed a high risk to internal validity of the data. To minimize the risk, I collected secondary accounts as many as I could find in available databases. I went to the database of the British Library and the National Archives to obtain archives and reports of the government and professional association. I also went to Factiva and healthcare journal database to retrieve articles, news, and journal papers to gain understanding of the case study as much as possible.

I focus on actions that lead to successful translation. It would have been interesting if I have collected more interview data that represent actors who were opposed to the AHSC organizational form. In this way I could compare accounts of pros and cons regarding the adoption of the AHSC organizational form. However, as I moved along the research, I decided to focus on the actors and their actions that contribute to successful translation. This was mainly due to time and budgetary constraints. It is thus interesting for future projects to collect this data and to form more understanding of the translation process, which could also be linked to theoretical constructs of identity.

7.3. Future research

It would be interesting and relevant to continue this research to explore the later development of the five AHSCs. My study is limited to the establishment of the five AHSCs in 2009. Therefore, whether or not the AHSC organizational form will be institutionalized in the British healthcare is yet to be seen. However, at present there is an important milestone of the development of the AHSCs in the UK. The government recently announced open competition to designate more AHSCs in England. This second designation process is currently in progress, starting from submission of application in April 2013 and expectedly finalizing the successful applicants in April 2014. It would also be interesting to examine how AHSCs are institutionalized by focusing on the linkage between the five AHSCs and patterns of interactions among stakeholders , i.e. NHS authorities and healthcare organizations, the related governmental departments and agencies, patients, students, and the industry. For this future project, I could use both qualitative and quantitative methods such as surveys and questionnaires to find out the level of entrenchment of the organizational form within the five AHSCs and their stakeholders. Whether it will become a fashion, then fade away, or a rational myth in the British healthcare field is yet to be seen. Either case is interesting to explore the process of translation.

Another interesting future research would be to explore whether and how the British version of the AHSC organizational form affects the global diffusion and identity of the AHSC. I am interested to see how the British AHSCs interact with AHSCs in other countries. At present, there are international forums and symposia, organized specifically for AHSC organizations around the world to exchange information and views on challenges of global healthcare and roles

of AHSCs in improving healthcare for patients and populations. It would be interesting to examine whether and how the global field of AHSC will be structured, and how this influences and shapes identities and forms of AHSCs in England.

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Appendix A: The Ten Key Principles

Strategic principles

I. The aim of undergraduate medical and dental education is to produce doctors and dentists who are able to meet the nation's present and future health and healthcare needs. To this end, doctors and dentists should be educated in an atmosphere which combines high professional standards (set by the GMC/GDC) with a spirit of intellectual enquiry and innovation based on active research and development programmes;

II. The objective of medical and dental research is to maintain and improve the nation's health and healthcare by contributing to the promotion of health and the understanding of disease;

III. The universities and the NHS have a shared responsibility for ensuring high standards are achieved and maintained in undergraduate medical and dental education and research;

Operational principles

IV. The provision of undergraduate medical and dental education and research, guided by clearly defined and co-ordinated national policies, must be supported by effective joint planning at regional and local levels;

V. Universities, health authorities, Trusts and, where appropriate, GP fundholders, should share relevant information and consult one another about their plans. Once agreed, policies and plans should be disseminated locally and reviewed regularly;

VI. The NHS and universities should consult one another about the special interests and contribution to service, teaching and research of senior medical and dental appointments;

VII. Where agreement cannot be reached locally, the NHS Executive Regional Director and the Vice Chancellor of the University should confer;

Funding principles

VIII. The NHS and universities should ensure that undergraduate medical and dental education and research are undertaken efficiently and cost-effectively;

IX. The universities and NHS should work closely together in funding research & development within the NHS in England;

X. SIFT should be allocated on the basis of mutually agreed service plans to support teaching. Universities should be joint signatories to all SIFT contracts.

Appendix B: Members of SGUMDER and an independent task force

Steering Group on Undergraduate Medical Education and Research or **SGUMDER** (1987 – 1997) was commissioned by Ministers in November 1987 "to consider how the current arrangements for undergraduate medical education can be improved to ensure that the policies and programs of the bodies concerned are properly co-ordinated and directed, reporting as necessary" (the interim report of Steering Group, 1989). Below are the members of the SGUMDER (number of representatives in the bracket):

- Chaired by the Secretary of State, DH
- UGC (2)
- CVCP (4)
- NHS (2)
- GMC, GDC (observers, 2)
- DES (2)
- DH (5)
- Secretariat (DES 1, DH 2)
- Scottish Home and Health Department (2)

An Independent Task Force on Clinical Academic Careers, chaired by Sir Rex Richards (hence 'the Richards report'), was commissioned by the CVCP in 1997 to investigate the situation of the recruitment and retention of clinical academic staff in UK universities. Below are the members of the task force (number of representatives in the bracket):

- Universities (9)
- NHS teaching hospitals (3)
- Wellcome Trust (1)

Appendix C: The information of the five AHSCs in England

AHSC's Name	Partner University	Partner NHS Organizations	Location	Model
Imperial AHSC	Imperial College London	• Imperial College Healthcare NHS Trust (merger between Hammersmith Hospital and St Mary's Hospital)	London	Integration
UCL Partners	University College London	• Great Ormond Street Hospital for Children NHS Trust • Moorfields Eye Hospital NHS Foundation Trust • The Royal Free Hampstead NHS Trust • University College London Hospitals NHS Foundation Trust	London	Partnership
King's Health Partners	King's College London	• Guy's and St Thomas' NHS Foundation Trust • King's College Hospital NHS Foundation Trust • South London and Maudsley NHS Foundation Trust	London	Partnership
Cambridge University Health Partners	Cambridge University	• Cambridge University Hospitals NHS Foundation Trust • Cambridgeshire and Peterborough NHS Foundation Trust • Papworth Hospital NHS Foundation Trust	Cambridge	Partnership
Manchester AHSC (MAHSC)	Manchester University	• Central Manchester University Hospitals NHS Foundation Trust • The Christie NHS Foundation Trust • Manchester Mental Health and Social Care NHS Trust • Salford Royal NHS Foundation Trust • Salford Primary Care NHS Trust • University Hospital of South Manchester NHS Foundation Trust (South)	Manchester	Partnership