

# Institutionalism and the Professions

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The study of the professions, as they are defined in the developed world, has been deeply intertwined with institutional theory and topics central to institutional theory (legitimation, symbolism, isomorphism, decoupling, power, agency, and organizational fields). The professions represent the quintessential triumph of Durkheimian occupational communities over and above the mass-society-based anonymity of impersonal markets and the grinding rigidity of bureaucracies. But, as we'll see, the classic autonomous, peer-oriented professional practice is under pressure from institutional constituents interested in lower costs, more accountability, and ethical transparency at the same historical moment that technological changes put pressure on traditional, institutionalized methods for delivering professional services. The combination of new places, new people, new technologies, and new clients has pushed professionals in new and uncharted directions.

In this chapter, we examine recent developments in the study of professional work through the lens of institutional theory. The delivery of professional services is

undergoing changes in the markets, organizational forms, and technologies that provide fertile ground for the use and extension of institutional theory. The institutional norms of several key professional sectors are changing drastically as well as the assumptions about market structures and the nature of technological changes currently at the forefront.

For the purposes of this chapter, we define professional work as occupational incumbents: (a) whose work is defined by the application of theoretical and scientific knowledge to tasks tied to core societal values (health, justice, financial status, etc.), (b) where the terms and conditions of work traditionally command considerable autonomy and freedom from oversight, except by peer representatives of the professional occupation, and (c) where claims to exclusive or nearly exclusive control over a task domain are linked to the application of the knowledge imparted to professionals as part of their training (Leicht and Fennell 2001: 25–30). This definition encompasses the traditional classic professions (physicians, lawyers, and university professors) but

also includes other abstract workers and symbolic analysts such as accountants, pharmacists, engineers, and scientists.

In the next two sections we look briefly at the more traditional literature on the professions, and then move on toward contemporary institutional theory and the ways in which it has addressed the professions and the organizational structures where professional work is done. Finally, we develop an updated version of an institutional analysis of the professions, focusing on change within professions themselves, change in the relative importance of institutional and technical environments, and demands for greater transparency and accountability following well-known ethical scandals that resulted in significant harm to clients and employees. Our analyses throughout will draw heavily (though not exclusively) from research on the health and medical professions, where the impact of institutional change has been substantial.

### **PRIOR LITERATURE ON THE PROFESSIONS AND PROFESSIONAL PRACTICE**

Sociological theory on the professions moved away from trait theories (theories that defined professions based on a series of fixed characteristics such as credentials, codes of ethics, and knowledge mastery) in the late 1960s and 1970s. The prevailing movement was toward models of professional organizations and knowledge claims (Leicht and Fennell 2001). These new models of professions and professional practice moved beyond the conception of professional organization as a rational, goal-oriented system designed around core tasks carried out and controlled by professionals themselves toward organizational and institutional claims regarding professionals and their activities. Other classic studies of 'professionalism' as a historical process have emphasized the political and social power of professional groups in medicine (Larson

1977; Starr 1982), and management accounting (Johnson and Kaplan 1987). More recent historical work on the professions has examined the export of western professional ideals on economic and legal systems to Latin America (Garth and Dezalay 2002), emphasizing the impact of local political struggles on the success or failure of such export attempts.

Early sociological efforts to consider both professional work and the structures within which that work takes place are best exemplified by models developed by Scott (1992) and his colleagues. Scott discussed three models for embedding professionals in organizations. *Autonomous* organizational forms represent the ideal-typical practice setting where professionals retain authority to control and evaluate themselves as a group. *Heteronomous* organizational forms subject professionals to more line-authority control, as exemplified by healthcare managers in today's managed care organizations. *Conjoint* organizational forms produce separate domains of power controlled by professionals and administrators who recognize the shared benefits of their division-of-labor and collaboration.

The different dimensions of professional work that are subject to change have been discussed by Friedson (1986) and Hafferty and Light (1995). Changes in the actual *content*, or technical core, of professional work refer to specific decisions made and procedures used during task performances. In medicine the proliferation of practice protocols and research on medical effectiveness represent examples of attempts to limit control over the content of professional work. Changes in the *terms* of work refer to characteristics of the professional work contract (pay, hours worked, and reimbursement arrangements). The replacement of fee-for-service delivery with salaried work conducted according to fixed schedules would be an example of changes in the terms of work. Finally, changes in the *conditions* of work refer to changes in the organizational structures, staffing arrangements, and

resources made available for professional practice. The rising expectation that academic scientists will produce patentable discoveries and large research grants to pay for their laboratory infrastructure would be an example of this change. Changes can occur in any of these domains independently, but changes in the terms and conditions of work often have implications for the content of work that is performed.

Others have focused on systems of professions and knowledge claims among professional groups (cf. Abbott 1988, 1991). These researchers move away from studying single professions in isolation toward studies of professional groups who claim to control the same (or very similar) task domains. More important for our purposes, these researchers also focus on the entire system of professional claims within specific societies and cultures. Systems of knowledge claims are studied when boundary and domain disputes develop among competing professional groups. These competitions determine each group's relative prerogatives and prestige. Relatively prestigious occupations (e.g. medical practice prior to the 1980s) rarely have their task domains challenged by competing groups. But this perspective points out that there are far more cases where professional task domains are contested (see our discussion below of the relationship between pharmaceutical companies, scientists, and new technologies or our discussion of conflicts of interest between managerial consulting and accounting practice). Through watching these competitions in new organizational and institutional arrangements, researchers can study how task domains are controlled and how challenges to the conventional organization of professional practice occur.

Light's (1993, 1995) theory of countervailing powers is another variant of the focus on systems of professions, a conception that is echoed by Friedson (2001). The dynamics of change in the status of professions is linked to a profession's location in a field of institutional and cultural actors. This theory

builds on the concepts of agency theory to discuss ways that competing professions make countervailing claims to dominance over specific task domains. Friedson's work (2001) follows in this tradition by claiming that professions represent a 'third logic' for the institutionalized organization of service delivery as a Durkheimian alternative to markets and bureaucracies.

### CONTEMPORARY INSTITUTIONAL THEORY AND THE PROFESSIONS

Institutional theory suggests that the regulation of organizational behavior occurs through and is a consequence of taken-for-granted beliefs, schemas, and values that originate in larger institutional contexts (cf. Powell and DiMaggio 1991; Scott 1987; Meyer and Rowan 1977; Greenwood and Hinings 1996; Friedland and Alford 1991). In most institutional accounts these beliefs, schemas, and values are not primarily responses to market pressures and efficiency dynamics. Instead, these arrangements represent active responses to dominant sets of norms, values and beliefs of key organizational actors (elite business managers, partners in professional practices, key regulators, and powerful clients). Specific ways of organizing become archetypes that represent coherent patterns of organizing in response to underlying values and beliefs (cf. Greenwood and Hinings 1993).

Mechanisms for enforcing institutional configurations are the key to the establishment and maintenance of a strong correspondence between institutionalized values and beliefs and methods of organizing. In institutional theory these forces usually are classified under the headings of normative, coercive and mimetic pressures. *Normative pressures* result from the socialization of institutional actors into a set of beliefs that define specific organizational arrangements as the 'best and customary' way of organizing specific activities. Professional schools

and professional associations are classic examples of groups that exert normative pressure through their socialization (and continued re-socialization) of occupational incumbents. *Coercive pressures* result from the actions of regulatory oversight agencies and major resource providers. These stakeholders have the ability to enforce their will on organizational actors by conferring or withdrawing legitimacy and resources. Certifications, inspections, and claims to speak for broader unorganized constituencies (in addition to the sheer ability to pay large fees, secure bank loans, and take legal action) make coercive pressures in well-institutionalized organizational domains credible. *Mimetic pressure* is a consequence of the establishment of taken-for-granted methods of organizing. Once specific organizational practices dominate a specific field, resorting to those practices as the best solution to a problem is simply a matter of borrowing from what others do.

More recently neo-institutional theorists have been interested in examining change processes (cf. DiMaggio and Powell 1991; Greenwood and Hinings 1993; Oliver 1991). There are two broad strands of institutional research and theory that attempt to understand change: (1) a tradition focusing on variations in embeddedness in specific institutional contexts that promote specific organizational archetypes (cf. Greenwood and Hinings 1993, 1996), and (2) a somewhat less prominent tradition that talks about strategic responses to institutional processes (cf. Oliver 1991). In the first conception, embeddedness in an institutional context makes gradual change less likely and radical (or revolutionary) change more likely. Embeddedness also reflects the structure of the institutional context – the extent that contexts are permeable and the extent that institutional monitoring practices are tightly or loosely coupled. Not all organizations operate in highly institutionalized environments (e.g., restaurants, big-box retailers), and some environments are vulnerable to new practitioners with different organizing logics

and archetypes (such as discount brokerage houses, mail-order pharmaceuticals, internet social-networking sites). Organizations and/or the professionals within newly developing organizational fields can themselves have significant influence on defining the institutional logics that will become imprinted upon that sector. Suchman's work on the legal community in Northern California's Silicon Valley provides an excellent example of how local law firms developed and 'set' legal patterns for linking venture capitalists with startup firms in the high tech sector (2003; Suchman et al. 2001). Greenwood and Suddaby's (2006) study of new forms of multidisciplinary practice firms in Canadian professional business services provides another cogent example of institutional change – entrepreneurship – initiated from the center of a mature organizational field.

In the second conception, strategic responses to institutional processes, there are a wide variety of responses to institutional pressure, and simply following the norms (acquiescence) is only one of those. In Oliver's conception, organizational leaders can engage in *compromise*, *avoidance*, *defiance*, and *manipulation* of the institutional environment. These responses may vary depending on how embedded the organization is in the institutional environment in the first place and the overall availability of alternative templates and logics for organizing.

In the next section we provide an extension of earlier institutional theory treatments of the professions, by focusing on change from several directions, including both internal and external changes. Specifically, we assert that the professions have undergone changes in their institutional environment that reflect the following:

- (a) changes from inside the professions as practitioners become more diversified demographically and in terms of their professional interests and specialization. Not only are the classic professions now populated by an unprecedented ethnic, racial and gender diversity of practitioners, but continued professional specialization and

- rising earnings inequality threaten to undermine what little professional solidarity remains.
- (b) changes in the relative salience of institutional and technical environments in altering the logics of professional service delivery (cf. Scott, Ruef, Mendel and Caronna, 2000; and D'Aunno, 2003). Historically there have always been tensions between concern for the overall institutional and professional service ethos of professional activity and the technical environment (markets, technology, and innovation) where professional practice takes place. We argue that many professions in the past 25 years have seen shifts toward the rising salience of the technical environment (markets and technologies) in relation to traditional institutional concerns of professional practice delivery. We argue that one of the environmental precursors of this shift was the Keynesian crisis in macroeconomics in the mid-1970s and the resulting questions this raised about a future post-industrial society dominated by technical, professionalized experts. The other contemporary change is in the technological interface used by professionals as they attempt to keep abreast of new developments in information and nanotechnology. These developments, and the organizational responses to them, are especially apparent in the healthcare professions where new technologies raise questions about old organizational forms used to deliver healthcare services.
- (c) demands for greater transparency and accountability in light of well-publicized scandals affecting service delivery. These scandals are a product of the new institutional environment for professional service delivery that highlight the fault-lines between traditional conceptions of professional practice and new avenues for exploiting information gaps and the speed of transactions between geographically dispersed clients.

## CHANGES WITHIN PROFESSIONAL GROUPS – DEMOGRAPHIC AND INTEREST DIVERSITY

### *Growing demographic diversity among professionals*

One of the more obvious trends of the past 30 years is in the growing representation of women and minorities (non-whites) among

professionals (see Leicht and Lyman 2006).<sup>1</sup> The US trends on both fronts have been gradual, but the overall change has been dramatic. Women have gone from representing fewer than two in every ten professional jobholders to almost 50 percent, and much of this increase has happened since 1980. The representation of non-whites in the professions has increased as well, but from a lower baseline and with a much more gradual rise. The representation of non-whites among professionals currently hovers around 12 percent.

By any standard, the slow but steady demographic diversification of the professions is a reality that is here to stay. These trends in demographic diversification are most apparent among the professions closely associated with business services; accounting and law. Women constitute a near majority of accounting practitioners (both CPAs and non-CPAs), and women's representation among US lawyers has dramatically increased as well. Women now constitute a majority of students in US law schools and a substantial percentage of students in US accounting and business schools (although Hammond (2002) shows that accounting has not become more racially diverse). Perhaps not coincidentally, accounting and law are precisely the professional groups where the reorganization of working arrangements and the creation of the one-stop business service firm (similar to the multidisciplinary practice firm examined by Greenwood and Suddaby) is most evident. This is a significant (but certainly not the only) component of the increasingly fragmented institutional environment professionals face.

### *Growing earnings inequality among professionals*

There has always been (for the last 30 years at least) considerable diversity in the earnings of professionals and the earnings gaps among professionals have been wider than earnings gaps in the rest of the working population. Assessing the growth in earnings

inequality among professionals is an important (but far from the only) component of assessing claims that the interests of professionals are diversifying.

More interesting from the standpoint of potential professional interests is that, since 1970, inequality has been rising more drastically among professionals than among the general population (Leicht and Lyman 2006). If professional practice (in part) represents the creation of common occupational communities with strongly identified common interests, it is a bit difficult to see how drastically rising earnings inequality could do anything but strain those normative institutional ties.

At minimum, these trends indicate a considerable shift in the material and social basis for the production of common occupational communities in the professions. This common community is a key component of promoting and maintaining dominant organizing archetypes that stress autonomy, equality, and a common set of ethics in the delivery of professional services. Whatever else professional occupations represent, they are no longer elite occupations full of people from homogeneous social and economic backgrounds.

Demographic and material diversity is compounded further by the growth of specialty groups within most professional occupations. The role of the general, omnibus practitioner whose professional status and prestige rested on their ability to apply professional knowledge to a wide variety of conditions is yielding to increasingly specialized practice settings, where clients come to have specific and narrow sets of needs addressed. The combination of demographic diversification, rising income inequality, and extreme specialization have led some researchers (e.g. Barbara Reskin) to detect a growing gendered and racialized division of professional labor as glamorous, high-visibility specialties become the prerogative of whites and men and less glamorous generalist/public service specialties become the domain of women and traditionally

underrepresented groups (see also Epstein 1993, 2004).

## **CHANGES IN THE RELATIVE SALIENCE OF INSTITUTIONAL AND TECHNICAL ENVIRONMENTS IN PROFESSIONAL SERVICE DELIVERY**

### ***Cost and quality pressures from clients***

The costs of many professional services (for example, medical care and college tuition) have risen at several times the inflation rate since the early 1980s. This increase in fees, and the growing affluence of some of the more visible segments of most professional groups (e.g. partners in large urban law firms, financial analysts for corporate banks, and college presidents), has occurred at the same time as median income and earnings (in real dollar terms) have stagnated, leaving the average middle-class consumer of professional services at the mercy of the market. Health insurers, in particular, have been unable to control the sharp increase in medical costs as new and expensive technologies come on-line that promise more effective treatment for an ever wider variety of diseases. Scientific instruments necessary to establish a university research laboratory in any of the physical or biological sciences now routinely cost \$500,000 to \$1 million or more and much of this equipment needs to be replaced every few years, some of it for safety reasons.

The rise in college tuition has been accompanied by the rising expenses associated with professional and graduate education. In the US, young professionals now leave university-based training hundreds of thousands of dollars in debt, and the need to pay off these debts often distorts and/or limits the specializations and areas of professional practice they choose to pursue.

Complicating this entire process further is the institutionalized price signaling that

occurs in the most professional practice settings. In this environment, price is often a proxy for quality and clients and others are at a severe disadvantage when it comes to evaluating the quality of professional services they receive. Since the lowest price isn't always the best or expected quality, and the client has no way of evaluating the opportunity costs of selecting different service providers, those that set prices have relatively free rein to charge what they will for professional services.

On top of this, there has been considerable growth in inequalities among clients and traditional purchasers of professional services. Colleges and universities increasingly rely on affluent parents with deep pockets to subsidize financial aid programs for students who can't pay full tuition. Private foundations and corporations increasingly partner with science laboratories at universities to lavishly fund research and support researchers. Healthcare delivery increasingly is geared toward clients with health insurance plans who can afford to pay exorbitant fees for new medical technologies, fees that take into account the inability of most patients to afford treatment. These plans (in the US) are paid for by employers who see their health insurance premiums rise at double-digit percentage rates every year. Law firms increasingly find their most affluent, corporate clients shopping around for the cheapest (and most expedient) legal advice, cutting off steady, long-term income streams and placing a premium on 'rainmaking' (the solicitation of high-priced legal work by partners in law firms).

### ***The salience of markets as a key component of the technical environment***

The traditionally-defined professions have always walked a tightrope between the institutional logic of professional practice centered on professional-client relationships, autonomy, collegiality, and professional

ethics on the one hand, versus a technical environment stressing market efficiency, technological change, and organizational innovation on the other (see Malhotra, Morris and Hinings 2006). In the last 25 years, *the rise of neo-liberal political and economic ideologies* has threatened the expert claims of professional groups and the logic of professional organization as an alternative to and protector of client and public welfare. This historic change was triggered by the crisis of Keynesian economics in the mid-1970s and the implications this crisis presented for a post-industrial future dominated by technical and administrative expertise (cf. Bell 1976). This change is reflected in the Western European context by the rise of new public management ideas in professional civil service bureaucracies.

The contemporary situation of the professions can be contrasted with the early- to mid-1960s predictions regarding the spread of professional expertise and reliance on liberal-technocratic professionals in the new post-industrial developed world (see, for example, Bell 1976; Frank et al. 1995; Frank 1997). In this world of the future, professions and knowledge-based work roles develop in response to the demands of post-industrial capitalism. The process of filling these jobs and the larger societal adjustments that come with the demand for highly educated workers (educational expansion, credentialing, longer stretches of time in school, and mass higher education) create a professional elite that applies their specialized knowledge to an ever-broader range of problems.

The growing ideology of the efficacy of professional expertise dovetailed nicely with 1950s and 1960s conceptions of Keynesian economics and the Great Society programs of the Johnson administration. Through the use of demand management and other technical macroeconomic tools, Keynesian economics turned decisions about the appropriate levels of inflation, unemployment, and poverty into technical decisions of technocrats and professionals whose actions would guide the US Federal Government

toward full employment, low inflation, and prosperity for all (see Stein 1983).

This view of a post-industrial world where knowledge experts would manage the economy in the name of full employment, low inflation and general prosperity, was challenged by two developments: (1) the crisis in Keynesian economics that resulted from the stagflation and economic stagnation of the 1970s; and (2) the subsequent inability of skill-based models to explain rising income and earnings inequality among professionals and between professionals and non-professional groups. These developments led to a broad-based questioning of the relationship between technological expertise and general social welfare while also leading to serious questioning of the ability and desirability of attempting to manage the economy.

The sets of policy tools advocated by monetarist, new classical and (eventually) supply-side economics differed considerably from those who advocated expert-based Keynesian macroeconomics. These policies included:

- (1) Deregulation of heavily regulated industries;
- (2) Promotion of greater economic competition by lowering trade barriers;
- (3) Repeal of special subsidies and tax loopholes for specific industries;
- (4) Across-the-board tax cuts especially targeted toward taxes on corporations and higher marginal income tax rates.
- (5) Cuts in government domestic spending in an attempt to remove disincentives to work, invest, and save.

Regardless of their distributional consequences, the subsequent success of these policies at restoring economic growth led to the vindication and promotion of market-based solutions to other vexing problems, including the calls for accountability and lower costs in the provision of professional services.

The present challenge of neo-liberalism as an economic and political ideology has profound implications for the professions as coherent occupational entities that control

task domains and exercise discretion over the performance of complex tasks for the benefit of clients and the larger society. Many of these challenges are clarified if we take the colloquialisms of the new neo-liberal consensus and contrast those with traditional conceptions of professional practice and the concept of expert labor:

1. *Consumers know best.* Any attempt to interfere with, regulate, or affect consumer choice costs consumers money. This means that any interference with service provision (such as licensing procedures, legally defined monopolies over task domains, competency tests, and other devices for restricting professional service provision) extracts costs that are rarely if ever justified. Consumers of services eventually will reward competent, scrupulous providers and punish incompetent, unscrupulous ones. All that is necessary is to let the market do its work with the dollars of the consuming public voting for best practices.
2. *Markets will determine what is right.* The market becomes the locus of human perfection (see Giddens 1994). No expert can make, guide or direct choices in the ways that markets will. No authority can make the wise choices that markets can make. Let markets do their job and stay out of it.
3. *No credentialing or licensing.* These are simply attempts to collect monopoly rents. Consumers will naturally be led to choices that are best for them, and credentialing and licensing are just an attempt to extract windfall profits at the expense of consumers.
4. *No codes of ethics.* Markets will naturally reward those who behave in the best interests of those who purchase professional services. Information about ethical and unethical practices can be sorted out in the wash and those practitioners who do what clients want them to do and who act in their best interests will win out in the end.
5. *Competition will lower fees and salaries.* Service delivery from a variety of professional groups, in a variety of settings, with a wide range of organizational arrangements, will keep fees and salaries low and service delivery of the best quality.

In European contexts, the 1970s and 1980s and the accompanying economic recessions and deindustrialization led to a widespread



questioning of the salience of European models of capitalism (cf. Esping-Anderson 1989; Rifkin 2004; Ironside and Seifert 2003; Fourcade 2006). Because professional practice (and especially the delivery of health care and education) have much more extensive ties to the public sector in most European countries, the main response to this general crisis in confidence (for professional groups) was the rise of New Public Management (NPM). While New Public Management is a label applied to a diverse set of reforms, ideas, and ideologies (cf. Manning 2000; Savoie 1995), the general thrust of NPM initiatives is to subject the provision of public service by professionals to market forces through disaggregation, competition, and incentivization (see Dunleavy, Margetts Bastow and Tinkler 2005).

The specific manifestations of marketization and New Public Management vary from place to place and affect a wide array of professional groups. Attempts to implement New Public Management concepts in the UK national health service, in particular, have been controversial (see Ironside and Seifert 2003). As with the case of attempts to bring market incentives to professional practice in the United States, there are very few examples of the successful implementation of New Public Management concepts in European professional health services (see especially Bottery 1996; Scott et al. 1997; Dunleavy et al. 2005; Christiansen and Laegreid 1999; Lynn 1998; Reschenthaler and Thompson 1996; Kaboolian 1998). The criticisms of New Public Management in these contexts revolve around the disarticulation between public service and revenue maximization, and the inability to 'get prices right' in the provision of services and intermediate goods that are government-supported natural monopolies. These changes in the economic side of the technical environment for professionals have been equaled or exceeded by changes in the technologies used to deliver professional services, as we discuss below.

### **PROFESSIONS AND THEIR INTERFACE WITH TECHNOLOGY – THE NEW TECHNOLOGICAL IMPERATIVE IN HEALTH/MEDICAL CARE**

During the 1980s and 1990s, when a number of interesting statements and refinements of institutional theory were appearing, DiMaggio and Powell's important paper (1983) launched a number of studies, often focused on classifying organizations by the characteristics of their technical and institutional environments. This work helped remind the field of the importance of both types of environmental pressures, as well as leading various scholars to consider historical changes in organizations as well as in their institutional and technical environments. Thus, early conceptualizations of technical and institutional environments by Scott and colleagues (1983, 1995, 2000) provided a matrix for classifying organizations by the characteristics of their environments, and by differentiating between powerful constraints presented by one or the other environmental type.

Scott's empirical focus was often health-care organizations, as this particular industry provides a history of both well-developed institutional and market pressures. It is also a field in which the prominence of the medical profession (as well as increasing attempts by other professional groups within healthcare to define their own arena of control) has provided a most fertile field for examinations of larger societal and institutional changes in healthcare organizations and the professionals linked to healthcare delivery (Light 1991; Hafferty & Light 1995; Leicht and Fennell 2001).

Scott's conceptualization was followed by the work of Alexander and D'Aunno (1990), who tracked the transformation of the institutional environment of health care organizations from post WWII to the late 1980s. They suggested the norms of the medical/health industry were changing in important ways, so that the pressures of the

technical environments of healthcare organizations in the 1990s (both the growing costliness of the technological imperative in health care, as well as increasing pressures to control costs through the mechanisms of managed care) were gaining in strength. Concomitantly, the traditional institutional norms surrounding the autonomy of medical professionals and physician control over decision-making were losing steam in the face of managed care. More recently, Scott and colleagues (2000) have examined in detail the healthcare organizations, material-resource environments, and institutional environments in one large metropolitan region of the US – the San Francisco Bay Area, from 1945 to 1995. This study also took pains to examine environmental pressures as they transformed over this period, and did so by considering three environmental levels of analysis: local, regional and national environments.

Most of the research on healthcare organizations has focused primarily on the providers of healthcare services (hospitals, physicians, nursing homes, etc.), or the payers for healthcare services (employers, insurance companies, the federal government). Sometimes, regulatory programs and their designers have been examined (Williamson 1985; Singh, Tucker and House 1986; Streeck and Schmitter 1985). Until recently, however, there have been few analyses of that portion of the industry that has become increasingly more important to the material/resource/technical environment: the producers of new healthcare technology. Burns has investigated supply chain relationships in the healthcare industry (2005), focusing on trading relationships between healthcare providers and their upstream suppliers. Most recently Burns has provided a detailed overview of the pharmaceutical, biotechnology, genomics-proteomics, medical device, and information technology sectors within the healthcare value chain (2005), as well as the business models and corporate strategies of firms within these sectors. In doing so, Burns has tapped into

an extremely rich vein of organizational relationships, new organizational forms, and technological pressures affecting healthcare professionals, university research laboratories, for-profit R&D laboratories, and marketing organizations. The intertwined markets and institutional forces linking these diverse actors are ripe for an institutional theory analysis.

Burns' overview of current technological innovations in medical/healthcare treatment provides at least three examples of how the 'new technological imperative' is driving healthcare professionals and organizations toward vastly different configurations in both the healthcare value chain and eventually in the patient treatment arena: (1) the proliferation of merger and acquisition (M&A) and strategic alliance (SA) development across multiple parts of the value chain, particularly in the pharmaceuticals sector, and between biotechnology and pharmaceutical companies; (2) changes in the methods used to communicate with and persuade key stakeholders and customers (particularly physicians); and (3) the globalization of manufacturing, marketing and distribution of drugs.

### ***Strategic alliances and mergers***

The pharmaceuticals sector is a particularly appropriate example of a growing sector within health care where the characteristics of new technologies and products have led to an increase in interorganizational connections. All five technology producers in health care (pharmaceuticals, biotechnology, genomics-proteomics, medical device, and information technology) share several very important characteristics: they are all increasingly interdependent, research-intensive, and technologically complex. They differ, however, on a number of dimensions related to time (development cycles, age of firms, age of the sector, expected product impact as short- or long-term), and space (local vs. global dominance).

Pharmaceuticals as a sector are particularly held captive to very high-risk product development models (two out of every hundred new drug projects make it to market), and very long time lines for the 'bench to bed' program (an average of twelve years; Northrup 2005). Investment costs are high for the intellectual capital part of this process (discovery through scientific review) and marketing, but quite low for ingredient costs and processing charges. In fact, the returns for successful products are then priced to cover the costs of the many failed projects.

Northrup (2005) describes the interplay between traditional pharmaceutical firms (the older actors in new drug/biologics/bi-products innovation) and more recently developed biotechnology firms (most created since the completion of the Human Genome Project). Pharmaceutical firms have historically focused on chemistry-based, small molecule products (often referred to as new chemical entities, NCEs), whereas biotech firms typically focus at first on proteins, peptides, or monoclonal antibodies, all of which are bigger than most NCEs, and require some route of administration into the body other than taking a pill. Biotech firms tend to evolve from university-based discoveries that become licensed to a new (and often small) biotech company, headed by the academic PI (see Stuart and Ding 2006). Financing comes from venture capitalists during the long drug development stage, perhaps finally involving an initial public offering (IPO) when the biotech firm goes public. Many successful new product cycles later, the small biotech firm may reach the stage of a fully integrated pharmaceutical company (FIPCO). More likely, however, is the scenario in which the biotech firm links with other specialty firms to handle preclinical development/testing, such as a contract research organization (CRO), a contract manufacturing organization (CMO) and a contract sales company to handle marketing (CSO). Another route is for all three later stages to be cycled through a big pharmaceutical firm, after the development

of either an SA or a merger. From the viewpoint of big pharma, connection to innovative discoveries in biotech can be handled either internally (make your own, or more cost-effectively, buy your own biotech company), or externally, through alliances with smaller biotech companies. In either case, it is generally recognized in the pharmaceutical sector that most firms cannot handle all aspects of the product cycle, in both small and large molecule development. Further, alliances are also increasingly common between pharma firms and genomics-proteomics companies in order to manage licensing agreements and intellectual property issues. Such alliances are commonly based on either a specific therapeutic area, or for data mining activities (large-scale screening of libraries on a specific gene sequence), or technology transfer (Sammut, 2005).

### ***Changes in communication with market targets***

The traditional method of communicating with targeted markets for new pharmaceuticals has always been the one-on-one selling of the new product to physicians, either in MD offices, over lunch, or at the conference cocktail party/dinner. In their quest for more effective and most cost-efficient methods of marketing, pharmaceutical firms have been innovating with the use of information technology. Although 'detail reps' are still a commonly-used mechanism, firms such as Lilly have been experimenting with the use of a 'sales productivity process' (Northrup 2005), which employs more frequent electronic/phone/video communication with physicians who have been pre-identified as the right target for the new drug (right specialty, use of data on past prescribing behavior, preferred communication channels, etc.). E-detailing combines multiple channels of communication with repeated contacts to get information out on the new product, without taking time from the physician's busy office schedule for the traditional one-on-one.

The use of patient-oriented sales of prescription drugs through media advertisement has increased in volume and advertising sophistication. Advertisements stress the personal benefits to the individual patient with cancer, acid reflux, insomnia, etc. with a dreamy backdrop, colorful costumes, or shots of happy middle-aged active people, followed by rapid 'fine print' instructions to contact your physician and a list of patient conditions which would counter-indicate the appropriateness of the new drug. These advertising strategies are no doubt riding on the perception of increasing numbers of well-educated, independent consumers who will march into their doctor's offices with demands to 'let me try this new drug.'

Both of these changes in marketing strategy, away from personal contact with physicians, and toward the use of either new IT-based marketing, data-based marketing strategies, and consumer targeting, are examples of how the role of the physician in the new drug market has changed. The institutional environment of new healthcare products has shifted toward more complicated multi-organizational relationships, just as the traditional autonomy and dominance of the physician in the healthcare sector has been replaced by a matrix of corporate actors. The 'new technological imperative' is one in which biotech firms, big pharmaceutical firms, a range of contract service firms, and advertising strategies have further diminished the physician's independent decision-making. The comparison to the old imperative of demands from physicians and patients fueling the need for access to new technologies is striking.

### ***The globalization of drug manufacturing and marketing***

Although the biotechnology sector is far more mature in the US than elsewhere, this sector is definitely growing in both Europe and Asia. Major increases in state-supported

efforts to build this industry have been seen in Germany, Canada, China, Korea, Taiwan and Singapore. In addition, large US pharmaceutical firms have expanded both their marketing reach and their manufacturing networks into South America, Asia, and Central/Eastern Europe (Pfeffer 2005). Outsourcing globally, once regulatory issues are managed, allow big firms to enjoy reduced manufacturing costs and reduced marketing costs; but the costs involved in startup of infrastructure, regulatory and cultural differences are usually beyond the means of smaller firms. We have also seen recent efforts to outsource biomedical R&D globally by US firms, in order to avoid some US regulatory constraints. Singapore actively supports stem cell research, unlike the US, where limits are placed on usage of only approved, pre-existing stem-cell families, and embryo research is limited due to bioethical concerns (Pfeffer 2005).

There is another surprising and somewhat troublesome side-effect of globalization and the rising costs of employer-based health insurance plans in the US. Some have noted recently an increase in interest in the concept of 'medical tourism' among smaller, self-insured employers (Jonsson 2006). Medical tourism (also known as 'global health care') is the practice of sending employees overseas to receive surgery and post-surgical follow-up as part of their health insurance coverage. Employees are encouraged to travel to India, Jarkarta or Bangkok for serious surgical interventions, such as hip replacements and heart stents. The costs for overseas surgeries like these can be up to 80 percent less than the same procedure in the US, and the overseas surgery includes resort-style convalescence. This is another example of how the technical environment (markets) of health care has globalized, while the traditional, formerly institutionalized, concepts of US health care as unmatched, and US doctors as a key partner in the patient-provider relationship, have receded dramatically.

## RECENTLY-PUBLICIZED SCANDALS AND FURTHER INSTITUTIONAL CRISES OF ACCOUNTABILITY

Some of the antecedents and consequences of the changing institutional environment for professional groups are well-publicized scandals in the delivery of professional services. Many of these most recent scandals involve business services like accounting, law, and finance (Enron; MCIWORLD.COM; Royal Ahold) but there are also scandals involving medicine and healthcare (the Harold Shipman scandal in the UK; the organ transplantation crisis in the University of California hospital system). Each of these scandals points to the promises and perils of deregulation, market incentives, and technological change in professional practice.

### ***Harold Shipman, Kaiser Permanente, the University of California-Irvine and crises of medical confidence***

Between 1976 and 1998, Harold Shipman (a general practitioner in the UK Health Service) murdered at least 236 people all over central England. Most of Shipman's victims were elderly women, and almost all of the victims were murdered through drug overdoses (mostly morphine). Shipman was convicted of 15 of the murders on January 31, 2000 and sentenced to 15 life terms. He committed suicide in prison in January, 2004.

The public inquiry that followed the revelations of Shipman's behavior, the extent of his crimes, and the inability of the UK health service system to detect and respond to the problems in its midst have led to a widespread overhaul of the checks and balances in the UK healthcare system. Postmortems are now required in all patient deaths, and deceased patients cannot be cremated until a proper and independent postmortem has been conducted.

But the case raised other disturbing questions about the role of professional autonomy and the inability (or unwillingness) of other professionals to police Shipman's activities. The cumulative record of suspicious deaths was never scrutinized (even though UK medical record collection is centralized through the health service). Suspicious colleagues were placated by Shipman's assurances that he knew what he was doing and that no scrutiny of the deaths of his patients was necessary. His colleagues assumed Shipman was being honest and open with them when he was being anything but. The healthcare system did not require post-mortem investigation of patient deaths in a situation where simple blood tests would have revealed massive drug overdoses. And Shipman moved to no fewer than four locations when outside constituents became suspicious, but he had no trouble securing another job and continuing his bizarre and grizzly practices. This case reflects a gross failure of oversight in a traditional, state-supported professional setting that has changed the nature of medical practice in the UK and in continental Europe as well (cf. Weaver 2006).

The organ transplantation scandal that broke in California in May–August, 2006 (involving Kaiser Permanente and the UC-Irvine hospitals) is another example of the problems new organizational forms present when they are confronted with new technologies. In mid-2004, Kaiser sent a letter to all would-be kidney transplant patients and told them that they would no longer pay for kidney transplants at outside hospitals. Instead, patients would have to come to a new transplant facility in San Francisco where doctors affiliated with Kaiser would perform the transplant.

What happened after this is a matter of dispute. Kaiser went from having no transplant program to having the longest transplant waiting list in the nation. In the process, their patients drastically lowered their chances of receiving new kidneys, many patients died waiting for organs, and Kaiser failed to fill

out the necessary paperwork to obtain organs for their patients. According to the *Los Angeles Times*, in 2005 Kaiser performed only 54 kidney transplants and at least 108 patients died waiting for organs. The national statistics for other transplant programs are usually the opposite of this – twice as many transplants in proportion to the number of patients who die waiting for organs.

National transplant regulators paid no attention to these troubling trends even though the data were available on the internet. The case was broken when the *Los Angeles Times* began an investigative report on transplant programs in California and uncovered the discrepancies (*Los Angeles Times* 2006). Kaiser closed their transplant program in May 2006.

California assemblymen recently called for more oversight and regulation of transplant programs in light of the Kaiser Permanente scandal and a related scandal in the University of California-Irvine Hospital system. UCI closed its liver program in November 2005 after the *Los Angeles Times* reported that 32 people had died awaiting transplants in 2004 and 2005 while the UC-Irvine hospital had turned down scores of donated organs. Unbeknownst to patients, UCI had not had a full-time liver transplant surgeon for more than a year when it closed the program. St. Vincent Hospital in Los Angeles also halted its liver transplant program in September 2005 after acknowledging that its doctors had violated national transplant standards in 2003. Surgeons transplanted a donated liver into a patient who ranked 52nd on the regional waiting list, bypassing dozens of people whose conditions were considered more dire. Staff members subsequently falsified documents to cover up the action. Both of these actions have prompted California assemblymen to call for new transplant oversight in California and renewed ability for the state to fine hospitals up to \$100,000 for failure to meet basic national healthcare standards.

In both the Shipman case and the hospital transplant cases, there were systemic

violations of professional ethics that were not detected by the traditional system of institutional oversight. But the response to these problems has been a call not for more market-based accountability but for more regulation of professional activity in the name of traditional institutional norms involving patient interests and welfare. This, and the business, financing and accounting scandals we discuss below, seems to suggest that there are bumps on the road to the use of market mechanisms and technical environments to bring discipline to professional practice.

### ***Enron, MCI-WORLDCOM and Roya Ahold: bumps on the road to professional omnibus business services***

The accounting and financing scandals that rocked the American business community in 2005 and 2006 (and the European business community through Royal Ahold, a Dutch food market supplier) point to many of the institutional and technical problems with deregulated financing systems and deregulated financial markets. For our purposes, these cases also expose some of the more fundamental problems with the interface between management consulting, accounting, and law that will likely prevent the consolidation of these professional groups into new organizational forms.

In each of these cases (and the case of Tyco International), the problems were highly similar, as were the abuses. Top executives of each company were paid through stock options. These options were supposed to tie the compensation of top officials to the financial performance of the company, but instead they provided a built-in incentive to report ever-rising profits to Wall Street and the larger financial community so that stock prices would rise. None of this would be problematic if the professional groups (lawyers and accountants) exercised their professional prerogatives to

independently monitor the legal and financial behavior of the firms involved. But, in each case, there were significant conflicts of interest that prevented this from happening.

The Enron case is a typical example. Enron purchased consulting and accounting services from Arthur Anderson, at the time one of the 'Big Five' accounting firms. Enron also retained external legal counsel that assumed that Arthur Andersen was doing its job of monitoring the financial transactions of the company so that the certified profits of the company were legitimate. Both Arthur Anderson and Enron's legal firm received millions of dollars in fees, fees that rose with Enron's reported profits.

When these cases began to unravel, each revealed a tangled web of financial transactions that (a) systematically misrepresented the financial health of the firm, misrepresentations that were certified by accounting firms with substantial financial interests in the consulting income they were deriving from the firms they were auditing, (b) law firms that were more than content to look the other way as long as legal fees were regularly paid and audits were certified as legitimate, and (c) CEOs and top managers who made millions from falsified corporate profits and backdated stock options (see Froud et al. 2004 for an analysis of Enron as both an example of corporate failure through 'financialization,' and as a firm embedded within a political web of special interests and powerful actors).

All of these situations have led to fundamental questioning of Generally Accepted Practices in accounting and the ability of accountants and lawyers to remain independent from their clients. They have also struck a (for now) fatal blow to the concept of clusters of accounting, legal, and management consulting services (ombibus business services firms) given the likelihood of fundamental conflicts of interest in a deregulated financial environment.

## CONCLUSIONS AND IMPLICATIONS

The study of professions and professional work is intimately tied to institutionalism and institutional theory, as our chapter illustrates. The questions we raised have direct implications for future research programs on institutional theory and professional work.

One of the more interesting implications of the new institutional environment for professional practice is the virtual disappearance of individual clients from our discussion here. Traditional professional practice norms focused on forging links between professionals and clients. But the newly developing networked linkages we discuss seem to leave individual clients behind in the name of pursuing profit and efficiency. Researchers will want to study new organizational alliances, forms and marketing strategies for the provision of healthcare, both in the United States and elsewhere, documenting the evolution and growth of new institutionalized norms and practices. The interface between pharmaceutical companies, physicians, hospitals, biotechnology firms, advertisers, and governments, is spreading in a distinctively North American environment where deregulation of health care (even in light of the transplantation scandals in California) seems to be on an upswing. Researchers interested in the interface between professional work and institutional theory should also examine more closely the increased ability of insurers, big clients, and others to purchase professional services in a global outsourced labor market where price competition will become increasingly salient. The growing embeddedness of these networked connections between large institutional and corporate actors, to the exclusion of the best interests of individual clients and consumers of professional services, suggests that not all forms of embeddedness are desirable.

Another area of research will be the development of new collaborative alliances between management consultants and economists as would-be professional groups,

and the interface between consultants, accounting, and legal practice as business services (see Gross and Keiser 2006). Management consultants and economists are competing over the task domain to reorganize professional practice in the name of efficiency and cost effectiveness. Since management and economic consulting is the least regulated of these occupational groups, students of the professions will need to examine the evolving institutional and technical environment that consultants, accountants, and lawyers face in the wake of the well-publicized scandals discussed here (see also Fourcade 2006).

These research problems, among others, suggest that the interface between the professions and institutional theory will continue to attract substantial interest. The ability of institutional theory to provide insight into both the dark ethical scandals of the early 21st century and the growing embeddedness of well-networked corporate actors at the expense of clients attests to the flexibility and strength of research on the professions framed by institutional theory.

## NOTE

<sup>1</sup> Data are from the Current Population Survey, 1970–2004, US Bureau of the Census, and reflect changes among physicians, lawyers, accountants, natural scientists, social scientists, and professors of natural and social science.

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