

**INSTITUTIONAL CHANGE AS AN INTERACTIVE PROCESS :  
THE MODERNIZATION OF THE FRENCH CANCER CENTERS**

Revised version

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Like all human endeavors, sociological theories do not come into being on a *tabula rasa*, but are tributary to the intellectual setting and climate in which they originate. It therefore comes as no surprise if neo-institutional theory in organizational analysis shares some of the basic assumptions of structural contingency theory (Burns and Stalker 1961; Woodward 1965; Lawrence and Lorsch 1967; Perrow 1967; Hage and Aiken 1970) and its intellectual heir, population ecology (Hannan and Freeman 1977, 1984)<sup>1</sup>, which was the dominant paradigm in organization theory by the time it received its first formulation in the three seminal articles by Meyer and Rowan (1977), DiMaggio and Powell (1983) and Scott and Meyer (1983).

This is not to underestimate or to downplay the radical differences which separate neo-institutionalism from structural contingency theory. While the latter emphasizes the technical and economic environment and its demands, and considers the efficiency constraint as the main adaptive force for organizations, the latter underscores the importance of the symbolic and cultural environments of organizations, and introduces the constraint of legitimacy as the main adaptive force of organizations. Bringing sociology and society (Friedland and Alford 1991) back into the study of organizations, albeit on a different level, it strongly challenged the strictly utilitarian, not to say technicist orientation of contingency theory and opened up an entirely new perspective on organizational responses to societal change.

This difference, however, crucial as it may be, should not have us forget some important commonalities shared by both approaches or paradigms. Three of these, which in fact are acknowledged if not actually claimed by DiMaggio and Powell's introduction to their 1991 reader (DiMaggio and Powell 1991: 13), are of particular importance here. First, there is the inter-organizational focus: instead of looking at the internal processes of singular organizations, the primary focus is on populations of organizations treated as a field. The second is the emphasis on organizational form : the *explicandum* is the formal structure of organizations and its transformation, instead of action in organizations. And last, but not least, there is the understanding of organizational change as an adaptive process : the motor is in the environment, and organizations obey, and conform to, changing environmental conditions and forces<sup>2</sup>.

All three added up to giving neo-institutional theory an actor-less perspective on organizations and institutional processes<sup>3</sup>. Institutional and organizational change was seen as driven by impersonal dynamics of different kinds, the emergence and existence of which were observed and used as explaining variables, but not really explained for themselves. Human agency all but disappeared, and was replaced by impersonal forces characteristic of society, institutional sectors and organizational fields. And organizations were seen as legitimacy-seeking entities which had no way of influencing what was legitimate : they had no potential for structuring their institutional environment, but could only adapt to whatever happened to be or become its message.

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<sup>1</sup> We are aware that this is of course a considerable and contestable simplification, especially in the light of later developments of the population ecology of organizations (see among others Baum and Singh 1994, 1996). It can be said, however, that some of the themes of this paradigm consist of a radicalization of the original argument of contingency theory (Friedberg 1997[1993]: chapter 3).

<sup>2</sup> In quite a provocative way, Barnett and Carroll (1995) go even further, since they put contingency theory, resource dependence theory, neo-institutional theory and transaction cost economics into the same "adaptational camp" (p. 218).

<sup>3</sup> Which, incidentally, it also shares with contingency theory (Crozier and Friedberg 1980 [1977]: chapter 4).

This initial bias of neo-institutional theory has rapidly attracted considerable criticism and has been challenged in almost all its dimensions. As early as 1991, Oliver, in a widely quoted and influential article, has argued that “*institutional theory has tended to de-emphasize both the ability of organizations to dominate or defy external demands and the usefulness to organizations of pursuing these types of strategies*” (Oliver 1991: 150) and then discusses different strategies which organizations can follow in order to resist against institutional pressures or to conform to them. Ranging from acquisition and compromise to concealment, manipulation and open defiance, these strategies have in common to show at least two things. For one, they point to the segmentation, multiplicity and basic ambiguity of institutional environments, which open up possibilities of misperception or misinterpretation, and create opportunities and incentives for choice (for instance, downplaying some environmental pressures or playing one against the other), or even hypocrisy (through the de-coupling of internal processes from the official response to institutional pressures (Brunsson 1989)). Second, they underscore that organizations retain some leeway because “legal ambiguity” (Edelman 1992) allows them to “*preserve at least some managerial discretion*” (Ibid, p. 1557) when complying to environmental pressures : being able to choose among competing demands of their institutional environment, they can even try and bargain their way out of constraint (Slack and Hinings 1994; Suchman 1995; Beckert 1999; Scott 2001)<sup>4</sup>.

In the same vein, the predominance of the symbolic and institutional environment has been challenged. Some scholars have pointed to the fundamental complementarities of both market and institutional forces (Singh, Tucker and Meinhard 1991; Beckert 1999). Whereas authors like Kraatz and Zajac (1996), Hirsch (1997), Hirsch and Lounsbury (1997) and D’Aunno, Succi and Alexander (2000), have underscored the tension between the two, claiming (and brilliantly demonstrating) that organizations can (and do) choose to respond to changes in the technical environment even if this means going against the dominant myths, narratives and patterns of their institutional environment.

By the same token, the lack of human agency in neo-institutional theory, its failure to take into account interest-driven behavior and the “generative capacity of actors” (Hirsch and Lounsbury 1997; Friedberg 1998), its tendency to reify institutions and to view them “*as somehow distinct from those who comply and more importantly, from the act of compliance itself*” (Barley and Tolbert 1997: 95) have been critically underscored. Early on, DiMaggio (1988), DiMaggio and Powell (1991), Powell (1991), and Scott (1993) have acknowledged this weakness and have searched or called for remedies. Scott (1999) has called for more interaction and conceptual exchange between neo-institutionalism in organization theory and social movement theory, a call which has been heard by Rao, Morill and Zald (2000) who propose an analysis of how social movements and collective action create new organizational forms, i.e. contribute or produce institutional change. Kondra and Hinings (1998) and Fligstein (2001) have for their part proposed frameworks which put human agency at the center of analysis, interpreting institutional change as the product of crisis in an organizational field brought about by the “social skills” (Fligstein 2001) of a new group of actors (Fligstein’s

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<sup>4</sup> Clemens and Cook (1999) use similar arguments to improve (and to allow for) the analysis of durability and change in political institutions : an appreciation of the “*multiplicity and heterogeneity of the institutions*” (p. 443) is crucial to understand why institutional change is possible. One sometimes has the impression to read re-editions of arguments made around role-theory : in order to re-introduce some flexibility into role-theory and account for change in behavior which orthodox Parsonian role-theory was unable to explain, it was pointed out that role-occupants were able to gain some leeway from their respective role because of the heterogeneity, multiplicity and potential divergence of role-expectations. *Mutatis mutandis* the same argument is being made now in relation to pressures (expectations) of the institutional (and/or technical) environment.

“challengers” and Kondra and Hining’s “renegades”) acting as change-entrepreneurs. The role of these change-entrepreneurs is instrumental in at least two ways: they create the cognitive and social conditions of awareness of the crisis (of the problems to be overcome), and they propose the necessary resources for the solution of the crisis. In garbage can terms (Cohen, March and Olson 1972), they are bearers not only of the solution, but also of the problem (the crisis) which they have contributed to frame, if they have not created it altogether.

Our understanding of institutional change has been greatly advanced by all these contributions. The initial bias of institutional theory towards an actor-less evolutionary view of institutional change considered as the result of impersonal exogenous forces has been made more complex and realistic. A good deal of strategic choice has been given back to organizations which have become actors of their (only partial) compliance to institutional demands (Oliver 1991; Kraatz and Zajac 1996; Beckert 1999). And frameworks have been proposed which consider institutional change as the very product of human agency and skills, providing both an understanding of where institutional change comes from and how it is implemented.

In our contribution, we would like to take this argument further. The case which we are about to report about the successful modernization of the French Cancer Centers and their reinstatement as the leaders in their field indeed illustrates the importance of agency, i.e. of interest-driven, purposive action, for understanding institutional change, as well as the leeway which organizations have in dealing with new environmental pressures be they technical or institutional by nature. But it does more. It shows the interactive nature of institutional change. The word interactive refers here to at least two elements of the process which to our knowledge have received only scant attention in the literature so far. On the one hand, it points to the proactive nature of organizations, going out and succeeding in (re)structuring their institutional (as well as technical) environment. On the other hand, it would like to emphasize the fact that environmental pressures and the response to them cannot be understood separately in this case. Just as much as human choice relies on preferences which are themselves a product of the process of choice, the very ideas put forward by our change-entrepreneurs took shape in interaction with environmental pressures which they also contributed to mould. The process is an interactive one, environmental pressures and organizational responses being simultaneously resource and constraint for one another, both structured by, and structuring for, each other.

We shall proceed in three steps. In the following section, we shall give a short descriptive account of the process of reform which we studied. We shall then stress in our discussion the limits of the current literature to fully understand this process. In particular, we will underline that using the theoretical frame of institutional isomorphism, tempting as it may be at first glance, clearly does not do justice to the facts. In our concluding section, we shall argue that our case illustrates the need for a theory that takes seriously into account the interactive nature of institutional change, and we shall try to spell out some implications of such a theory.

## FRENCH CANCER CENTERS: A CASE OF ORGANIZATIONAL CHANGE

### 1. *A prestigious organizational field under increasing constraints*<sup>5</sup>

In the 1920s, some physicians with political and financial support from the State managed to create the French Cancer Centers<sup>6</sup>. These specialized medical establishments were set up following four major principles. First, these centers should manage research activities and treat patients at the same time. Second, each medical specialty was to participate in the decision process related to a patient's treatment strategy, a process labeled "multi-disciplinary" by the Centers in the second half of the 20<sup>th</sup> century. Third, only physicians could be appointed director of these centers. And last but not least, the Cancer Centers' founders aimed at, and succeeded in, convincing the authorities to limit to 20 the number of centers created. They considered this restriction as a way to draw the best radio-therapists into the Centers and thus foster radiotherapy as a new kind of treatment besides surgery.

From the 1920s to the 1970s, these Cancer Centers were the main organizations taking care of cancer patients in France. The National Federation of Cancer Centers, whose board was composed of the 20 directors, was created in 1964: it played the role of an employers' association in charge of lobbying authorities and of dealing with collective bargaining issues common to the centers. Over the whole period, the 20 Cancer Centers enjoyed something close to a monopoly over cancer-care in their respective regions: there was hardly any specialized equipment for cancer-treatment elsewhere, and only very few healthcare organizations claimed to participate in the treatment of patients. Thus, in 1965, the French government logically entrusted the Centers with organizing consultations for patients in other hospitals of their area. Until 1972 as well, the physicians appointed to the National Commission in charge of helping the government to define a national cancer policy, were exclusively drawn from the Cancer Centers.

But from then on, things changed drastically. Cancer Centers have been facing an increasing competition and their legitimacy has been challenged in multiple ways.

#### *Facing increasing competition*

The evolution of the French healthcare system as a whole explains part of the increase in competition. On the one hand, since the 1960s, physicians have become more and more specialized, their number growing from 30.000 in 1975 to 80.000 in 1985. On the other hand, the French government has increased its financial support to the development of hospital infrastructure. For instance, French hospitals gained 160.000 beds between 1962 and 1976.

However, this increase is also due to specific changes in the field of cancer-care. First of all, other hospitals were allowed to acquire radiotherapy equipment. By the end of the 1970s, Cancer Centers possessed only 22 percent of the French radiotherapy equipment, but still 40

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<sup>5</sup> For a detailed analysis of this reform process, which can only be sketched out in this article, confer to P. Castel, « *Normaliser les pratiques, organiser les médecins. La qualité comme stratégie de changement. Le cas des Centres de Lutte Contre le Cancer* », Unpublished PhD dissertation, Sciences Po Paris, 2002.

<sup>6</sup> For more details on anti-cancer policy in France at the beginning of the 20th century, see Pinell (2002).

percent of the linear accelerators (the most powerful machines, able to treat all kinds of cancer). By the 1990s, they still possessed 23 percent of the French radiotherapy equipment, but only 23 percent of the linear accelerators.

Then major improvements in cancer treatments have led an increasing number of physicians to get involved in cancer-care. Cancer is no more an incurable disease, of interest to scientists only. Surgery and radiotherapy have become more efficient and less mutilating. But the greatest technological change has been the improvement of medical treatments with the emergence of chemotherapies (Bud 1978; Löwy 1996), allowing new categories of physicians, who were not specialized in radiotherapy or surgery, to enter the field of cancer-care<sup>7</sup>. These changes turned out to be all the more dramatic for Cancer Centers as they depend for their production on the other actors of the health care field (hospitals, doctors, etc) who decide on the orientation of the patients they receive prior to the diagnosis of cancer.

As a consequence, the number of new cancer patients treated in the Cancer Centers stagnated during the 1980s whereas the total number of cancers was growing in France (see table 1): in other words, the absolute and relative market-share of Cancer Centers declined sharply. Furthermore, the number of hospitals relying on Cancer Centers' physicians for cancer consultations stagnated around 150 during the 1980s.

**Table 1: relative “market-share” of Cancer Centers<sup>8</sup>**

	1981	1985	1990
Number of new cancers treated in the Cancer Centers	25.210	26.216	24.875
Number of new cancers in France <sup>9</sup>	170.000	187.000	211.000
Percentage of new cancers treated by the Cancer Centers	14,7%	13,9%	11,8%

### ***Challenges to legitimacy***

The changing task environment and growing market pressures was not the only challenge Cancer Centers had to face. Their legitimacy itself began to wane.

First, some healthcare organizations promoted an alternative medical model that challenged the Cancer Centers' model. They were organized around physicians specialized in the treatment of specific organs (gynecologists, urologists, gastro-enterologists, etc.), cancer being only one among many other pathologies they treated, whereas Cancer Centers claimed that only physicians specialized in the knowledge of the pathology as a whole (oncologists)

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<sup>7</sup> This is all the more so as contrary to the United States, oncologists are not the only physicians allowed to prescribe chemotherapy. Every physician who passes the required exam –not subject to a *numerus clausus*– is allowed to do so (Löwy 1996).

<sup>8</sup> These data are rough estimates based on the Enquête Permanente Cancer (Permanent Cancer Survey) which has been recording the number of cancers treated in the French Cancer Centers from 1943 onwards (Menoret 2002). Nonetheless, they are congruent with the results of a (much criticized) study conducted by the French Ministry of Health between 1985 and 1987 and showing that French Cancer Centers treated only about 11% of cancer patients (IGAS 1993).

<sup>9</sup> Sources : Remontet (2003).

were able to propose the appropriate treatments. One type of healthcare organization created after the Cancer Centers was particularly threatening to them: the University Hospital. In 1958, the Hospital Reform Act was passed to modernize the French hospital system by linking regional public hospitals to university medical schools (Jamous and Petoille 1970). Called University Hospitals, they have become the keystone of the French healthcare system, since they are expected to offer the best and most advanced treatments, to train physicians and to conduct medical research for all pathologies. From the 1980s on, they began to claim that Cancer Centers were not useful any more since they had the same missions in the field of cancer-care and argued that their physicians, specialized in organ treatments and at the forefront of clinical research, were more qualified to treat (and cure) cancer.

The second challenge was related to increasing criticism coming from the regulative authorities. As early as 1968, the French Ministry of Health worked on a project to integrate the Cancer Centers into the public hospitals. The National Federation stepped in and was able to stop the project. Twelve years later, in 1982, the new socialist government initiated a national debate about the organization of ‘the fight against cancer’ and about the role of the 20 French Cancer Centers, and the administration again attempted to merge one of the smallest Cancer Centers with the University Hospital of its region. Once again, the Centers and their lobbying organization succeeded in stopping these projects. Later on, between 1988 and 1998, no less than three public reports raised the question of maintaining these atypical hospitals: they were costly and did not show evidence of their added value whereas more and more new health organizations participated in the fight against cancer.

## **2. *Time for reform***

At the beginning of the 1990s, a small group of five physicians belonging to different Cancer Centers particularly exposed to competitive pressures in their respective local environment<sup>10</sup>, decided to join forces in view of initiating an economic and medical reform at the level of the Federation of the Cancer Centers. These physicians, who had been newly nominated as director of their center (between 1988 and 1991), posited that Cancer Centers had to change if they did not want to disappear.

### ***The emergence of a group of reformers***

Four of the five directors did actually play an active role in the design and implementation of the reform<sup>11</sup>. These four physicians shared a number of distinctive features

First, their medical specialization contrasted with those of the previous directors of the center in which they were nominated. Three of them were the first medical oncologists to be nominated at the head of a Cancer Center while the fourth was the first radiotherapist after

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<sup>10</sup> Four of them perceived their *local* environment as a real threat for their center. Three were managing a center for which competition in the area had been increasing rapidly. The fourth one still had in mind the (aborted) attempt of the Ministry of Health, 10 years earlier (in 1982), to plan the absorption, by the regional University Hospital, of the small Cancer Center he was operating in (cf. *supra*). The fifth director was running a small center, and he considered the size of his center as constraining his ability to maintain his regional leadership in the face of increasing medical supply.

<sup>11</sup> The fifth one was not an oncologist and had begun his career in public hospitals. As a consequence, although he backed up the other directors, he was less actively involved in the reform-process.

three surgeons and a pathologist: in other words, they shared a disciplinary interest in the face of surgery as another, still dominant treatment technique.

Second, these reformers had been actively involved in research activities, a fact which strongly contrasted with other directors of the National Federation's board. In particular, the three medical oncologists had been appointed as research fellows in some of the most famous American institutions who developed these new treatments through experimental research and multi-center clinical trials. One of them had spent one year in the laboratories of the National Cancer Institute between 1971 and 1972 where he had worked with physicians who tried to develop new immunology treatments such as Interleukin. Upon his return to France, he created the first "labeled research unit" in his country<sup>12</sup> and tried to initiate clinical research in his center. The two other ones, who later on were to assume the leadership of federal scientific projects, had been research fellows at the Fred Hutchinson Cancer Research in Seattle respectively in 1981 and 1982. This institution was specialized in hematology and in particular in bone marrow transplantation which was a new technique intended to allow the prescription of higher doses of chemotherapy to patients. When they came back to France, they both became director of a bone marrow transplantation service in their respective center, founded the French association of bone marrow transplantation and became advisers for the Ministry of Health on this matter. Later on, between 1987 and 1989, they spent some months in the NCI laboratories of Prof. Steven Rosenberg, who was a much reputed specialist of Interleukin 2. As a result of their specialized training, all four had published articles in some of the most famous American medical journals such as the *Lancet*, the *Journal of Clinical Oncology* edited by the American Society of Clinical Oncology and *Blood* edited by the American Society of Hematology.

In short, the group of reformers shared common interests, had similar career paths which had brought them in touch with the cutting edge of research in their respective fields of expertise, a similar vision of where cancer-care was headed and a similar experience of crisis in the face of mounting outside pressures. They set out to "awaken" the Federation, i.e. their fellow directors, to the dangers of inaction, and proposed a reform-program which was designed to have Cancer Centers regain their past influence and to bring them again to the forefront of the fight against cancer.

Their reform ideas were organized around three guiding principles. First, they held the view that Cancer Centers should be more than well-managed healthcare organizations: they had to become scientific leaders, if they were to survive. In a competitive environment, they thought, research and teaching activities should allow the Centers to make a difference with other organizations. There were several reasons to this position. For one, it was congruent with their own professional orientation. It also corresponded to the historic mission of the Cancer Centers. And it was a good way to uphold their claim for leadership in the French system of cancer-care and to reposition them in their competition with other healthcare organizations: instead of competing with other healthcare organizations for the same patients, they would now act as a support for them, thus introducing a *de facto* hierarchization of cancer-care in their region. As one of them, standing in for directorship, put it:

"Our center (...) has a limited size and cannot pretend taking care of more than 20% of cancer patients in our region. It seems to be a weakness but, in fact, it is not: it is a specific feature of Cancer Centers which are not intended to enjoy a monopoly in cancer-care but are

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<sup>12</sup> In France, two main public organizations fund medical and scientific laboratories: the French Institute of Health and Medical Research (INSERM) and the French National Center for Scientific Research (CNRS). Only labeled units may benefit from such funding.

commissioned to be the driving force in the promotion of techniques, prevention and research in their region. (...) To be the driving force does not depend on the size of our center but on our capacity to set the example.” Discourse of a reformer in front of the Board of a Cancer Center, June 1989

The second idea behind their reform drive was that, in order to loosen financial constraints imposed by the regulatory authorities, Cancer Centers should consider them as potential allies and signal cooperation. The reformers were convinced that, since their lobbying capacities were low compared to those of other hospitals which were more numerous and more important financially, as much compliance as feasible with the demands and expectations of the regulatory authorities was their best strategy.

“One way to achieve our ends will be medical and administrative transparency which will demonstrate the limits of our room for manoeuvre. Of course, these added funds will be allocated on a contractual basis and thus regularly called into question. (...) *What is important is to assert that we, as benefiting by public funding, accept the constraints of public funds’ management.*” (emphasis in the text) Discourse of the reformers in front of the Federation board, 24/11/1992

And third, they believed that the Federation was the relevant level to drive the reform<sup>13</sup>. Two main reasons explained this position. First, unified responses to environmental threats and demands were conceived to be a way for overcoming the weak position which they at that time considered the Cancer Centers to be in. Second, designing the reform at the federal level was a way to mutualize financial and human resources, and thus to develop significant scientific projects.

### ***An incremental reform***

The reformers did not succeed at once in convincing their colleagues of the other Cancer Centers of the necessity and the urgency of a reform, nor did they devise and propose the Board a major plan for action to be implemented from scratch. The design of the reform and its implementation have been progressive and incremental during the 1990’s. All through the period they nevertheless did assume the role of change-entrepreneurs, pushing the reform drive while adjusting their views and projects to unfolding events, to progressively emerging demands of the environment and to the resources which could be mobilized as well as to the necessity of popularizing the reform ideas among their fellow directors and physicians, i.e. make them acceptable to what could be considered the collective identity of Cancer Centers and their institutional heritage. Four events of particular significance trace the progress of the reform agenda.

In 1991, the reformers as a group for the first time successfully attempted to initiate some change. They succeeded in convincing their colleagues of the board of directors that the National Federation be, for the first time, the sponsor of a clinical trial they wished to conduct. At the end of that same year, they organized a seminar during which they convinced the board to accept a considerable strengthening of the federal level in relation to the individual Centers: the Federation was to become the main public sponsor of clinical trials in their field in France, and was authorized to recruit a new executive Director whose mission would be to help Cancer Centers improve the management of their human resources.

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<sup>13</sup> This meant a major break away from the traditional autonomy of Cancer Centers, since up to the reform, the Federation of Cancer Centers had not been a structure for mutualization, but only a lobbying body as well as an employers organization concerned with collective bargaining for the Centers.

In 1992, they reiterated their efforts much more explicitly in another board meeting in the course of which they openly criticized the functioning of the Cancer Centers as well as the way in which the Federation was run. They commissioned a member of their group to officially run against the federal President in office, who was a surgeon and who had been at the head of the Federation for 10 years. In their proposal, they mentioned three lines of action, but did not substantiate them any further: 1) the definition of medical guidelines for treatment; 2) the development of research activities by the Centers as well as the Federation ; 3) the re-negotiation of professional statutes for non-medical staff (in order to cut down wage costs and introduce a variable share in wages). But mainly they tried to convince the board that the time had come to act and that they had the recipe for the necessary reform.

They used two lines of arguments which tried to sell their diagnosis and frame their directions of reform in terms acceptable to their colleagues. The first one summoned the recent transformation of the medical and legal environment of Cancer Centers. They emphasized the loss of their monopoly in cancer-care. They underlined the foreseeable impact of the 1991 law which aimed at reorganizing the French healthcare system on the regional level by fostering (or even forcing) cooperation between hospitals. They mentioned also the start of a public inquiry on the usefulness of Cancer Centers. To face up to these challenges and threats, they pleaded in favor of a quick change, as a “laissez-faire” strategy would only bring about coercive intervention from the regulatory authorities.

“This is an emergency because the current public inquiry has nothing to do (contrary to what you say) with what you have known before. The previous context (which, by the way, you have well controlled) was an ideological one against Cancer Centers. Current stakes are economic and organizational. It is required that we justify the place of Cancer Centers in the healthcare system. We have to bring unambiguous answers to Ministries and to other funding organizations which ask this question very directly and clearly. We’d better produce this answer ourselves before some other people, from outside the Cancer Centers, do it for us. This is an emergency (...) because new regional organization plans lead to the redefinition of the role and missions of Cancer Centers in the healthcare system, in an healthcare environment which has much changed since 1945. (...) We must accept this evolution, *and even anticipate it, and above all not submit to it*. Let us recall, dear colleagues, that transfusion centers thought they were enjoying a monopoly which would guarantee them a peaceful future. (...) Last, if we do not change, we are supporters of corporatism... and we will soon be considered as one of the oldest and most rigid hospitals. (...) What is at stake is a challenge; we have to be able to act at a moment when national and regional healthcare scenery is moving quickly.” (*emphasis added*) Discourse of the reformers in front of the Federation board, 24/11/1992

While pushing for drastic reform along the lines which they sketched out, the group was careful to show that their reform was in line with, and therefore able to protect and to enhance, the founding project of Cancer Centers which directors and physicians are very proud of<sup>14</sup>. They underlined that the two distinctive organizational features of Cancer Centers (their specialization around the pathology and their organization based on the participation of every medical specialty in the decision process related to a patient’s treatment strategy - also called multi-disciplinarity), were seriously threatened by other medical approaches. They also recalled that the initial missions of Cancer Centers were not only to treat patients but also to have an influence on general cancer-care: their proposal to produce medical guidelines and to develop research were presented as a way to regain scientific legitimacy and leadership.

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<sup>14</sup> Cancer Centers are proud of their history as pioneers in the fight against cancer. As a symbol, each Cancer Center is named after one of the founders. And the multi-disciplinary tradition of cancer care is cherished and valued.

“We do not reject the fundamental historical public enactment of our creation, which is (we do all agree with it) a strong asset, but we think that if we are holder of a public health mission, this mission has changed since our creation. (...) Our assets are competencies, multi-disciplinarity, flexibility, capacity of experimentation and critical mass to allow good research. (...) We do not mean that Cancer Centers have to put aside their mission of treatment in favor of exclusive research activities. We mean that Cancer Centers should balance it with evaluation of standards of treatment and therapeutic innovations which justify our presence in our healthcare system. (...) *We have to take the lead in our regions of the defense of a pathology-centered model against the organ-centered one. (...) How can we come back to the founding project of Cancer Centers ?* We mean the very driving and leading role in cancer-care. (...) We have got, Mr President, dear Colleagues, a new vision of the role of the Federation (...)” (*Emphasis added*) Discourse of the reformers in front of the Federation board, 24/11/1992

The reception of this reform program by the fellow-directors was ambiguous. On the one hand, they endorsed the general orientations proposed by the reformers and entrusted them with the implementation of the sub-projects mentioned earlier. They did not, however, hand the reformers full power. First, they re-elected the outgoing President, the reformers becoming only Vice-Presidents in charge of the projects. Second, they did not agree with an increase of their center’s subscription to the National Federation. But the overall result was an infusion of the spirit of reform inside the Cancer Centers as is illustrated by the succession of documents and initiatives coming forth from the Federation whose resources begin a steady increase from then on<sup>15</sup>.

At the beginning of 1993, a document which resumed the axes of the reformers was elaborated and adopted by the board. In particular, the will and necessity to increase the scientific activities in Cancer Centers was put forward and, for the first time, reformers came to give a more precise definition of the “guidelines project” by referring to science-based medicine, in reference to an emergent trend in the American medical profession which called for the development of guidelines based on the current state of scientific knowledge (Institute of Medicine 1990; Evidence-Based Medicine Group 1992):

“The list of diagnostic and treatment procedures which, in oncology, are considered and *evaluated as standard, relative to the current state of scientific knowledge.*” (*emphasis added*) Internal document, February 1993

As a consequence, they organized in May of the same year a trip to the United States where they met with actors of two prestigious institutions in oncology: the MD Anderson Cancer Institute and the National Cancer Institute. The reactions of their American counterparts proved to them the relevance and the appropriateness of their project as well as its ambitious scope since no national project had been initiated so far in the US<sup>16</sup>. But they also came away with a new idea for them, as they became convinced that a federal team of methodologists was needed in order to coordinate the work of the Cancer Centers’ physicians during the elaboration of the guidelines and to make sure that the guidelines were based on an objective evaluation of the literature and not only on the opinions and experience of some medical leaders. In order to recruit this team, they obtained from the Board an exceptional subscription

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<sup>15</sup> This increase is due particularly to partnerships with the Ministry of Health (for the medical guidelines project), the National League Against Cancer (which is the main French patient organization in oncology) and the pharmaceutical industry (in relation to clinical trials).

<sup>16</sup> For instance, the National Comprehensive Cancer Center Network in the United States would begin to elaborate such guidelines in 1995.

which was the first step in the strengthening of the federal level in the organizational field, which had not been foreseen from the start.

In implementing the guidelines project, the reformers took advantage of already existing patterns of inter-Centers exchange which had sprung up since the 1980's through the organization of thematic discussion groups around common scientific and therapeutic problems. They were able to enroll those physicians who had taken responsibilities in these inter-Centers groups and who had been able to acquire a kind of scientific legitimacy among their peers. Under the leadership of these physicians, the movement for the elaboration of therapeutic guidelines spread quickly and enjoyed high acceptance among Cancer Center physicians<sup>17</sup>. In 1993, 300 Cancer Centers' physicians took part in this project, whether in the development or in the external review of the guidelines. In 1995, they were more than 600 (out of a total of 1000 working in the Cancer Centers).

In 1994, a new project was initiated. It consisted in promoting the accreditation approach in the centers. This was of course a direct response to the public inquiry which had just been published and which challenged the Cancer Centers to prove their commitment toward quality of care. But this response was also an anticipation, since the Ministry of Health would institute accreditation for French hospitals only two years later, in 1996.

In 1997, the once candidate of the reformers became President after the first successes of the projects (cf. *infra*). This brought about a 33% increase of Cancer Centers' subscription (see table 2) and the beginning of the renegotiations on the collective agreement for non-medical staff. More importantly, it gave a general impetus to reform in the Cancer Centers and resulted in the acceleration of reform efforts on all levels. The new vision of the role of Cancer Centers in the French Healthcare system had received official legitimacy.

### **3. *Things have changed***

With the beginning of the new century, things have changed considerably. The structure and functioning of the organizational field of Cancer Centers has been centralized and somewhat unified, their production has evolved towards diversification and they have gained a new legitimacy.

#### ***A more centralized and unified organizational field***

Traditionally, the federation was not a center of power in the organizational field formed by the Cancer Centers: it was an employers' organization with weak prerogatives, and a representative body for the common interests of the twenty Cancer Centers. Power rested in the board of directors which functioned on a consensual basis, and while there were of course differences in the weight of individual directors, the board of directors was a collective body where the voice of each director counted. In short, the organizational model looked more like a confederation of highly autonomous centers than like a unified organization.

The situation today is quite different. By the end of the 1990s, the National Federation has grown bigger, stronger and more influent: 1) it has gained a significant increase in resources,

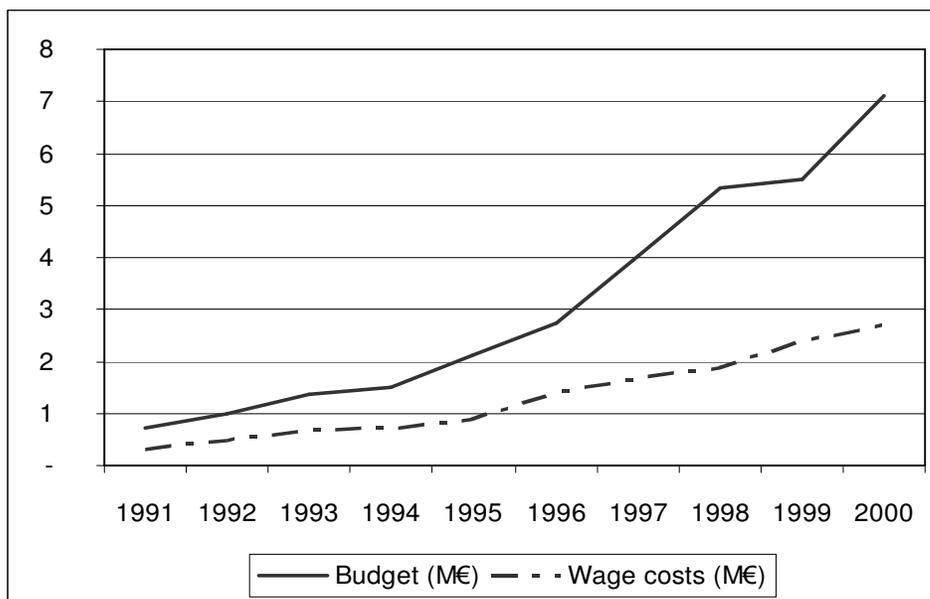
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<sup>17</sup> One could add that this was also true because of another organizational or processual innovation. Whereas medical guidelines in the French healthcare system are elaborated on a national level and then prescribed for local medical practice, cancer guidelines are elaborated nationally, but then implemented regionally through regional oncology networks which give the local practitioners a chance to work over the national guidelines and adapt them to local conditions (Castel and Merle 2002).

2) its legitimacy to initiate and lead collective projects for the 20 Cancer Centers has been acknowledged and enacted, and 3) strategic orientations of Cancer Centers are congruent with the federal reform.

The first and most evident indicator of this change is of course the evolution of the federation's budget and wage-costs. As is shown in table 2 below, both have steadily increased during the past decade, with a sharp increase of the federation's budget in 1999: the number of employees and the budget had been multiplied respectively by more than 5 (from 9 to more than 50 employees) and by nearly 10 (from 0,73M€ to 7,12M€). Even though a new request for another increase has lately been rejected, the overall growth of resources is impressive and denotes the new importance of this organizational level.

**Table 2: Evolution of the budget of the Federation**



Cause and result of this budgetary evolution, the federal level has become a center of initiative for new activities of its own, in the field of research and clinical trials and in the initiation and steering of the guidelines program as well as of the accreditation of the Cancer Centers. Indeed, the impetus for change is still in progress. Three new projects have been initiated since 1999. First, a new collective agreement for the physicians of the Cancer Centers has been negotiated and approved in 2001 by the Federation. Second, a body for multidisciplinary training (for physicians and nurses from inside and outside Cancer Centers) has been created. Third, documents to inform patients on the possible treatments have begun to be published. These innovations are of great significance. They show that the Cancer Centers' directors are more and more willing to let the Federation become active in fields which until then they had considered of their sole strategic responsibility: the contractual relations between their Center and their physicians (their core human resource), the relations between their Center and their patients, and the education and training of their employees as well as their potential providers.

Furthermore, the Federation is more influent at the local level. Indeed, Cancer Centers' strategic plans are very similar to each other and congruent with the federal reform. Each

strategic plan emphasizes that the Cancer Center intends henceforth to be a center for assistance and expertise for other healthcare organizations of its area rather than their competitor. And the development of research activities and the improvement of the quality of care through treatment protocols and patients' participation are identified as priorities in every Cancer Center, even in the centers which had been focused until then only on care:

“The weakness of our center was caused by the fact that we had functioned so far like a clinic, which took care of patients, but which did not have much developed teaching and research activities. ... A change has been introduced by our director: we have developed these activities. Our center devotes a bigger part of our budget to them.” Interview with an administrative director of a Cancer Center, September 2000

We do not want to overstate this organizational change. Even if their internal functioning has certainly become more alike than before and even if the new collective agreements have curtailed their leeway in the management of their human resources, individual Cancer Centers still enjoy high organizational autonomy. More importantly, the growing importance of the federal level has become a subject of growing criticism, and the latest moves by the federal executive to strengthen even more the level of the Federation have met with fierce resistance by some of the Centers. However, the very existence of this criticism, along with the range of new activities developed by the federal level bear witness that the power balance, although not completely tipped yet, has shifted quite clearly in favor of the center, i.e. the Federation.

### *A more diversified output*

A second dimension of the transformation of the situation is the diversification which the production of Cancer Centers has undergone since the beginning of the 1990s.

**Table 3: Main sponsors of clinical research in France**

	1995 <sup>18</sup>	1999-2002 <sup>19</sup>
University hospitals	16%	11%
Pharmaceutical industry	70%	49%
Medical associations	6,5%	19%
Others (Cancer Centers included)	7,5%	-
Cancer Centers	-	<b>20%</b>

While continuing to provide cancer-care, their initial core-business, Cancer Centers have invested more and more in research activities. At the beginning of the 1990s, 4 centers hosted less than 10 labeled units of fundamental research. In 2000, 40 units were operating in 11 centers. As a consequence, their share in clinical research has also sharply increased. About 10% of the Cancer Centers' patients were included in clinical trials in 2000<sup>20</sup>. Table 3 clearly

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<sup>18</sup> Source: Oudin (1998).

<sup>19</sup> Source: Commission d'Orientation sur le Cancer (2003).

<sup>20</sup> This level is quite high since it is the level that the National Cancer Institute of the United States wants to achieve and since it is twice the estimated level in Canada (Stratégie canadienne de lutte contre le cancer, 2002).

indicates that Cancer Centers have increased their relative “market-share” concerning sponsorship of clinical trials<sup>21</sup>.

Simultaneously, Cancer Centers have become increasingly involved in the production of medical guidelines, both at the national and regional levels. On the national scale, the Federation of Cancer Centers has been leading an exhaustive collection and review of the existing scientific literature (clinical trials, meta-analyses, etc.). Over time, other institutions (mainly University hospitals and medical associations<sup>22</sup>) joined in, but the Federation still holds the leadership. Most types of cancer have been reviewed since the project was started. Yet research goes on, as more than 2000 papers presenting the results of cancer clinical trials are published each year and have to be reviewed and analyzed.

This activity has been highly successful both on the national and the European level. Of the 75 guidelines in oncology published in France between 1993 and 2002, 60 were issued by the Federation of Cancer Centers. The success is such that its influence now reaches beyond the French borders towards the European level, as the guidelines it has produced have recently been published in international top reviews such as the *British Journal of Cancer*.

The same can be said for the regional level. Cancer Centers’ physicians<sup>23</sup> play a leading part in the creation of cooperative networks for the elaboration and implementation of regional treatment protocols adapted to the characteristics and resources of the local healthcare system in order to be relevant and handy for everyday practice. This entails two activities. First, it means initiating and monitoring the discussion process at the regional level through which federal review monographs are in fact transformed into decision algorithms and into specific recommendations of one among several scientifically appropriate treatments. The actual implementation of these recommendations is then monitored through the organization and monitoring of voluntary regional networks for cancer-care involving an increasing number of physicians concerned with cancer-care.

### ***A renewed legitimacy***

In the same period and as a result of this diversification, Cancer Centers have also been able to restore their legitimacy in the field of cancer-care.

The first indicator of this is the increase of their relative “market-share” which reflects the fact that more and more professionals call on their competencies to treat patients. While the number of new cancers treated in the centers had stagnated around 25.000 by year during the 1980s (cf. table 1), it reached near 40.000 at the end of the 1990s. The last national report on cancer-care (Commission d’Orientation sur le Cancer 2003) estimates that Cancer Centers produced 18,8% of cancer-care in France, which is more than the 29 regional research hospitals (16,3%). Even more impressive, 55% of their patients are recruited outside their nearby territory: in other words, they have been draining difficult cases from outside their traditional territory, reflecting their role of support for the other organizations. But even when they do not treat patients, Cancer Centers’ physicians do participate very often in the

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<sup>21</sup> The data are extracted from two different investigators, which may imply differences in the methods of investigation. Nevertheless, they have been published by public reports, which means that Cancer Centers are henceforth considered as major actors of French clinical research.

<sup>22</sup> French Association of Urology, French Society of Cancer, French Society of Oncologic Gynaecology...

<sup>23</sup> Depending on the area and the relations between the different actors operating in the region, physicians belonging to other local healthcare organizations might participate in the process.

treatment decisions. More and more frequently, physicians of other hospitals ask for their opinion about the right treatment to choose. In 2000, Cancer Centers' physicians were invited to 200 hospitals to discuss medical cases of local patients. This shows an increase in comparison to the 1980s (cf. *supra*). Furthermore, between 1995 and 2000, the number of medical records which have been seen by Cancer Centers' physicians during these meetings has grown up from 33.000 to 50.000. Last, the number of Cancer Centers' physicians who are teaching oncology in the medical faculties has grown from 50 in 1995 to 150 at the end of the 1990s.

The second and no less important indicator of the restored legitimacy of Cancer Centers is the fact that since 1998, the regulatory authorities have not only stopped their criticism of the centers, but have even made them into icons of what ought to be done. In the past decades, national plans for the fight against cancer had been traditionally the occasion to raise questions about the legitimacy of the Cancer Centers, to criticize their functioning if not their very existence. Not so any more: in the last two plans launched in 2000 and 2002, Cancer Centers have regained an influential position. Already in 1996, when the Ministry of Health initiated the accreditation program for French hospitals, the executive director of the National Federation of Cancer Centers was nominated as President of the Scientific Council of the structure in charge of this procedure, since Cancer Centers had been precursors (cf. *supra*). And the last national plan launched in 2002 stipulates that each Cancer Center is *de facto* the leading regional pole, in collaboration with the university hospital. This plan also (re)creates a national committee in charge of elaborating recommendations on French cancer policy. In this committee, 3 members out of 6 represent Cancer Centers and a fourth one is the President of the National League Against Cancer which is also the main financial partner of the National Federation<sup>24</sup> (cf. *supra*).

An even more striking example of this regained legitimacy lies in the recognition by the university hospitals of the medical model that Cancer Centers have been defending since their creation: pathology-oriented specialization and multidisciplinary organization. Traditionally opposed to this model, university hospitals have progressively aligned their position to this model. In 1997, they created a national federation of oncology whose aim is twofold: it is to start negotiations with the National Federation of Cancer Centers (thus recognizing it as a major player) but also at promoting in every hospital a more pathology-oriented organization beside the traditional organ-oriented organization – in particular through the creation of multidisciplinary meetings. By 2001, every university hospital had created such a coordination-structure.

“Our will is strong to go beyond these old quarrels [between us and Cancer Centers]. These quarrels were based more on fears and misunderstandings than on a real disagreement. They were principally due to the old organization of oncology inside our hospitals, where organ-specialists were responsible for this domain, independently of the other specialties. Current organization allows in most of our hospitals to go beyond this individual system. (...) This situation is the consequence of the fact that for long cancers had been treated in Cancer Centers and not in our hospitals. Thus, I think our hospitals lack an “oncology sense” which allows a student who wants to specialize in oncology to find in his organization the necessary structures to acquire a training in this specialty. Today, future oncologists are bound to acquire such a training in a Cancer Center or in another healthcare organization. (...) Such an organization [that we put in place] is obligatory to acquire this “oncology sense”.” (emphasis added) Hearing of a

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<sup>24</sup> Furthermore, this President had been President of the National Federation for 15 years between 1982 and 1997.

Pneumologist, President of the National Federation of oncology of the university hospitals, in front of the Senate commission, 03/05/2001

Furthermore, from 1998 on, the necessity of developing multidisciplinary meetings has been put forward by the regulatory authorities. Significantly, it is one of the priorities of the last national cancer plan presented in 2002. The pathology-centered approach of the Cancer Centers has indeed been officially and explicitly endorsed and officially legitimized by the regulatory authorities. Thus, the Ministry of Health now has plans to increase the number of oncologists, who are not specialized in the organs but in the pathology, and requires from university hospitals that they identify oncology as an activity (specialty) if they want to be considered as being part of the leading regional pole with the corresponding Cancer Center.

### *New “rules of the game”*

The end-result of this reform drive is impressive, indeed. Cancer Centers have clearly been reinstated as the leaders in the field of cancer treatment in France : they have increased their market share in cancer-care, they have regained their scientific and medical legitimacy, they have been endorsed by the regulatory agencies, their representatives participate decisively in the elaboration of the national policy for the fight against cancer. Indeed, this reform drive has produced a new set of “rules of the game” or conventions which structure and canalize the behavior of all the stake-holders in the sector of cancer-care in France. These new “rules of the game” can be seen at three different levels.

First of all, the medical approach or paradigm in the field of cancer-care in France has been deeply transformed and unified around two ideas which were controversial in the eighties and which are now commonly shared and taken for granted by the medical as well as administrative actors of the field. The first is that therapeutic decisions must be multi-disciplinary, with at least the participation of surgeons, radiotherapists and medical oncologist, and that organizational arrangements in healthcare organizations must foster such multi-disciplinarity. The second convention is the general acceptance of the superiority of a pathology-centered paradigm for cancer-care: to state it in an oversimplified manner, in the name of the improvement of quality of care for patients, oncologists have won over organ-specialists, and have gained their recognition as a specialty.

Second, the representation of the role of Cancer Centers in the field of cancer-care has been deeply transformed. The directors of the individual Cancer Centers now broadly acknowledge the necessity of developing research activities in their center and to position it as a regional coordinating structure rather than as a competitor with other general hospitals. And this new orientation is accepted and enacted by the other stake-holders in the field of cancer-care who see Cancer Centers as a source of medical expertise and support. As a result, a growing hierarchization and organization of the sector of cancer-care can be observed: the difficult cases for the Cancer Centers, the routine cases for general hospitals and private clinics.

Last, but not least, the “rules of the game” inside the federation of Cancer Centers have been reshuffled: the traditional independence and organizational autonomy of individual Cancer Centers have been moderated. The Federation is now an accepted partner for individual Cancer Centers whose directors have come to accept inroads into their traditional prerogatives in the name of collective efficiency, a notion which is relatively new in the world of Cancer Centers.

## 2. DISCUSSION

The chain of events which lead to the successful modernization of the French Cancer Centers and their reinstatement as dominant actors in the field of cancer-care seems to provide a clear evidence of institutional change: an organizational field is being transformed in its internal structure as well as in its relations to its different environments in both its technical and institutional dimensions. The characteristics of this process of change directly challenge what could be called the “strong program” of neo-institutional theory viewing institutional change essentially as the passive alignment to impersonal exogenous forces, while they corroborate most of the literature which has criticized this strong program by emphasizing the ambiguous and diverse nature of environmental pressures as well as the importance of strategic choice, i.e. of interest driven purposive action, in explaining institutional change.

Two features of the process we observed seem to us to be of particular significance and to warrant further discussion. First, our process illustrates how change is in fact the product of the meshing or hybridization of exogenous pressures from the environments with endogenous dynamics of the organizational field: outside pressures are not just passively taken in and conformed to, they are translated, interpreted and accommodated to internal dynamics (Callon 1986; Friedberg 1997). And second, the crucial role played by the group of reformers in initiating and monitoring this process of accommodation. Put together, these two features make up a more complex and interactive picture of organizational or institutional change, where the motor of change structures and simultaneously is structured by the process it is driving and where the initiators of reform and change have to create their proper and specific combination of old and new in order to build an innovative dynamic.

### ***2.1. Between compliance and resistance : accommodation***

It could be tempting to interpret the whole modernization process of the French Cancer Centers (its initiation as well as its timing and its contents) as the pure manifestation of the forces of isomorphism in its “coercive”, “normative” and “mimetic” dimensions (DiMaggio and Powell 1983; see also Scott 2001). And some points could certainly be made to underpin this interpretation.

Some of the features of the reform can certainly be interpreted as an alignment to pressures from the regulatory authorities. Indeed, the strategy to reposition Cancer Centers as a support for other healthcare organizations in their region was congruent with the 1991 law which aimed at organizing the French healthcare system on a regional level and at promoting complementarity and cooperation among the actors in the healthcare sector. In the same vein the emphasis on the production of guidelines for treatment could be understood as conforming to what has become a central orientation of the French healthcare policy: the 1991 law encouraged the evaluation of medical practices (but did not propose any concrete disposition) and, in 1993, another law for the lucrative sector put forward some medical standards that liberal physicians must abide.

By the same token, there are some characteristics of the modernization process which could be linked to normative pressures stemming from professional constituencies (DiMaggio and Powell 1983). One could argue that the emphasis on the development of clinical research in Cancer Centers as well as the commitment to producing guidelines corresponds to a major trend in modern medicine (Berg 1995; Löwy 1996; Marks 1997; Bensing 2000; Timmermans and Berg 2003) which Cancer Centers and the leaders of reform merely took over. More specifically, it could be argued that the content of the reform was determined by the

professional career tracks of the French reformers who had brought to France what they had learnt in the United States, since they had been research fellows in some famous American medical institutions during the 1970s and the 1980s. Indeed, the implementation of state-of-the-art practices in every hospital is a goal that our French reformers share with their American peers. They belonged to what Marks (1997) would have called therapeutic reformers: they tended to improve the efficacy and reduce the heterogeneity of medical practices through the development of rational methods. Further, it is possible to partially link the reformers' inclination towards evidence-based medicine – that is to say their will to base medical practices on the results of clinical research – and their participation in multi-center, international clinical trials. Indeed, this participation meant that they were more in relation with American medical elites than other French (elite) physicians and that they were therefore more or less aware of what happened in the United States.

And last but not least, one could argue for mimetic isomorphism which would interpret the Cancer Centers' policy of hosting labeled research-units in fundamental research as their attempt to reproduce structural features of, and thus to catch up with, the most legitimate organization in the French healthcare system, i.e. the university hospitals.

However, none of the evidence is overwhelming, and plausible counter-arguments can be developed. The mimetic relations between university hospitals and Cancer Centers were indeed not univocal and imitation went both ways. Cancer Centers also innovated in other organizational areas and intended also to affirm and to defend some organizational peculiarities, which in turn influenced university hospitals' medical organization. For instance, they successfully resisted the organ-centered approach which was represented by university hospitals: in the end, oncology and the Cancer Centers' pathology-driven, multidisciplinary approach won out. The organization of clinical research tells a similar story. The idea to transform the National Federation into a structure able to conduct multi-center clinical trials was not the result of a mimetic process, since such a national structure did not and still does not exist for university hospitals<sup>25</sup>. And that organizational as well as intellectual innovation (at least in the French context) in turn structured the area of clinical research in cancer beyond the confines of the federation: today physicians from university hospitals have come to participate in the Federation's trials. And last but not least, Cancer Centers were precursors in the production of guidelines in oncology, an effort which eventually drew participation from interested physicians of the university hospitals.

The case for normative isomorphism is not much stronger: French reformers did not simply duplicate the American way. First, the goals pursued with clinical research are not the same in the two countries. In both, the primary goal is of course the improvement of cancer treatments. The secondary goal pursued, however, is different in France from what it is in the United States. Indeed, in two important books, Marks (1997) and Kaluzny and Warnecke (2000) show that clinical research is conceived by the American medical elites as the main way to implement state-of-the-art practices in non-university hospitals and hence tries to increase the participation of community physicians in clinical trials. Our French Cancer Centers reformers on the other hand conceived of it as a way to distinguish themselves from community hospitals and clinics (which are not involved in research activities) as well as a way to conduct a complex, ambiguous competition with university hospitals: in short, clinical

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<sup>25</sup> And this idea has to be placed in a context larger than the mere competition with university hospitals. One advantage of the Federation taking up this new role was to strengthen considerably the financial resources of the Federation. It is probable that this consideration had also something to do with the reformers proposing such a measure.

research was a way to regain a competitive advantage in the field of cancer-care in France and it is only logical that they did not at all seek to increase participation of community hospitals in clinical research<sup>26</sup>.

Another difference, which is partially linked to the first one, lies in the fact that French reformers thought and still think that evidence-based guidelines are the best way to improve medical practices in their own centers and in the community hospitals, whereas their American colleagues have much doubt about it (which explains why they chose instead to develop the participation of community physicians in clinical research): *“But the projects indicated in a general way that community physicians probably would not accept guidelines “handed down” from university physicians. (...) Thus, from the perspective of the NCI, guideline strategies did not seem to effectively alter physician behavior.”* (Kaluzny and Warnecke 2000: 20). This may explain why the Cancer Centers’ program for guidelines has been a precursor in France and even outside France, since the number of publications related to evidence-based medicine has begun to grow up only from 1995 on (Bensing 2000; Timmermans and Berg 2003). Last, but not least, the NCI and our group of reformers did not promote and structure clinical research the same way in the two countries. In France, it is a more centralized and, in the same time, a less constraining process than in the US. The French reformers chose both to elaborate protocols and to control data at the central level (i.e. the Federation), whereas Kaluzny and Warnecke described convincingly that the NCI delegates these tasks to the co-operative groups and to the “local alliances”. At the same time, the NCI requires minimum patients accruals per year and an official affiliation to co-operative groups in order to be allowed to participate in NCI clinical trials, whereas such requirements do not exist in France. So all in all, some superficial correspondence of the lines of action of the group of reformers with what happened elsewhere in the professional world of cancer-care cannot and should not be interpreted as a case of normative isomorphism: the timing and the contents of what was being undertaken just does not bear out such an interpretation.

The strongest case could probably be made for coercive isomorphism, since the financial prerogatives of regulatory authorities (especially social security) in the field impose indeed heavy constraints on all healthcare organizations. But again, without denying or even diminishing the influence of this regulative environment, its importance should not be overestimated. Analysts consider that the impact of the 1991 law on the French healthcare system was actually very small, since it created neither legal obligations nor even real financial incentives (Contandriopoulos and Souteyrand 1996; Minvielle and Contandriopoulos 2000). Cancer Centers had been one of the few healthcare organizations to react to it. The same could be said about the 1993 public report on Cancer Centers. First, reformers took the initiative for reform way before its publication. Second, it did not contain any concrete propositions<sup>27</sup> nor did it in itself have any coercive power: it was only a report to inform regulatory authorities on the basis of which they could eventually have taken appropriate steps<sup>28</sup>.

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<sup>26</sup> Indeed they did not: only university hospitals and some other physicians already involved in clinical research did participate in French Cancer Centers’ trials.

<sup>27</sup> Paradoxically, the only corrective action it mentioned was immediately rejected a few lines later: the renegotiation of the social status of the non medical personnel, in order to limit the cost of the wages, was judged impossible because of the social troubles it could carry.

<sup>28</sup> As a matter of fact, regulatory authorities never used the report publicly.

So the evidence is muddy at best. Pressures from the environment do exist of course, but the content of the reform cannot easily be linked precisely to these pressures, and in many instances goes beyond to what mere alignment to the relevant environments would and could have required. Not to forget that the reform also impacts on the environment and in turn structures it differently, bringing the environment to align to its own practice. These difficulties in the appreciation of institutional change as the result of isomorphic pressures point to at least three difficult methodological and/or substantive problems linked to the very idea of isomorphic change.

The first is the question of the frame of reference. Isomorphism might appear to be at work or not according to the frame of reference chosen. For instance, one could plausibly argue that put into the framework of the field of cancer-care in France (all the organizations concerned by cancer), a good deal of the change-program implemented by the Cancer Centers (collegiality, centralized organization of clinical research, massive reliance on evidence-based medicine and the production of guidelines) actually could be seen as *illegitimate change*, i.e. change going against the dominant professional and organizational myths, rationales and repertoires of the field. The same conclusion (with minor modulations) could be drawn if the frame of reference were the French healthcare system: in almost all its aspects, the modernization of the French Cancer Centers was anticipating and setting trends more than following them. If the international field of cancer-care were the frame of reference, the conclusion would be less clear: in some, but certainly not in all aspects and dimensions, the reform we observed indeed imported into the French context what was becoming standard procedures in the international professional community of oncologists. And still another conclusion would have to be drawn if the frame of reference was the organizational field of Cancer Centers itself over time: here, the impact of isomorphic pressures on the individual Cancer Centers and pushing them towards more homogenous and unified styles of functioning are clearly observable. They can even be considered as a direct outcome of the modernization process.

The second question is linked to the nature of what can be considered proof of the impact of isomorphic pressures. What on a purely formal level could appear as isomorphic alignment turns out quite differently when studied in detail. A case in point would be the issue of guidelines in cancer treatment. As we have shown above, this could superficially be seen as the alignment to what has become a major orientation in French health care policy. However, as soon as one looks deeper into the matter, discrepancies become evident. First of all there is the question of timing: strictly speaking, as we have shown above, Cancer Centers would have to be considered precursors instead of followers. Then there is the use one wants to make of the guidelines. In the minds of the regulators, treatment guidelines are a means of raising quality of treatment, rationalizing medical practice and (last but certainly not least) cost-saving. Implemented by the Cancer Centers, it becomes a way of raising quality of treatment, but also of re-legitimizing professional practice in the Cancer Centers and (last but certainly not least)... for justifying rising costs by pointing to the scientific basis of treatment guidelines which in particular incorporated expensive progress in chemotherapy. In other words, they played along with the idea of guidelines, but made something quite different out of them, transforming into a resource what was meant to be a mechanism of constraint and a means of control<sup>29</sup>.

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29 The same could be said of the trend towards clinical trials. Cancer Centers innovated in promoting clinical research while at the same time making it an instrument for draining resources for the Federation. Today, the Federation of Cancer Centers is the main national organization to conduct clinical trials besides the pharmaceutical industry.

The third question has to do with the unilateral vision isomorphic pressure implies. No process of isomorphic change is ever a unilateral alignment. If thought through concretely, it is an interaction process mediated by purposive actors who learn in the course of the process, i.e. partially change their identities on both sides, on the side of where the pressure comes from as well as on the side of where alignment seems to take place. In the end, isomorphism may prevail, but as a meshing of the nature and characteristics of the “pressuring” and the “aligning”, as an outcome of some thing like a process of (tacit) negotiation.

## ***2.2 The importance of interest-driven, purposive action for the explanation of change.***

All this underscores the importance of agency in understanding this particular process of institutional change. And bringing agency back into the picture, also implies the recognition of the contingent nature of institutional change. Neither the initiation, nor the contents of the reform and the particular dynamic it followed was the “natural” or “inevitable” or “mechanical” result of environmental pressures. It unfolded the way it did because of the nature and the purposive action of the group of reformers who took it upon themselves (and succeeded) to modernize what they considered an instrument worth while keeping and promoting.

To begin with, as we all too well know, the rapid decline of the Cancer Centers’ relative position in the field of cancer care in France, which was the consequence of the drastic transformations in their technical as well as institutional environments, is in itself not sufficient to explain that individual Cancer Centers as well as the Federation in charge of the organizational field eventually responded to the multiple challenges they faced. It took the emergence of a group of skillful actors in order to construct a response and enroll their colleagues in support of their line of action. The emergence of that group of actors as well as the fact that they happened to be “skillful”, i.e. actors capable of mobilizing and negotiating change with their colleagues as well as with the relevant stakeholders in the various relevant environments was neither natural nor inevitable. It owed to a series of factors, some of which were purely contingent.

As we have shown above, the members of this group shared common disciplinary interests as oncologists in the face of surgery as the then dominant treatment technique for cancer, they had similar career paths<sup>30</sup> and hence a similar vision of where cancer-care was heading. Therefore it is not surprising that they would consider evidence-based medicine in general and clinical trials in particular as the appropriate way to improve the visibility of Cancer Centers. By the same token, it is interesting to note that they were the directors of Cancer Centers which were particularly exposed to competition from other healthcare organizations in their region and which as a consequence had experienced a sharp decline in their “market-share” and a direct challenge to their role as a leader of cancer-care. They were thus more sensitive than their colleagues from other, still more protected regions, to the overall threats of a changing environment.

Taken together, all of these characteristics make for a distinctive group of physicians among their fellow-directors. They facilitated the coming together of our four reformers and can account for their emergence as a group of new contenders for leadership in the organizational

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<sup>30</sup> In her study of the regional reform of 1964 in France, Grémion (1979) has shown the influence of different career-paths on the construction of the different options of reform.

field of Cancer Centers as well as for the lines of action which they decided to privilege. One could say that as a group, our reformers/contenters were at the same time sufficiently central and legitimate in the power-structure of the organizational field (as they were directors of important, even though destabilized centers and mastered the new skills of chemotherapy central to the progress in the fight against cancer) and sufficiently marginal in regard to the professional profiles of their fellow-directors and of physicians in Cancer Centers in general, to be sensitive to the upcoming crisis and to have the cognitive and relational skills for projecting a different future for their institutions.

However, we should keep in mind that this is an after the fact explanation or interpretation. The factors mentioned above point to the probability of their encounter and be rationalized after the fact, just as on Monday mornings it seems evident to everyone what the quarterback should have done in this or that situation. But if we want to avoid historical hindsight, the reform-coalition as well as the nature of the policies proposed and implemented by them were not predetermined in any way by normative or coercive pressure. Nor can it be said that their program of reform was just an imitation (or a transfer) of another model already existing elsewhere. What they wanted to obtain and what they really did bring about may bear some resemblance to repertoires having been developed (or in the stage of being developed) elsewhere. The package they (and the process of transformation) really proposed was an original mixture of old and new, of imitations and genuine organizational innovations.

Much more important than the initial characteristics and the initial project of the group of reformers, was the way in which they developed their action, the manner in which they succeeded in creating awareness and in progressively mobilizing the professional community around them by translating the transformations in cancer-care and in the wider health care scene as well as the themes of reform they had chosen into cognitive categories and repertoires familiar to their colleagues, while at the same time renovating these repertoires and reformulating their lines of action. How, in other words they succeeded in marrying traditional ingredients of the organizational and professional culture of Cancer Centers with the new constraints of action and the goals they had set for their institutions.

The insistence on guidelines, on certification and on medical research were new for the Cancer Centers. They came from the outside and were imported into the organizational field by the reform program. The insistence on multi-disciplinarity, on collegiality and on a pathology-centered approach to cancer-care was capitalizing on the specific competence and skills (Selznick 1957) of Cancer Centers, which make up their historical identity and which provide some common ground valued by all physicians in Cancer Centers. Indeed, this identity was put forward as an issue to be defended, and used as a basis and as a tool of mobilization in favor of change. Throughout the 1990s, the argumentation used by the reformers was to say that change was needed in order to save the essential, i.e. the pathology-centered, collegial model of Cancer Centers. And this model did in fact provide peculiar resources to push along other important dimensions of the reform. For instance, as early as the sixties, the principle (or idea) of collegiality had led to the creation (acted out even in formal organization) of regular (often weekly) meetings where physicians discussed about the choice of the right treatment. Physicians in Cancer Centers thus had grown accustomed to showing their patients' records to other physicians, and were ready to understand the utility of guidelines as a coordinating mechanism. They also had started to organize inter-Centers meetings to exchange information and discuss therapeutic issues. The implementation of the scientific sub-projects was thus able to (and indeed did) capitalize on these cognitive and relational capabilities developed through collegiality.

Another example can illustrate the skills of the reformers in accommodating new ideas in old repertoires, thus changing their significance completely. It was an established rule for Cancer

Center physicians to consult on difficult cases in other healthcare organizations to which they brought their expertise. Such consulting had been used as a recruitment procedure for patients, as a tool for draining patients to Cancer Centers, and had therefore come under growing criticism from the other healthcare institutions which, with expertise being less rare, had a tendency to avoid calling on Cancer Centers, if that was possible, in order to keep their patients “under control”. The reformers capitalized on this tradition, by turning it around and by plugging it into the guidelines project. Local networks for the implementation of guidelines became the organizational infra-structure for exchange around difficult cases and the *de facto* hierarchization of cancer-care : the “normal” cases for small non-profit and for-profit hospitals, the difficult cases for the Cancer Centers and the regional University-hospital(s).

Again, it should be kept in mind that as the product of human agency, the change process was highly contingent. None of its features was inevitable. It would not have happened hadn't it been for our group of reformers and their skills. At the same time, the process we observed was conditioned, but not determined by the context of action in which it unfolded. Cancer Centers could well have been merged with, and dissolved in, university hospitals, and the organ-centered approach to cancer-care could have won out. Or the process could have followed different roads, at different speeds and with different results. It unfolded and developed the way it did because a group of reformers decided to take action and managed the change process in certain ways and towards certain results.

But admitting this role of agency does not and should not presuppose mastery of the process. There was not a group of super-lucid challengers who had it all planned and laid out and were then able to impose their design and a new set of practices, repertoires and rules of the game fixed and packaged from the start. It was a process full of surprises and partial redefinitions, where projects took form progressively, where problems were discovered during implementation, where reformers tried to understand experience and learn from it, where they had to accept compromise in order to build alliances, etc. To take but one example: the idea of using the federation as a coordinating device for clinical trials and creating a body of expertise at that organizational level (an innovative organizational feature which was most important in explaining the strengthening of the Federation and the unification of the organizational field of Cancer Centers) had not been planned from the start by the reform coalition. It emerged as a possibility during the process, was seen as an opportunity and was implemented with all the consequences linked to it. In other words, what we observed was a process of institutional change, where the goals of the reformers evolved with the unfolding of the process they had initiated, and where the events and compromises of each stage fed back on, and influenced, the initial design. Like in any genuine change process, neither the identity of the reformers, nor the goals, content and scope of the reform, nor naturally the identity of the Cancer Centers themselves stayed quite the same during the process, but were redefined by the interaction processes through which reformers vision was being implemented.

Our case thus corroborates the analyses of some authors who recently tried to “bring actors back in” the study of institutional change (Fligstein 1997, 2001; Kondra and Hinings 1998; Beckert 1999). Indeed, the reformers of Cancer Centers can be defined in Fligstein's words as “socially skilled actors”. On the one hand, they succeeded in making sense of the situation that directors and physicians of Cancer Centers were encountering and in redefining their collective interests and identity. On the other hand, they were pragmatic enough to use the resources at disposal and induce co-operation among actors. Nonetheless, the frame of analysis explaining institutional change roughly as the victory of “challengers” over “incumbents” seems to us too simplistic to be really meaningful. If, to its credit, this distinction recognizes (and rightly recalls) that power is crucial to understand organizational

as well as inter-organizational phenomena (Crozier 1965 [1964]; Crozier and Friedberg 1980 [1977]; Pfeffer and Salancik 1978; Pfeffer 1981), it is based on a dichotomized vision of the field of action which as such is hard to find in reality. Three points can be raised in this regard.

First, in our story, it is very difficult to distinguish who were the incumbents and who were the challengers: as we have shown, the university hospitals and the Cancer Centers were altogether and on different topics both challengers for each other and incumbents. And if the frame of reference is the narrower organizational field of Cancer Centers, can we really assume that our oncologists were challengers? We demonstrated that they had on some topics more resources (and also more legitimacy) than what could be called the “traditional surgeons”, so here again by some token they were challengers whereas by some other they were also incumbents. Second, and perhaps more important, this dichotomy prevents to see that it was precisely the fact that our “socially skilled actors” were both insiders and outsiders which helped them succeed in their reform enterprise. They were challengers who tried to change the traditional approach of cancer-care, but they were able to accommodate the reform with “old repertoires” and “traditional identity” because they were also part of the “incumbents” (and incidentally had been educated in this group). And last, but certainly not least, the rigid vision of a fight between “challengers” and “incumbents” or “renegades” against “institutional operators” tends to forget that the issues of change owe more to an interaction between these foes than to a revolutionary upheaval where one victorious vision replaces another defeated one. A reform is an encounter of conflicting claims, but never an all for nothing proposal : if it is to succeed, its content owes as much to incumbents as to challengers, it is the product of their interaction. Successful reformers or change entrepreneurs are not simply “destroyers of institutions” (Beckert 1999: 788), and they do not simply operate “outside institutional norms” (Kondra and Hinings 1998: 753). Reality is more complex: successful reformers may destroy some institutions, they may disregard some institutional norms, but they do so by using (and thus strengthening) other existing institutions or other institutional norms, and more importantly by turning around old repertoires to make them produce new results, by combining, operating through “bricolage” and tinkering of old and new, to construct something different from what there was.

### **3. CONCLUSION: THE INTERACTIVE NATURE OF INSTITUTIONAL CHANGE**

The characteristics of the process of institutional change which we have observed lead us to emphasize the interactive nature of such processes. The word interactive has implications on two levels of analysis which we should like to comment on in this conclusion.

The first and most evident meaning of the word refers to the simple empirical fact that the modernization of the organizational field of Cancer Centers cannot be seen as reflecting mere adaptation to outside pressures. Outside pressures were not strong, not explicit, not specified and not consistent enough to determine any precise direction of change. At best they provided a background and a climate on which the project or will for reform could be grounded and which was loaded with possible and divergent directions and repertoires of action on which modernization could draw. When we look at the unfolding of the process, we realize that action by the reformers actually blurred the distinction between what is inside the organizational field and what is part of its environment. Their action consisted of programs and ideas taken from different environments and different constituencies, blending them with endogenous ingredients based on the traditional collective identity of Cancer Centers and

mixing everything into an original package the implementation of which succeeded in reinstating Cancer Centers as the leading institutions in French cancer-care<sup>31</sup>.

What's more, we realize that instead of unilateral adaptation, we have a process where transformations in the environment generate pressures for change inside, but where in turn changes in the organizational field of Cancer Centers transform conditions in the larger environment of cancer-care and even healthcare. Here again, to give but one example. As we have shown, the sector of cancer-care is now quite different from what it was at the beginning of the 1990s: it is now much more hierarchically structured than before (with Cancer Centers and university hospitals on top, and other general hospitals and clinics in a subordinate role), and it is structured around the pathology-centered approach represented by the Cancer Centers.

Therefore, the reform-strategy the unfolding of which we have observed cannot be described in terms of acquiescence, manipulation, resistance, imitation (Oliver 1991): it is not any of these categories alone. It is all that and more, it is a mix of endogenous ingredients and exogenous elements. It is the story of internal resources enabling the perception, the re-framing and the transposition of external transformations. It is a package put together by skilled actors using their cognitive and political frames and resources and capitalizing on endogenous and exogenous dynamics, a package which in turn provides resources to become proactive and to in turn structure the environment, i.e. exert pressure on the outside. Inside and outside are in this perspective not a dependent and an independent variable, but an interdependent entity, environmental pressures and organizational responses being simultaneously resource and constraint for the actors who are engaged in the field and whose action is both structured by, and structuring for, each other.

This theoretical frame seems to us congruent with some convincing case studies dealing with social movement theory, although the authors did not emphasize this point. For instance, the story of the US recycling industry told by Lounsbury, Ventresca and Hirsch (2003) shows well how the interdependence between institutional factors and the actions of key actors must be taken into account. In this case, changes in the regulative environment opened up opportunities for grass-roots activists to promote, in alliance with some national advocates, the recycling frame at the expense of the resource recovery frame. Their actions contribute to changes in the institutional environment (creation of social-movement organization, de-institutionalization of the resource recovery frame, creation of some non-profit recycling centers, "diffusion of a set of understandings and practices among consumers and communities", etc.), which in turn allow some solid waste conglomerates to capitalize on these changes to instate themselves as leaders of an emergent for-profit recycling industry. Another illustration of such mechanisms can be found in the creation of the Health Maintenance Organizations (HMO) and the Independent Practice Association (IPA) (Rao, Morrill and Zald 2000). Both organization forms emerge as some entrepreneurs convinced other actors of their relevance in a changing environment. On the one hand, Nixon administration had been convinced that HMO could be the solution to "the rising popular concern with health care and health costs". On the other hand, IPA was a "counter-movement" to the development of HMO promoted by physicians (Rao, Morrill and Zald 2000: 268). IPA represented an organizational compromise for physicians who were very prone to defend their formal independence while conforming to the pre-payment orientation

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<sup>31</sup> Clemens (1993) underlined similar phenomena in her study of the feminist movement: she pointed at the ability of the women's groups to use and adapt existing non-political models of organization – what she called "organizational repertoires" – for political purposes.

in the American healthcare system. It is also particularly interesting to notice that both organization forms derived from marginal “old” organizations that already existed in the field, which fits with our argument on the importance of studying the mix of endogenous and exogenous elements in any institutional change process.

More fundamentally, the word “interactive” refers to a theoretical perspective which could be called an actor-centered institutionalism, where social action is conceptualized as being carried out by purposive social actors embedded in a context of strategic interdependence. In such a perspective, institutional change as well as institutional stability and order are the outcomes not of impersonal processes, but of concrete interaction sequences the relatively autonomous dynamics and logics of which have to be reconstructed if we want to explain institutional change. Change, therefore, is never something that just happens. It is not a fatality, it is not the automatic product of the progress of society. It is a problem for human agency to manage (Crozier and Friedberg 1980 [1977]) in such contexts of strategic interdependence. Such management is obviously conditioned by the transformation of the technical elements in its environments: the progress of knowledge, the discovery of new technologies and new skills for problem-solving. It is also mediated to existing cultural templates, symbolic codes and normative frameworks wherefrom it draws its cognitive frames and its capacity to diagnose new problem-constellations. But it is also contingent in the true sense of the word: dependent upon environmental conditions of all kinds, but also indeterminate, i. e. the product of chance and the product of human choice.

Such a perspective on institutional change seems to us to have at least three major implications for social theorizing which we can comment on only briefly. The first concerns the underlying vision of society not as a unified, homogenous and continuous space of action, but as a patchwork and juxtaposition of relatively autonomous local, i.e. partial orders subject to a multitude of partial regulations, the consistency, homogeneity and hierarchization of which are never complete. Individuals or more generally social actors, be they individual or collective, are parts of many such orders each of which exerts pressures on their respective rationalities and contributes to the formation of their identities which must therefore be considered to be open, unfinished and unstable. As Granovetter in a much misunderstood article has shown convincingly (Granovetter 1985), the stability (or, for that matter, the instability) of their behavior is not obtained once and for all, through a general socialization and/or through general, non contextualized rules, nor through general contractual arrangements (as a hard rational choice perspective would have it). It is in fact (re)constructed by the actors’ “embeddedness” in ongoing interaction processes, i.e. concrete exchange and bargaining relations, in which social control is continually challenged and (re)produced.

Such a vision of society as a patchwork of discontinuous and often contradictory, partial regulations and local orders, and that is the second comment, carries a vision of the actor which is incompatible both with holistic approaches leading straight to a sociologistic “over-socialized” conception of man as the passive bearer of social norms and social structure, and with “hard”, de-contextualized and “under-socialized” conceptions of intentional, utility-maximizing man characteristic of standard economic theory as well as of much of efficiency-driven organization theory. As Menger (1997) has shown in a well documented and well reasoned article, each of these two views share the same tendency to deterministic reasoning and have difficulties in integrating change in their analytical framework<sup>32</sup>. What we need

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<sup>32</sup> In particular, Menger (1997) shows that economics and sociology can both be partitioned along a divide between deterministic and non-deterministic frameworks, the latter being the characteristic of inter-actionist perspectives in which the identity of actors is specified only by the nature of their participation in cooperative relations of strategic interdependence (p.597) and in which interaction is always also a

instead, is a theoretical perspective which at all levels of analysis<sup>33</sup> makes place for an “*actors capacity to reinterpret and mobilize an array of resources in terms of cultural schemas other than those that initially constituted the array*” (Sewell 1992: 19) as well as of his or her capacity to exert “*some degree of control over the social relations (structures) in which one is enmeshed, which in turn implies the ability to transform those social relations (structures) to some degree*” (Sewell 1992: 20).

What is at stake here, is the conception of what could be called a soft methodological individualism which cuts across this well established divide between holistic and individualistic perspectives on social action. This special blend of methodological individualism attempts to follow a middle road by recognizing the relative autonomy of the individual in his or her relationship to social structure, and thus his or her capacity as actors, i.e. generators of the very structures (identities) which constrain them. As a consequence, social structure is conceived of as at the same time producing the actors and their action<sup>34</sup> and being (re)produced by them and their action. In other words, actors and structure, while being analytically distinct categories, are reciprocally related in mutual non-identical (re)production. And as social actors, individuals are always both rule-following and consequential in their action. Rules are a resource in their quest for intelligence by helping them overcome their cognitive limitations. And intentional, consequential action will help them in their constant effort to change the relational construct through which they may exist as social actors.

A last implication of such a perspective should be stressed. The relational constructs which at the local level mediate societal (cultural) influences and produce the stability of human behavior, are political constructs, i.e. are based on power and bargaining. Power therefore should again become a central concept in the analysis of institutional change. Not power in any abstract or conventional sense, as the product of structural domination, where those who have power impose their will on those who do not have any power. Power in a concrete sense where it diffuses in the entire social structure (Foucault 1976), where in fact it is a basic ingredient of the exchange relations between actors placed in a context of strategic interdependence (Emerson 1962; Crozier 1965 [1964], 1973 [1970]). There, power can be conceptualized relationally as the unequal and (tacitly or overtly) negotiated exchange of possibilities of action (capacities to solve problems), which, once institutionalized through habit and calculus, will generate rules of the game which momentarily (but never definitely) canalize the participants’ behavior (Crozier and Friedberg 1980 [1977]; Friedberg 1990, 1997 [1993]). These “rules of the game” simultaneously function as cognitive frames which define around which relevant uncertainties (or problems) the interdependence among actors is structured and what each of them can win or lose in the game<sup>35</sup>.

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formative process of the identities of the actors participating in the interaction (p.599), where in other words the individual actors change over time as they produce a changed context. Biggart and Beamish (2003) develop quite a similar argument, and propose the economic sociology of conventions as a solution. However, it seems to us that conventions, at least as we have seen them used, lead us back to the problem of institutions: unless one brings back in human agency and interactive processes understood as power-relations, i.e. unequal exchange relations of possibilities of action, the only (not very plausible and not very satisfactory) explanation for the emergence of such conventions seems to be their function (making possible human coordination).

<sup>33</sup> For individuals as well as for organizations (collective actors of all sorts) interacting with one another.

<sup>34</sup> Which therefore always have to be concrete and contextualized (Friedberg 1993 [1997]: chap. 8).

<sup>35</sup> Such a relational conceptualization of power and its implication for the understanding of the endogenous structuring of fields of action has been presented in detail in Crozier (1964 [1965] and 1973 [1970]), in

Neo-institutionalism has brought society back into organizational and institutional analysis. In doing so, it has called attention to important social mechanisms and has rendered great service to the realism and social relevance of the study of collective action and organized behavior. In doing so, however, it has had a tendency to over-socialize organizations and institutional settings, to downplay the relative autonomy of the different parts and levels of society and to neglect, if not to say ignore human agency as the motor of social processes. Bringing the actor back into the picture necessarily complicates matters. It makes sweeping generalizations more difficult, it calls for contextualized description and, more important still, for the reconstruction of the empirical interaction systems and feedback loops through which social action and institutional order (as well as its obverse, institutional disorder and change) are produced. But that is what an actor-centered institutionalism for the study of complex interaction processes in multi-level nested fields of action is about.

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## Bibliography

- Barley, S. R., and P. S. Tolbert** (1997). "Institutionalization and Structuration: Studying the Links between Action and Institution." *Organization Studies* 18 (1): 93-117.
- Barnett, W. P., and G. R. Carroll** (1995). "Modeling Internal Organizational Change." *Annual Review of Sociology* 21: 217-236.
- Baum, J. A. C., and J. V. Singh** (1994). "Organizational Niches and Dynamics of Organizational Mortality." *American Journal of Sociology* 100 (2): 346-380.
- Baum, J. A. C., and J. V. Singh** (1996). "Dynamics of Organizational Responses to Competition." *Social forces* 74 (4): 1261-1297.
- Beckert, J.** (1999). "Agency, Entrepreneurs and Institutional Change. The Role of Strategic Choice and Institutionalized Practices in Organizations." *Organization Studies* 20 (5): 777-799.
- Bensing, J.** (2000). "Bridging the Gap. The Separate Worlds of Evidence-Based Medicine and Patient-Centered Medicine." *Patient Education and Counseling* 39: 17-25.
- Berg, M.** (1995). "Turning a Practice into a Science: Reconceptualizing Postwar Medical Practice." *Social studies of science* 25: 437-476.
- Biggart, N. W., and T. D. Beamish** (2003). "The Economic Sociology of Conventions: Habit, Custom and Routine in Market Order." *Annual Review of Sociology* 29: 443-464.
- Brunsson, N.** (1989). *The Organization of Hypocrisy*. New York: J. Wiley & Sons.
- Bud, R. F.** (1978). "Strategy in American Cancer Research after World War II: a case study." *Social Studies of Science* 8 (4): 425-459.
- Burns, T., and G. M. Stalker** (1961). *The Management of Innovation*. London: Tavistock.

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Crozier and Friedberg (1980 [1977], especially part three) and Friedberg (1990 and 1997 [1993], especially part two).

- Callon, M.** (1986). “Eléments pour une sociologie de la traduction.” *L’année sociologique* 36: 169-208.
- Castel, P.** (2002). *Normaliser les pratiques, organiser les médecins. La qualité comme stratégie de changement. Le cas des Centres de Lutte Contre le Cancer*, Unpublished Ph.D. dissertation, Sciences Po Paris.
- Castel, P., and I. Merle** (2002). “Quand les normes de pratiques deviennent une ressource pour les médecins.” *Sociologie du Travail* 44 (3): 337-355.
- Clemens, E. S.** (1993). “Organizational Repertoires and Institutional Change: Women’s Groups and the Transformation of U.S. politics, 1890-1920.” *American Journal of Sociology* 98: 755-798.
- Clemens, E. S., and J. M. Cook** (1999). “Politics and Institutionalism: Explaining Durability and Change.” *Annual Review of Sociology* 25: 441-466.
- Cohen, M. D., J. G. March and J. P. Olsen** (1972). “A Garbage-Can Model of Organizational Choice.” *Administrative Science Quarterly* 17 (1): 1-25.
- Commission d’Orientation sur le Cancer** (2003). *Rapport remis au Ministre de la Santé*. Paris: Direction Générale de la Santé.
- Contandriopoulos, A.-P., and Y. Souteyrand** (1996). *L’hôpital stratège. Dynamiques locales et offre de soins*. Paris: John Libbey Eurotext.
- Crozier, M.** (1965). *The Bureaucratic Phenomenon*. Chicago: University of Chicago Press (French first edition: *Le Phénomène bureaucratique*, Paris: Seuil, 1964).
- Crozier, M.** (1973). *The Stalled Society*. New York: Viking Press (French first edition: *La Société bloquée*, Paris: Seuil, 1970).
- Crozier, M., and E. Friedberg** (1980). *Actors and systems: the politics of collective action*. Chicago/London: University of Chicago Press (French first edition: *L’Acteur et le système*, Paris: Seuil, 1977).
- D’Aunno, T., M. Succi, and J. A. Alexander** (2000). “The Role of Institutional and Market forces in Divergent Organizational Change.” *Administrative Science Quarterly* 45: 679-703.
- DiMaggio, P. J.** (1988). “Interests and Agency in Institutional Theory.” In *Institutional Patterns and Organizations: Culture and Environment*, edited by Lynne G. Zucker. Cambridge, Ma.: Ballinger, Pp.3-21.
- DiMaggio, P. J., and W. W. Powell** (1983). “The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields.” *American Sociological Review* 48: 147-160.
- DiMaggio, P. J., and W. W. Powell** (1991). “Introduction.” In *The New Institutionalism in Organizational Analysis*, edited by W. W. Powell and P. J. DiMaggio. Chicago: University of Chicago Press, Pp.1-38.
- Edelman, L. B.** (1992). “Legal Ambiguity and Symbolic Structures: Organizational Mediation of Civil Rights Law.” *American Journal of Sociology* 97 (6): 1531-1576.
- Emerson, R. M.** (1962). “Power-Dependence Relations.” *American Sociological Review* 27 (1): 31-41.
- Evidence-Based Medicine Working Group** (1992). “A new approach to teaching the practice of medicine.” *JAMA* 268 (17): 2420-2425.

- Fligstein, N.** (1997). "Social Skill and the Institutional Theory." *American Behavioral Scientist* 40: 397-405.
- Fligstein, N.** (2001). "Social Skill and the Theory of Fields." *Sociological theory* 19 (2): 105-125.
- Foucault, M.** (1976). *La volonté de savoir*. Paris: Gallimard.
- Friedberg E.** (1990). "Generalized Political Exchange, Organisational Analysis and Public Policy." In *Generalized Political Exchange, Antagonistic Co-operation and Integrated Policy Circuits*, edited by B. Marin. Frankfurt/Main Boulder: Campus/Westview, Pp.185-199.
- Friedberg, E.** (1997). *Local orders*. Greenwich: JAI-Press (French first edition: *Le pouvoir et la règle*, Paris: Seuil, 1993).
- Friedberg, E.** (1998). "En lisant Hall et Taylor : néo-institutionnalisme et ordres locaux." *Revue Française de Science Politique* 48 (3-4): 507-514.
- Friedland, R., and R. R. Alford** (1991). "Bringing Society Back In: Symbols, Practices, and Institutional Contradictions." In *The New Institutionalism in Organizational Analysis*, edited by W. W. Powell and P. J. DiMaggio. Chicago: University of Chicago Press, Pp.232-263.
- Granovetter, M.** (1985). "Economic Action and Social Structure: The Problem of Embeddedness." *American Journal of Sociology* 91 (3): 481-510.
- Grémion, C.** (1979). *Profession: décideurs. Pouvoir des hauts fonctionnaires et réforme de l'Etat*. Paris, Gauthier-Villars.
- Hage, J., and M. Aiken** (1970). *Social Change in Complex Organizations*. New York: Random House.
- Hannan, M. T., and J. Freeman** (1977). "The Population Ecology of Organizations." *American Journal of Sociology* 82 (5): 929-964.
- Hannan, M. T., and J. Freeman** (1984). "Structural Inertia and Organizational Change." *American Sociological Review* 49: 149-164.
- Hirsch, P. M.** (1997). "Sociology without Structure: Neoinstitutional Theory Meets Brave New World." *American Journal of Sociology* 102 (6): 1702-1723.
- Hirsch, P. M., and M. Lounsbury** (1997). "Ending the Family Quarrel. Toward a Reconciliation of "Old" and "New" Institutionalisms." *American Behavioral Scientist* 40 (4): 406-418.
- IGAS** (1993). *L'apport des Centres de Lutte Contre le Cancer à la politique de lutte contre le cancer*. Report n° 93158.
- Institute of Medicine** (1990). *Clinical practice guidelines: directions for a new program*. Washington: National Academy Press.
- Jamous, H., and B. Petoille** (1970). "Professions or self-perpetuated systems? Changes in the French University-Hospital System." In *Professions and professionalization*, edited by J. A. Jackson. London: Cambridge University Press, Pp.109-152.
- Kaluzny, A.D., and R.B. Warnecke** (2000). *Managing a Health Care Alliance: Improving Community Cancer Care*. Washington D.C.: Beard Books.
- Kondra, A. Z., and C.R. Hinings** (1998). "Organizational Diversity and Change in Institutional Theory." *Organization Studies* 19 (5): 743-767.

- Kraatz, M. S., and E. J. Zajac** (1996). “Exploring the Limits of the New Institutionalism: the Causes and Consequences of Illegitimate Organizational Change.” *American Sociological Review* 61 (5): 812-836.
- Lawrence, P. R., and J. W. Lorsch** (1967). *Organization and Environment: Managing Differentiation and Integration*. Cambridge, Ma.: Harvard Business School.
- Lounsbury, M., M. Ventresca, and P. M. Hirsch** (2003). “Social Movements, Field Frames and Industry Emergence: a Cultural-Political Perspective on US Recycling.” *Socio-Economic Review* 1: 71-104.
- Löwy, I.** (1996). *Between Bench and Bedside*. Cambridge, Mass.: Harvard University Press.
- Marks, H.** (1997). *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900-1990*. Cambridge, Mass.: Cambridge University Press.
- Menger, P.-M.** (1997). “Temporalité et différences inter-individuelles : l’analyse de l’action en sociologie et en économie.” *Revue Française de Sociologie* 38: 587-633.
- Menoret, M.** (2002). “The Genesis of the Notion of Stages in Oncology: the French Permanent Cancer Survey (1943-1952)”, *Social History of Medicine* 15 (2): 291-302.
- Meyer, J. W., and B. Rowan** (1977). “Institutionalized Organizations: Formal Structure as Myth and Ceremony.” *American Journal of Sociology* 83: 340-363.
- Minvielle, E., and A.-P. Contandriopoulos** (2000). « La conduite du changement : quels enseignements tirer des opérations de restructuration hospitalière ? », *Premier colloque international des économistes français de la santé*, Paris.
- Oliver, C.** (1991). “Strategic Responses to Institutional Processes.” *Academy of Management Review* 16 (1): 145-179.
- Oudin, J.** (1998). *La politique de lutte contre le cancer en France*. Rapport d’information du Sénat, Commission des finances.
- Perrow, C.** (1967). “A Framework for the Comparative Analysis of Organizations.” *American Sociological Review* 32: 194-208.
- Pfeffer J.** (1981). *Power in Organizations*. Boston: Pittman.
- Pfeffer J. and G.R. Salancic** (1978). *The External Control of Organizations*. New York: Harper and Row.
- Pinell, P.** (2002). *The birth of a scourge: the anti-cancer war in France 1890-1940*. London-New York: Routledge.
- Powell, W. W.** (1991). “Expanding the Scope of Institutional Analysis.” In *The New Institutionalism in Organizational Analysis*, edited by Walter W. Powell and Paul J. DiMaggio. Chicago: University of Chicago Press, Pp.183-203.
- Rao H., C. Morrill, and M. N. Zald** (2000). “Power Plays: How Social Movements and Collective Action Create New Organizational Forms.” *Research in Organizational Behaviour* 22: 239-282.
- Remontet, L., and al.** (2003). *Evolution de l’incidence et de la mortalité par cancer en France de 1978 à 2000*. Institut National de Veille Sanitaire.
- Scott, W. R.** (1993). “The Organization of Medical Care Services: Toward an Integrated Theoretical Model.” *Medical Care Review* 50: 271-303.

- Scott, W. R.** (1999). “A Call for Two-Way Traffic: Improving the Connection Between Social Movement and Organization/Institution Theory.” *Working Paper*.
- Scott, W. R.** (2001). *Institutions and Organizations*. Thousand Oaks, CA.: Sage.
- Scott, W. R. and J. W. Meyer** (1983). “The Organization of Societal Sectors”, in *Organizational Environments: Ritual and Rationality*, edited by J. W. Meyer and W. R. Scott. Beverly Hills, CA: Sage, Pp.129-154.
- Selznick, P.** (1957). *Leadership in administration*. New York: Harper and Row.
- Sewell, W. H.** (1992). “A Theory of Structure: Duality, Agency, and Transformation.” *American Journal of Sociology* 98 (1): 1-29.
- Singh, J. V., D. J. Tucker and A. G. Meinhard** (1991). “Institutional Change and Ecological Dynamics.” In *The New Institutionalism in Organizational Analysis*, edited by W. W. Powell and P. J. DiMaggio. Chicago: University of Chicago Press, Pp.390-422.
- Slack, T. and C.R. Hinings** (1994). “Institutional Pressures and Isomorphic Change: an Empirical Test.” *Organization Studies* 15 (6): 803-827.
- Stratégie canadienne de lutte contre le cancer** (2002). *Rapport final, Groupe de travail sur les traitements*. Ottawa.
- Suchman, M. C.** (1995). “Managing Legitimacy: Strategic and Institutional Approaches.” *Academy of Management Review* 20 (3): 571-610.
- Timmermans, S., and M. Berg** (2003). *The Gold Standard*. Philadelphia, Pa.: Temple University Press.
- Woodward, J.** (1965). *Industrial Organization: Theory and Practice*. London: Oxford University Press.