THE INFLUENCE OF SOCIAL POSITION ON SENSEMAKING ABOUT ORGANIZATIONAL CHANGE

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Traditionally, scholars have examined the influence of actors' sensemaking on context; in this paper, we explore the reverse. Employing Bourdieu's theory of practice we explore how actors' unique contexts, as encapsulated by their social positions, provide the important "raw materials" for their sensemaking about organizational change. Drawing on a case study of three focal actors, located in different social positions in the National Health Service in England, but tasked with enacting a common organizational change, we explore how actors' capital endowments and dispositions shape their sensemaking about organizational change. We conclude by developing a theoretical model of the influence of social position on sensemaking about organizational change and discuss the practical implications of paying closer attention to the social positions of actors engaged as change agents.

Organizational change projects rarely claim the substantial success that is intended (Beer, Eisenstat, & Spector, 1990; Taylor-Bianco & Schermerhorn, 2006). Organizational change is problematic because it undermines and challenges actors' existing schemata, which serve as the interpretive frames of reference through which to make sense of the world (Moch & Bartunek, 1990). The resultant ambiguity necessitates the development of new schemata through sensemaking processes (Bartunek, 1984). In developing new schemata, actors do not sensemake in a vacuum (Taylor & Van Every, 2000; Weber & Glynn, 2006); rather, actors sensemake from a variety of organizational positions, histories, and personal backgrounds, which serve to orient their sensemaking about organizational change towards the development of different schemata (Dutton & Dukerich, 1991; Gephart, 1993; Weick, 1995), negotiated through processes of social interaction (Maitlis, 2005).

Traditionally, scholars of sensemaking and organizational change have examined the influence of actors' sensemaking on context, through the (re)formation of roles and relationships (Bartunek, 1984; Labianca, Gray, & Brass, 2000; Maitlis, 2005; Nigam & Ocasio, 2010). In this paper, we explore the reverse: the influence of context on sensemaking. To date, scholars have examined actors' contextual influences on the social processes of sensemaking in terms of actors' group membership (e.g., Balogun & Johnson, 2004, 2005) and patterns of social interaction (e.g., Balogun & Johnson, 2004, 2005; Maitlis, 2005). Although the literature acknowledges that individual actors' contexts

shape their sensemaking about organizational change, the focus of analysis has been on group-level sensemaking processes. Absent from these studies is a consideration of the role of individual actors' contexts on their sensemaking, which embraces individuals' unique positions, histories, and backgrounds.

Addressing how individual actors' contexts shape sensemaking is important because it provides actors with a "manual or set of raw materials for disciplined imagination" (Weick, 1995: 18), which acts as an important antecedent that shapes actors' sensemaking about organizational change. By understanding how actors' unique contexts shape sensemaking, we will be better able to understand why the content of actors' sensemaking may differ when confronted with a common phenomenon and how the social processes of sensemaking processes will be influenced accordingly. In so doing, our aim is to understand why attempts to enact organizational change—as shaped by sensemaking processes—rarely claim the substantial success that is intended and, in many cases, lead to unintended outcomes.

In this paper, we draw on field theorists' concepts of social position (see Sauder, 2008) and the "theory of practice" proposed by Bourdieu (1977), to conceptualize the interaction between actors and the context in which they are located (Battilana, 2006, 2011). For Bourdieu (1986), each actor is located in a unique social position, as defined by his or her control of the capital resources (economic, cultural, and social) that actors accumulate through their lived experience. Capital resources, in turn, shape actors' dispositions towards the field (Bourdieu, 1988). Dispositions are actors' enduring schemes of perception, interpretation, and action, which are acquired through the lasting experience of their social position (Bourdieu, 1989). Employing Bourdieu's notions of "capital" and "disposition," we explore the multidimensional nature of social positions (Battilana, 2006, 2011), to examine how an actor's social position influences his or her sensemaking about organizational change and his or her subsequent actions.

In connecting actors' social positions to their sensemaking about organizational change, we draw on an in-depth qualitative case study of the National Health Service (NHS) in England. Our study examines the sensemaking of three focal actors, located in different social positions, but tasked with interpreting and enacting a common organizational change for the "mainstreaming" of cancer genetics services.

SENSEMAKING AND ORGANIZATIONAL CHANGE

Over the last 20 years, scholars have devoted significant attention to understanding the cognitive and social processes that shape attempts at organizational change (Bartunek, Balogun, & Do, 2011). Organizational change creates tensions between old and new, proposed schemata, creating the need for sensemaking as actors begin to act in a conscious and less automatic fashion (Balogun & Johnson, 2004; Fiske & Taylor, 1991). Sensemaking is based on the idea that "reality is an on-going accomplishment that emerges from efforts to create order and make retrospective sense of what occurs" (Weick, 1993: 635). Actors work through a process of social construction, whereby they interpret and explain the information that they receive in order to produce what appears to them to be a plausible account of the world to enable action. Sensemaking therefore forms the groundwork for understanding actors' perspectives on organizational change and is an ongoing process as actors make sense of change as it happens (Gioia & Chittipeddi, 1991; Gioia & Thomas, 1996; Maitlis, 2005; Sonenshein, 2010).

Context and Sensemaking

In assigning meaning to experience, scholars have drawn attention to the importance of schemata, which are the cognitive frameworks (Labianca et al., 2000) through which knowledge from prior experiences are stored (Bartlett, 1932; Rumelhart & Ortony, 1977). Schemata act as data reduction devices, enabling actors to make sense of complexities of organizational change (Bartunek, 1984; Bartunek & Moch, 1987). Actors' sensemaking about organizational change depends on their unique individual contexts, including organizational positions, histories, and personal backgrounds, which orientate their sensemaking towards the development of different schemata (Dutton & Dukerich, 1991; Gephart, 1993; Weick, 1995). For Weick (1995), sensemaking is a process that is simultaneously ongoing and retrospective, such that it cannot be divorced from actors' "lived experience."

Weick (1995: 18) detailed seven properties of sensemaking, which he described as "an observer's manual or a set of raw materials for disciplined

imagination," of which three directly relate to actors' contexts. First, sensemaking is grounded in identity construction—that is, who people think they are in their context shapes how they see the world (Currie & Brown, 2003; Pratt, 2000; Thurlow & Mills, 2009; Weick, Sutcliffe, & Obstfeld, 2005). Second, sensemaking is retrospective, being based on "meaningful lived experience" (Schultz, 1967), with actors drawing on their experiences to make sense of what they are currently doing (Labianca et al., 2000). Third, sensemaking is a social process, which is both individual and shared, representing "an evolving product of conversations with ourselves and with others" (Currie & Brown, 2003: 565).

In linking actors' contexts to sensemaking, scholars have explored the influence of actors' organizational roles on the social processes of sensemaking (e.g., Balogun & Johnson, 2004; Bushe & Kassam, 2005; Bushe & Marshak, 2009; Huy, 2002; Sonenshein, 2010; Thomas, Sargent, & Hardy, 2011). Change actors in different groups (Donnellon, Grey, & Bougon, 1986; Heracleous & Barrett, 2001; Meyerson & Martin, 1987), in different functional areas (Strasser & Bateman, 1983), or at different hierarchical statuses or levels (Chreim, 2005; Gioia & Chittipeddi, 1991; Gioia & Thomas, 1996) often see the same event in very different ways, as they draw on different schemata for sensemaking and the development of new schemata to support change.

Relatedly, scholars have examined how actors' patterns of interaction shape the social processes of sensemaking (Balogun & Johnson, 2004; Bartunek, Rousseau, Rudolph, & DePalma, 2006; Maitlis, 2005; Maitlis & Sonenshein, 2010; Sonenshein, 2010). For example, Balogun and Johnson (2004, 2005) focus on the role of middle managers in sensemaking around organizational restructuring, arguing that, through processes of social negotiation, new schemata emerge as the basis of collective activity across different functional divisions. Similarly, Maitlis (2005) shows how the extent to which diverse organizational stakeholders engage in sensemaking shapes the resulting patterns of social interaction and associated sensemaking activities and outcomes. Thus the elaboration or development of new schemata is achieved through social processes of negotiation, in which old, existing frames of reference are challenged (Balogun & Johnson, 2004, 2005; Labianca et al., 2000; Maitlis, 2005).

In summary, the literature acknowledges that individual actors' contexts shape their sensemaking about organizational change—but there remain two important gaps in our understanding of how. First, existing studies have focused on group-level sensemaking processes and, in so doing, have not examined how actors' unique positions shape their sensemaking. Second, with the exception of Balogun and Johnson (2004, 2005), studies have neglected the multidimensional and interactive nature of actors' contexts, typically examining only single dimensions, such as group membership and patterns of social interaction. Hence the richness and importance of actors' "lived histories," which provide the "raw materials" of sensemaking, remain a largely empirically unexplored and under-theorized aspect of sensemaking. By addressing the influence of actors' unique contexts on sensemaking, we can explore how actors, when confronted with a common phenomenon, may sensemake in different ways, in terms of both the content and the process of their sensemaking. In so doing, our aim is to provide new insights into the process of organizational change and, in particular, into the sensemaking processes that inform or direct change, which in many cases lead to unintended outcomes.

To help to conceptualize actors' unique contexts, we draw on field theorists' concepts of social position and employ Bourdieu's theory of practice to link actors' social positions to their sensemaking about organizational change. We explore the concept of social position and Bourdieu's theory of practice in the next section.

Social Position and Bourdieu's Theory of Practice

Field theory is a "more or less coherent approach in the social sciences whose essence is the explanation of regularities in individual action by recourse to position vis-à-vis others" (Martin, 2003: 1). A central concept of field theory is "social position," which relates to an actor's "position in the structure of social networks" (Dorado, 2005: 397). Each actor's social position determines the set of persons to whom he or she is directly linked, which in turn affects his or her perception of his or her organizational field. As such, an actor's social position in a field "indicates the potential for a force exerted on the person, but a force that impinges 'from the inside' as opposed to external compulsion" (Martin, 2003: 1). Over time, actors' social positions become internalized, promoting the development of shared subjectivities and cultures

(Meyer, Boli, Thomas, & Ramirez, 1987; Meyer & Rowan, 1977).

Traditionally, scholars have drawn a distinction between social positions at the core and those at the periphery of fields (Battilana, Leca, & Boxenbaum, 2009). Actors located in peripheral social positions are more likely to initiate change that diverges from existing practice, but lack the power to be able to drive that change. Conversely, actors located in social positions at the core of a field are less likely to wish to enact change that diverges from existing practice, but are better able to do so if they so wish (Battilana et al., 2009). More recently, scholars have examined social positions between the field's core and periphery (Battilana, 2011; Phillips & Zuckerman, 2001). Drawing on two dimensions of social position, Battilana (2011) examined the joint effect of organizational and professional status—based on an elite/nonelite categorization—upon the nature of change initiated. She concluded her paper by arguing that social positions are more complex than her elite and nonelite categorization, which she employed for the purposes of her large-scale survey (of 93 clinical managers), suggesting that future research needed to account for what lies between the two positions. In doing so, Battilana (2011) cited the call of Phillips and Zuckerman (2001) to view social positions as multidimensional in nature.

To address the need to conceptualize social positions as being multidimensional in nature and following field theorists' interest in the work of Bourdieu (Sauder, 2008), we draw on Bourdieu's theory of practice (Bourdieu, 1977). Bourdieu's theory of practice focuses on the role of social practice in shaping, and being shaped by, the linked concepts of "field," "social position," "disposition," and "capital."[1] Fields represent a system of social positions, as defined by an actor's control of capital resources (economic, cultural, and social) and relationships among social positions (Bourdieu, 1986). Differences in actors' social positions, as reflected in their capital endowments, lead to a diversity of dispositions, which orient actors' subjective perceptions of the field (Bourdieu, 1988).

Dispositions are habitualized know-how, and enduring ways of seeing and believing, existing often at the unconscious and taken-for-granted level (Bourdieu & Wacquant, 1992), involving the inculcation of contextual elements into an actor's subjective, mental experience. Within a given field, influences will be manifest and articulated in various and uneven ways, depending on the actor's social position within the field (including formal role and relationships), thereby giving rise to subtle differences in individual and group dispositions (such as through membership of an professional occupation or organization). As dispositions become institutionalized, they shape social practice, producing regular and regulated action, without requiring the direct action or influence of others, much like institutional (rational) myths (Meyer & Rowan, 1977) or cognitive-cultural pillars (Scott, 2001). As such, dispositions act as a form of schemata, because they have a structuring quality that helps to reproduce patterns of behavior over time.

The particular form and features of actors' dispositions reflect individuals' unique social positions and relationships, and, importantly, the sources and forms of capital at their disposal. In its basic sense, capital refers to some form of currency, power, or endowment of resource that makes possible different actions and relations, with each field being characterized by different forms of currency, comprising the main three different capital forms (economic, cultural, and social).[2] Furthermore,

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[1] Bourdieu's theory of practice also includes the concept of "habitus" as a collective term for an actor's set of dispositions. In this paper, we focus on dispositions and how they link to specific capital endowments.

[2] In his later work, Bourdieu highlighted symbolic capital, which overlaps with economic, cultural, and social capital, and can be referred to as "the resources available to an individual on the basis of honor, prestige or recognition" (Bourdieu, 1984). It represents the ability to use and manipulate symbolic resources, such as language, writing, and myth (Everett, 2002). This capital captures "the capacity that systems of meaning and signification have of shielding, and thereby strengthening, relations of oppression and exploitation by hiding them under a cloak of nature, benevolence and meritocracy" (Wacquant, 1993: 1–2). Thus symbolic capital enables actors to impose their interpretations on others and control the perceptions that they provoke within others. As such, symbolic capital presents the ultimate basis of power through which field participants impose their vision of the way in which a field should be organized and the hierarchy of power effective in it (Meisenhelder, 1997). Furthermore, the "true nature" of the power associated with symbolic capital is typically misrecognized by the dominated field participants (Everett, 2002). We exclude symbolic capital from our analysis because it is enacted in and represented by the three main forms of capital.

capital structures the relationships in a field, because social relations are shaped by "differential access to a particular, dominant kind of capital" (Emibayer & Johnson, 2008: 37). Emibayer and Johnson (2008) argue that by (re)connecting Bourdieu's concepts of capital and disposition to organizational fields, scholars will be better able to deepen their understanding of the forces that shape actors' behavior.

Economic capital relates to the possession and control of financial capital, intellectual property, and shares, for example, and is directly and immediately convertible into money (Bourdieu, 1986). Economic capital is institutionalized through property rights and is commonly seen as a significant source of power.

Cultural capital comprises the knowledge, skills, tastes, preferences, and possessions that give advantage (or disadvantage) in the system of relations (Bourdieu, 1986). These aspects of culture and knowledge can take different forms, from the aesthetics, tastes, and ways of speaking acquired through socialization, to the institutionalized knowledge and skills that are acquired through formal training and qualification. Once acquired, these institutionalized forms of cultural capital also have symbolic potential to convey issues of reputation.

Social capital highlights the importance of the mutual relationships and acquaintances that reinforce or advance an actor's relative position of power within the field (Bourdieu, 1986), and includes interpersonal relationships and the resources embedded in those relationships (Burt, 1992). The three main dimensions of social capital are structural, relational, and cognitive (Nahapiet & Ghoshal, 1998):

- The *structural* dimension of social capital relates to an individual's network of contacts, which can be thought of as the density of relationships in a network, or the ability to span different networks.
- The *relational* dimension relates to the trust and reciprocity that underpins relationships.
- The *cognitive* dimension relates to understanding others' perspectives, and being seen to do so.

Individuals, through repeated interactions, can develop social capital through shared language and experiences, norms and sanctions, obligations and expectations.

Capital endowments define an actor's position and relative power within the field, and shape and reinforce his or her dispositions toward action (Crossley, 2001). Actors construct their social reality, entering into struggles and transactions oriented to promote their views, but do so with views and interests shaped by their dispositions and the (social) position that they occupy in the very world that they seek to transform or conserve (Bourdieu, 1989). Dispositions are generative in nature, shaping and being shaped by experience of the field and an actor's social position within it (Bourdieu, 1988; Bourdieu & Wacquant, 1992; Noble & Watkins, 2010). Bourdieu's theory of practice therefore enables scholars to connect actors' social positions to their sensemaking about organizational change.

EMPIRICAL SETTING AND METHOD

Our empirical setting is NHS England, which consists of numerous powerful stakeholders with divergent professional interests (Battilana, 2011). This provides an interesting vantage point from which to examine the interaction between an actor's context and sensemaking (Elsbach, 1994) surrounding organizational change. We employed an inductive research design, which was qualitative in nature, to enable contextualization, vivid description, and an appreciation of subjective views (Lee, 1999; Locke, 2001). We employed a multiple case study format, because it enables a more robust basis for theory building (Yin, 2003), and often yields more accurate and generalizable explanations than a single case study approach (Eisenhardt & Graebner, 2007).

Mainstreaming Cancer Genetics

The organizational change that we examine is an attempt to mainstream specialist cancer genetics services. In 2000, the Department of Health's *NHS Cancer Plan* (Department of Health, 2000) highlighted that cancer and genetics services were individual NHS priorities, but that cancer genetics services were poorly integrated with the rest of the system. Specialist geneticists and genetics counselors delivered cancer genetics care in tertiary care centers, which are specialist national or regional centers for health care in particular clinical domains, such as genetics, to which other "secondary" hospitals and community "primary" care clinicians may refer patients. However, the genetics centers were detached from patients' point of entry into the NHS via (mainly) primary care (encompassing community physicians, community nurses, and other local community-focused professionals)

and (to a lesser extent) secondary care (mainly hospitals, but some of which encompass tertiary care centers in particular clinical domains). The fragmented system led to inappropriate and unnecessary referrals, and use of specialist resources, and to low-risk cases being seen by specialists, while high-risk cases were sometimes missed, which was particularly significant in the face of a dramatic increase in the number of familial cancer referrals (Eeles, Purland, Maher, & Evans, 2007).

To address this problem, the Department of Health was keen to "mainstream" genetics knowledge and services into secondary care and primary care (see Department of Health, 2000; Secretary of State for Health, 2003). In conjunction with Macmillan,[3] it convened an expert working group to draw up a new model of patient service delivery (Eeles et al., 2007). The model was based on the development of two new organizational schemata: (a) genetics knowledge was to be distributed beyond tertiary care; and (b) there was to be an integrated model of referrals, across primary and secondary care. If achieved, the new schemata would enable doctors and nurses in primary and/or secondary care to perform a more effective risk assessment, triage, and genetics counseling role. However, the change would also have the consequence of substituting for the professional labor of cancer genetics specialist doctors that of doctors and nurses in primary and secondary care, with the additional consequence of moving resources from tertiary care to secondary and primary care.

The Department of Health funded a series of regional pilots to be tendered for and championed by healthcare professionals (Eeles et al., 2007). The policy intention was to "steer, not row" (Osborne & Gaebler, 1996), with the Department of Health's clinical lead for the program describing the pilots as "an experiment from which a template was expected to develop to inform future interventions, with considerable variation across the funded pilots, dependent upon local leaders and circumstances."

In the first set of awards, funding was allocated to four doctors, all located in tertiary or secondary care. No bids were received from actors located in primary care or from nurses. Consequently, a second tender was held in 2005, after which three awards were made to nurse-led services, all located

in primary care. Project award dates were staggered from late 2004 to late 2005. Once funded, each lead actor was tasked with developing the new cancer genetics services based on its vision of change between 2005 and 2006.

Data Collection

Three of the authors undertook data collection as part of a funded formative evaluation of the regional pilots. Given the potential closeness of the researchers engaged in the fieldwork and their closeness to the interviewees, we minimized stakeholder influence over the research in two main ways: first, the two remaining authors were kept separate from the data collection process at all times (Bernard, 2002); second, all interviewees and participants of observed meetings were presented with details of the nature of the project, and were required to complete a consent form before the interview and/or when the observation began. As such, the relationship between the researcher and the respondent was made clear at all times. The research was subject to strict NHS research governance and ethical guidelines.

Our research strategy involved collecting archival data, interview data, and observational field notes, to strengthen our ideas by triangulating sources of evidence (Jick, 1979). First, we examined relevant government White Papers (Department of Health, 2000, 2003) and associated publications (e.g., Macmillan Cancer Support, 2001). Second, we collected documentary information about all seven change interventions, including original bid documents and internal documents from pilots, such as strategy papers and minutes of meetings. In the terms of Gephart (1993: 1469), we were able to collate "a substantial archival residue."

We then embarked on a two-stage process of conducting interviews between 2004 and 2006. In the first stage (2004–05), we interviewed 21 stakeholders across the seven cases (including doctor and nurse service leads and business managers), focusing on the social positions of the focal actors charged with leading the pilot projects in terms of their dominant sources of influence and their embryonic visions of change.

Based on the analysis of the first-stage interviews (detailed below), in the second stage (2005–06) we theoretically sampled three cases employing a logic of "progressive focusing" (Parlett & Hamilton, 1976), examining actors located in different social positions, inter- and intraprofessionally. The re-

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[3] Macmillan Cancer Support is a charity that provides specialist health care, information, and financial support to people affected by cancer (www.macmillan.org.uk).

maining four cases informed our understanding of actors' social positions (including the sources of economic, cultural, and social capital) and our case selection for the second stage of our research, but we did not draw on them in that stage of the research. In total, we conducted 38 interviews in the second stage, with a range of different stakeholders, including geneticists, nurses (including nurse service leads), secondary care doctors, primary care doctors, business managers, and commissioners, to examine further what motivated actors to engage with the initiative, what they were seeking to achieve and why, and to what extent they thought that they would be able to achieve their aims. We ceased interviewing when we reached a position of theoretical saturation, in that the interviews were adding only marginal increases to our knowledge. The interviews were semi-structured, ranged in duration from one to two hours, were openly recorded, and afterwards were fully transcribed.

Third, we supplemented the archival information and interviews with over 70 hours of unique site-specific and program-wide observations. Two of the researchers conducted observations of the in-depth cases (including project management meetings, stakeholder forum meetings, dissemination events, and informal interactions and communications around the events) and attended program-wide meetings involving the focal actors for each case (including the national event meetings, dissemination events, and informal interactions and communications around the events). During the observations, the researchers took detailed notes and then wrote up a more expansive commentary post-observation, in which they reflected on what they had witnessed. Notes were written up on the day of the visit (Bernard, 2002).

Data Analysis

Data analysis involved three stages. In the first stage, the three authors who had conducted the fieldwork undertook initial coding of the data. In advance of the analysis, we assembled all of the documents, interview transcripts, and field notes for each of the cases into a single data file. This enabled us to share data across the research team. In order to understand the complexity of each project (Abbott, 1992), we coded the data on a within-case basis (Miles & Huberman, 1994).

The first stage of analysis, across all seven cases, examined the actors' social positions. The three researchers engaged in the fieldwork took two or three cases each and began with a fine-grained reading of the data (Strauss & Corbin, 1990). Guided by Bourdieu's theory of practice, the researchers coded for the focal actors' sources of influence and power, reflected in their economic, cultural, and social capital. We then consolidated our codes across the seven cases, drawing the following conclusions.

Actors' economic capital was based on the degree to which they were able to control financial resources, which centered on their influence over decisions about which services are to be delivered, the accompanying revenue streams that accrue, and additional funding from activities such as research. In NHS England, there is a separation of the commissioning (that is, the planning and purchasing of services) from the provision of services. Influence over commissioning may be formally granted by means of the role of commissioner or gained by means of providing the specialist knowledge, based on understanding of the complexity of healthcare delivery, necessary to inform commissioning decisions. In healthcare systems, because of their specialist knowledge, hospital-based doctors have a large degree of influence over commissioning decisions, even where such commissioning decisions are made outside of hospital arenas (Mays, Wyke, Malbon, & Goodwin, 2001).

Cultural capital shapes an actor's position in the professional hierarchy. Within the context of health care, in interprofessional terms doctors are positioned at the apex of the healthcare system, with nurses and other allied professionals subservient to them (Freidson, 1984). We also identified important stratifications within professions, with doctors or nurses located in tertiary centers (more highly specialized and research-focused) considered to be higher status than those in secondary or primary care (more generalist and frontline practice-focused). Those in primary care represented the lowest status intraprofessionally in the eyes of their peers. For the purposes of analytical clarity, we align cultural capital to inter- and intraprofessional group membership. However, our concern lies in understanding the nature of cultural capital—that is, the qualitative differences between knowledge, skills, tastes, preferences, and possessions, accruing from professional affiliation, which not only influence status, but also an actor's subjectivities—which defines group membership. In so doing, we are able to explain better *how* an actor's social position shapes his or her sensemaking about organizational change.

Based on the above analysis, we can describe our focal actors:

- *Ruth*, as a doctor located in tertiary care, represented high inter- and intraprofessional status;
- *Mark*, as a doctor in secondary care, represented high interprofessional status, but lower intraprofessional status; and
- *Florence*, as a senior nurse in primary care, represented low interprofessional status.

The cases presented are also drawn on in the work of Lockett, Currie, Waring, Finn, and Martin (2012), who examined the relationship between social position and the implementation of change—that is, the more downstream activities associated with change, drawing on the theory of institutional entrepreneurship. The cases in Lockett et al. (2012) can be cross-referenced with those in the current paper in parentheses as follows: Ruth (case B), Mark (case A), and Florence (case D).

The second stage of analysis involved each of the three field researchers taking one in-depth case in which to focus on the sensemaking activities of actors. We began with a fine-grained reading of the data (Strauss & Corbin, 1990); then, after inductively creating a list of first-order codes from the case evidence, we consolidated all of our codes across the three cases, progressing with axial coding, structuring the data into second-order concepts and more general aggregate dimensions (Corley &

Gioia, 2004; Strauss & Corbin, 1990). In doing so, we engaged in deductive reasoning whereby we linked our inductive codes with existing concepts and frameworks (Walsh & Bartunek, 2001). While we accept that our accounts are one of many potential interpretations (Van Maanen, 1998), we worked in two ways to ensure that we did not retrofit the data to service our theorizing (Wodak, 2004): first, we triangulated between data types; second, we triangulated across analysts, because only three of the five authors had been involved in data collection, which meant that the remaining two authors were able to challenge and interrogate their knowledge (Mantere, Schildt, & Sillice, 2012).

The structure of our data is presented in Table 1, for which we identified evidence from at least two interviews or observations and two archival sources. The coding for the actors' capital endowments was predetermined, based on Bourdieu's three main forms of capital (economic, cultural, and social). The remaining first-order codes were developed inductively.

We induced two main dispositions from our data. First was the extent to which an actor views the world through the lens of his or her professional group's interests, which we term "profession-centrism." In theorizing about the nature and influence of *profession-centrism*, we searched for relevant literature, which led us to Brennan et al. (2002) and Shamir (1995), and the literature on

TABLE 1
Data Structure

First-order codes	Theoretical categories	Aggregate theoretical dimensions
Degree to which actor has control over commissioning decisions	Economic capital	Social position
Control over multiple revenue streams to fund activity		
Inter- (doctor vs. nurse) and intra- (specialist vs. generalist) professional status	Cultural capital	
Status of primary, secondary, and tertiary care		
Diversity of relationships spanning inter- and intraprofessional boundaries	Social capital	
Focal concern of the actor's professional group	Profession-centrism	Disposition
Awareness and understanding of the interests and perspectives of other professional groups	Allocentrism	
Perception of degree to which he or she was able to act independently of the influence of others		
Why individuals had engaged with the model and what they saw as the opportunities arising from doing so	Opportunity construction	Schema of change
Expressed concerns as to whether or not they would be able to capitalize on the opportunity presented by the model	Opportunity problematizing	
Whether or not the change would lead to the coupling of services across primary, secondary, and tertiary care	Vision of change	
Potential distribution of genetic knowledge across primary, secondary, and tertiary		

sociology of professions (e.g., Abbott, 1988; Bucher & Strauss, 1961). We define profession-centrism as an orientation towards one's own inter- and intraprofessional group, which is inculcated through socialization (training and experience), and operates largely in a pre-reflexive manner, providing actors with a partial view of the game. Second was the extent to which an actor recognizes that his or her ability to enact change is contingent on the thoughts and actions of others, which we term "allocentrism." As with profession-centrism, we sought to link *allocentrism* with relevant literature, which we then linked to discussion of individualism and collectivism by Triandis (1995). Consistent with Bourdieu's theory of practice, we do not view the two dispositions as mutually exclusive: an actor can be both profession-centric *and* allocentric.

The first-order codes that we induced as to the actors' schemata of change related to three specific areas, which we organized around the second-order themes of "opportunity construction," "opportunity problematizing," and the "vision of change." Our coding structure here is consistent with the delineation of Balogun and Johnson (2004) between schema of the content and process of change. *Opportunity construction* comprised codes about why actors had engaged with the initiative and what they saw as the opportunities arising from doing so. *Opportunity problematizing* comprised codes about problems related to enacting any potential organizational change that actors identified. In developing our understanding of opportunity problematizing, we drew on the work of Labianca et al. (2000). *Vision of change* comprised codes about the nature of change that the actors sought to implement. Our interest was in identifying the extent to which the vision of change represented the creation of new organizational schemata promoted by the policy intent or the reproduction of existing organizational schemata.

The final stage of our analysis employed both inductive and deductive reasoning, traveling back and forth between data and theory, to develop an understanding of *how* an actor's social position shapes his or her sensemaking about the schema of organizational change (Locke, 2001; Miles & Huberman, 1994; Strauss & Corbin, 1990). In doing so, we induced the temporal sequencing of actors' sensemaking about the schema of organizational change, drawing on both within- and cross-case analysis (Eisenhardt, 1989). We present the second-order codes in the temporal sequence in which they emerged in the case histories (Van de Ven, 2007).

FIRST-ORDER WITHIN-CASE ANALYSIS

The following case narratives are presented in the words of the actors involved. We do not make any normative judgments as to the efficacy of actors' sensemaking about organizational change. All three actors sought to improve service, but did so in different ways. The illustrative data for our cases is presented in Table 2 (Ruth), Table 3 (Mark), and Table 4 (Florence).

Ruth, the Clinical Academic

Following her initial medical training, Ruth completed a Ph.D. and worked in a cancer research institute in the United States under the supervision of a world-renowned professor in cancer genetics. In terms of her current role, Ruth's primary affiliation was a professorship at a leading cancer research institute in England, but she also held an honorary clinical position (medical consultant) at a tertiary cancer center located in a leading teaching hospital. As such, she spanned the academic–clinician divide. Her focus was very much around "developing new knowledge" and "getting new discoveries in cancer genetics (to) immediately benefit patients." She described her peers as the international academic research community and policymakers in cancer genetics, commenting "I have not been too concerned with developing relationships with clinical practitioners, although I have tried to engage them in my research." Her lack of connectivity into the local cancer region was commented on by a cancer network manager, who described Ruth as being "fantastically knowledgeable about cancer genetics, wanting this baby bird to fly, [but she] has got no idea about how things work in the NHS." Despite this, Ruth perceived herself to be able to act with a relatively high degree of autonomy in translating knowledge generated by her research into practice. In the case of mainstreaming genetics, she assumed that doctors in primary care would merely "sign up" to her new service when visited by a representative of the project.

Prior to the launch of the initiative, Ruth had developed a model for reorganizing the delivery of cancer genetics care, so that referrals from primary care (and, to a lesser extent, secondary care) to tertiary care would be handled more efficiently through the use of a "virtual telephone-based clinic." The initiative presented Ruth with an opportunity to "test her model of service innovation . . . the hypothesis being that it would be a very

TABLE 2
Illustrative Evidence: Ruth

First-order codes	Theoretical categories
"We were quite privileged because we are a cancer centre, and a Trust, so we have more flexible funding possibilities, and have traditionally used funding streams from the cancer network."[a] The centre, located in the tertiary unit, has a good dedicated business development unit to help develop and sustain new services.[c]	Economic capital
"I am head of the cancer genetics unit . . . I have led a lot of the research because my primary contract is with the Institute of Cancer Research and I have an honorary contract with hospital A. Up until about a year ago, in fact I was entirely paid by the Institute."[a] The Cancer Genetics Unit is very research active and is a world leader in its field.[c]	Cultural capital
"We had links with the GPs, from memory, but the nurse counsellor will be able to tell you exactly, because she did the interactions."[a] The nurse counsellor based at [the tertiary care center] will establish links with various primary care groups and local hospitals in order to advertise the service.[c]	Social capital
"[The unit] has a big research infrastructure, a massive research infrastructure. [A]t the end of the day, we will take a decision about '[I]s having this particular service a logical part of our portfolio, given where we want to position ourselves in the market, what our core business is?' "[b] "The funding from [anon] was really a matter of funding the research."[a]	Profession-centrism
"We have found it difficult to engage GPs . . . and we don't know why. . . . I don't know why there is a difference with NHS GPs, whether it is a different motivation or feeling that it is not fair, but we have advertised it and it is also on a website."[a] "We always had a fair idea that it would meet targets [for the pilot]. We just thought it would work."[a]	Allocentrism
"We had already piloted some of the telephone clinics and thought that it was a good model, but we really hadn't had the opportunity to use it extensively, or to do a direct comparison because we didn't have the infrastructure to actually see if it really worked."[a] "It's also about being innovative and pioneering new services. So we have a lot to gain from first of all being a leader in cancer genetics services and being an innovator."[b]	Opportunity construction
"I think the engagement of GPs we need to assess in a bit more detail, but certainly it is my clinical impression that they maybe not making best use of the project."[a] The main issue is whether or not the service works—i.e., is cost-effective.[c]	Opportunity problematizing
"We're effectively charging the same amount for a telephone-based service as one that is face-to-face, and receiving increased referrals from some GP practices . . . [T]his will enable us to see a hell of a lot of people that you don't have to do much to in terms of diagnostics, which rakes in money for the hospital."[b] One key advantage of this application is that the key telephone-linked cancer genetics managed clinical network will not involve a large increase in the number of staff or clinics across the network, but will optimize the network staff already present in the tertiary centre.[c]	Vision of change

[a] Evidence from interview data with focal actor.
[b] Evidence from interview with additional stakeholders.
[c] Evidence from archival data.

flexible, cheap and efficient clinically effective service."

If successful, the model would enable Ruth to delegate the basic assessment of referrals to a nurse counselor, preventing inappropriately referred patients from seeing her and thus allowing her to "spend my time now doing what I really should be doing . . . [which is] seeing patients I really need to see, the more complex cases." In so doing, Ruth would be able to employ her time better in putting her latest research knowledge into practice. "If you feel that you're doing something that somebody else could be doing," she stated, "then you realize that you're not using your time effectively." She suggested that the model also held the possibility of generating an important new revenue stream, which "would keep the business manager in the centre happy," but moreover could be used to prime further cancer genetics research.

Ruth thought that the new service would sell itself, because "our hypothesis was that . . . there should be an increased patient satisfaction because you are actually talking to somebody in their own home, . . . taking better health care closer to home, to a total extreme." Ruth viewed the implementation of the new model as being akin to "running a

TABLE 3
Illustrative Evidence: Mark

First-order codes	Theoretical categories
"[Actor B] very much wrote it and led it and has driven it . . . [I]ndividual consultants are made aware of pockets of money available to bid for and say 'I want to bid.' [T]hey'd have to get clinical director's permission but they often come, bring it to the table and say 'Is everyone OK if I bid for this?'"[b]	Economic capital
"The last six months of this project has been very wearing as we have been under the 'commissioning cloud.' We were not sure if we would be funded and if we were, how much of the service would be funded."[b]	
"I'm quite a young consultant and I was about to launch into this service development, needing to negotiate with surgeons who were very senior, very, very set and committed, . . . and it was difficult."[a]	Cultural capital
"I know for a fact that he'd difficulty with particular individuals in secondary care who thought they were experts and doing it all properly anyway. So he was seen therefore as a threat to their empires."[b]	
"If you don't have networking, then you can't sustain a service, . . . To just sit down with somebody and explain exactly what you want to do, and for them to be able to pick up the phone and say I've got this patient . . . It's about simple human communication."[a]	Social capital
"She [the lead nurse] knows the system. [S]he's got an amazing knowledge of how to exert mild pressure to achieve different aims."[a]	
"There's no secret mystery to all this, it's just hard work and just networking . . . [I]t's about gaining support, getting people to sign up and getting them to change their practice . . . [I]t's understanding what change management really means."[a]	Profession-centrism
"[It's crucial] to be seen to be a good clinician. You can use audit processes to show that you actually do add value."[a]	
"Me going to talk to secondary care doctors is fine because they like that, they like people they consider to be experts coming to talk to them . . . [T]here's no point in me going to talk to a bunch of nurses because I don't speak their language."[a]	Allocentrism
"I decided that I just had to do this because firstly I had to prove my work so that they could take me seriously, secondly we had to prove that our model worked, and thirdly we had to prove that what they were doing wasn't any good and so the three of them combined would help, and so we did three audits last year."[a]	
[Actor B] had direct observational experience of a genetic risk assessment service at YY Hospital . . . [Actor B] felt that this approach lent itself to a cancer network-wide approach, but with a greater degree of buy-in from stakeholders.[c]	Opportunity construction
The opportunity was one finally get rid of service inequalities in the region through a unified service that spanned primary, secondary, and tertiary care.[c]	
"It was very difficult to get them to adopt new guidelines when they've done it like that for years . . . . [Our job was to] try to turn them round to saying 'Well, actually, a network approach and network guidelines will protect all of us.' It took a long, long time to get some people round to our way of thinking."[b]	Opportunity problematizing
"The Cancer Plan never really had very much in it . . . [A]ll you really had when you were going to talk to people was this genetics White Paper, which is lovely toilet reading for someone like me, but most people in the NHS will look at it and say 'oh, come on' and chuck it away and getting that credibility is an issue actually."[b]	
We are proud that we established a novel, efficient service and can demonstrate its benefit in a number of different ways. We have broken the boundary between tertiary genetics services and primary/secondary care. We are proud to be a "mainstreaming" genetics service.[c]	Vision of change
"The new system empowers people in primary care."[b]	

[a] Evidence from interview data with focal actor.
[b] Evidence from interview with additional stakeholders.
[c] Evidence from archival data.

research project to prove this hypothesis," because "the model either works or it doesn't." As a consequence, the problems that Ruth foresaw were couched in terms of collecting the right evidence to "test" whether or not the model worked. For her,

the main challenge was to set up a "control counselling service, one delivered along traditional face-to-face lines, against which the experimental telephone-based counselling service could be set." Thus she felt that her efforts were best focused

TABLE 4
Illustrative Evidence: Florence

First-order codes	Theoretical categories
"[The initiative] definitely did fit the strategic direction of the primary care organization. We were also, at the same time, having discussions about how do we support prevention or preventative services, and this is one of our big key areas."[b]	Economic capital
The impact of timely advice on risk, raising the profile of the disease, direct resource allocation, and dealing with lifestyle issues is consistent with PCT primary care strategy.[c]	
"Tertiary centres have been doing cancer genetics for at least a decade . . . They're now moving on to rarer genetics and want to have the time to do that so. What they see is basic, which we see as complex as it is new to primary care."[a]	Cultural capital
"Doctor–doctor referrals are far better than doctor to nurse referrals."[b]	
"A lot of those connections were already there so they happened. We could've ended up with a GP who hadn't worked in Oldham before or a nurse that hadn't been in XX before and we'd have had to build all these relationships."[a]	Social capital
"I was probably lucky because the Director I work for was happy to take it to Management Exec [of the primary care organization] and present it. Also, with our Director of Commissioning in on the project, he chaired the Steering Group. And I also saw the Director of Clinical Services, and all three said 'Oh, yes, we want it all to work,' so three out of six of them were going to say they've got Management Execs supporting the paper before it actually got there."[a]	
"I think now is the time and, with Fit for Purpose and the new commissioning healthcare directives that are within public health, everything seems to be focusing more on prevention rather than disease management and reinvesting that money to prevent disease."[a]	Profession-centrism
An essential part of the project was to define the roles within it to ensure it maintained: (i) The patient focus as its core, and (ii) A team based delivery of joint working. This was in line with the PCT's philosophy.[c]	
"We are not a screening organization, so we are actually doing something which we are not specifically trained (to do) . . . [S]o you do create a fair degree of anxiety both for patients and for the staff delivering the service."[b]	Allocentrism
"How can you link all these people together? Most of those people don't have an interest in this genetics project."[b]	
The aim of the service is to reduce anxiety in the worried well.[c]	Opportunity construction
XX secured their bid to develop a Cancer Genetics Service in primary care serving the local population . . . [I]t provided an excellent opportunity to test effective models of care consistent with the PCT's plans to develop community-based services and care closer to home.[c]	
"GPs [primary care doctors] are a bit cynical. They are concerned that we are going to increase patient anxiety by raising their awareness."[b]	Opportunity problematizing
"A doctor won't always refer to a nurse if they think it's a nurse-led service but they will refer to a fellow professional at the same level as they are."[b]	
The service will offer holistic advice and where appropriate family history investigation and risk assessment. In due course the project will discuss the "entry" to specialist services regarding the testing for genetic markers.[c]	Vision of change
The team also decided in partnership with tertiary care that the service would be known as "The XX Cancer Family History Service" as opposed to a Cancer Genetics Service.[c]	

[a] Evidence from interview data with focal actor.
[b] Evidence from interview with additional stakeholders.
[c] Evidence from archival data.

upon engaging research peers in a neighboring tertiary cancer genetics center to collaborate with her to ensure that a controlled experiment was set up.

Much less consideration was given to the broader organizational issues of getting other stakeholders to sign up to the service, primarily general practitioners (GPs). In her view, the pilot would simply launch the service and doctors would refer patients, as outlined in the original pilot bid document: "[W]e will educate GPs to use the appropriate referral guidelines and refer to the telephone clinic." In fact, Ruth left the job of eliciting their

support to a nurse on the project, who found the role challenging. As Ruth admitted, the nurse was viewed "a bit like a drug rep," and the nurse struggled to convince primary care doctors that "actually we are here to help you, not to try and sell you something."

Ruth's vision of change deviated very little from her initial "virtual telephone-based model." Ruth's interest was in testing her "hypothesis" that her telephone-based model would work and any potential challenges arising from organizational issues did not influence her view of the organizational change to be enacted. The "virtual telephone-based model" was presented as "an alternative to face-to-face clinics based in primary or secondary care," and was considered to be potentially more cost-effective, lasting only 15 minutes, compared to 45 minutes in tertiary center settings, and being delivered by less highly paid staff. The counselor delivering the telephone-based service was to be supervised directly by Ruth (the geneticist), who would check every single case before the summary letter of each appointment was sent out, enabling Ruth to retain control of the genetics knowledge. The nurse working for Ruth commented that "I know where my boundaries are . . . [I]f it's something much more complex, our model will bring that person into the [tertiary care] clinic, so I will never get into a situation where I'm out of my depth." Overall, the new model did not challenge prevailing organizational and professional relationships and boundaries, seeking rather to reproduce the existing organizational arrangements for service delivery, but in a more efficient manner.

Mark, the Secondary Care Consultant

Mark's career emphasis was on clinical practice. Having completed initial medical training, he undertook some supplementary specialist genetics training in the region in which he was currently located. He then advanced his career as a doctor in clinical genetics through practice-based experience, increasingly specializing in cancer genetics. He had recently returned from working in a more "advanced" region (for the delivery of cancer genetics), and he was deemed to be, by some stakeholders, a "thought leader" in terms of his experience of delivering more innovative services. As a relatively young consultant, he was now seeking to influence more senior consultants under whom he had trained earlier in his career. As such, Mark stated,

"I had to prove my work so that they could take me seriously."

Mark's day-to-day practice meant that he worked across both inter- and intraprofessional boundaries, enabling him to build relationships with a wide range of actors. Furthermore, because he had returned to the region in which he had trained, he was well known and was able to "piggyback" on the existing cancer network, accessing cancer nurses, doctors in primary and secondary care, and specialist doctors in cancer and genetics in tertiary care. His appreciation of the importance of networking was illustrated when he praised a nurse in his team, saying, "[G]oodness, this woman is so networked . . . [S]he's been a senior nurse for many years and she knows everyone."

Mark was oriented towards the delivery, and improvement, of frontline services, being "charged with the responsibility for delivering genetic services to a population of 1 million." The region in which he worked had one of the highest incidences of familiar cancer nationally, but with considerable variation across the region linked to socio-economic factors (Bid document). This led Mark to understand that he "had to come up with a different solution." He believed that the development and delivery of a new innovative service required collective endeavor. His role was to be the "networking person," because "properly managed clinical networks are the way to deliver services for relatively uncommon disorders, which allows such a free flow of information and expertise." Mark was aware that bringing people together was challenging "because status anxieties exist between different groups." However, he was optimistic that "status anxieties can be dissipated" through "quiet leadership skills," which involves "listening to others."

Mark considered the initiative to be an opportunity to "reduce inequity in the provision of cancer genetics services in the region" (Bid document). He commented that cancer genetics services across England had developed in a fragmented manner, in which "you have one or two breast care nurses who go on a course, learn a bit about genetics, and then get hold of a protocol from somewhere and set up their own family history clinic." The result is that you get "a huge variety of experience, of practice, with very little control over the process." For Mark, it was the heterogeneity of service provision that represented "a major stimulus to engage with the model. It was almost impossible to say we'll ignore this; we had to respond."

Mark's aim was to develop a model of service delivery drawing on his experience from the "advanced" region in which he had previously worked. He had witnessed an integrated pathway for cancer genetics care, whereby "[the hospital in which he practiced] had come up with [its] own solution in which an ex-radiographer and cancer nurse were charged with the responsibility for assessing all family histories of cancer within the hospital." Mark "saw in it a useful model of sort of pre-genetics triage, and just put it to the back of my head," but which he now "viewed as being suitable for his new region."

He recognized that implementing the model in other regions was likely to prove difficult owing to differences between inter- and intraprofessional groups. One service user, commenting on an initial stakeholder meeting, said: "You've instantly got their hierarchies round the table, between themselves, let alone when the service user turns up." However, Mark's awareness of the interests and opinions of others meant that he understood the need to "sell" the change to others. In terms of secondary care doctors, particularly higher status medical consultants, a member of Mark's team commented that "it's [all about] challenging their mind sets, particularly when they have already set up existing services, and think who are you anyway, and are you going to take it [the existing service] off us?" In addition, Mark foresaw challenges in getting primary care doctors on board, because "the gap between primary care and tertiary care is enormous." Mark perceived not only primary care doctors, but also nurses, to "speak a different language." He knew that the easiest way in which to get them both on board was to "just to talk their language" and not "some nebulous concept about cancer genetics." Primary care doctors "want snappy little bits of information that are very useful because they have to work quickly."

For Mark, successful implementation of the new service required an understanding of the different "drivers" of stakeholders, so that he could "meet them on their own terms," to negotiate the service's benefits and to ensure that they "owned" it. This included nurses, as well as doctors, with Mark enlisting the support of a senior nurse, "given [that] they are silo-ed, and [that] peer-to-peer influence [is] strong." He also convened a "visioning event for doctors, nurses, managers and involved service users to contribute to the service that was to be created." Mark and his team worked tirelessly at the process of engagement, with one of his team commenting that, "apart from pushing match sticks under our finger nails, I think we tried everything else to get people to sign up to the project." Engaging other stakeholders in finessing the vision at the local level meant that many of the problems could be ironed out, thereby facilitating implementation.

Mark's vision of change was to implement a unified care pathway across primary, secondary, and tertiary care, and to facilitate referrals and knowledge exchange across organizational and professional boundaries. The face-to-face clinics were to be located in secondary care, with the requirement that knowledge and resources be transferred in from tertiary care. If a patient were judged as high risk, there would be a clear pathway for referral to the tertiary center. Correspondingly, if a patient were triaged as medium risk, he or she would be referred for ongoing monitoring in primary care. Within the 45 minute face-to-face clinic, time was to be spent performing an in-depth analysis of an individual's genetic history to tailor treatment aligned with his or her risk profile.

Mark's intention was to distribute genetics knowledge more widely throughout the network, thereby allowing healthcare professionals beyond tertiary care to make informed decisions about a patient's cancer genetic profile. As one primary care doctor commented, "He devised a system of referral which really empowers people." The implementation of a new way of working had implications for traditional professional roles and power relationships. Specifically, the vision of change represented a challenge not only to powerful doctors located in the tertiary genetics center, but also to those located in a tertiary cancer center, who had not specialized in genetics, but who (as one of their cadre commented) "thought they were experts [in genetics] and doing it all properly anyway, so he [Mark] was seen as a threat to their empires." The success of the pilot was based on Mark's ability to demonstrate that the team could take on some of the work that might be undertaken by specialist genetics or cancer services, and could train nurses to do the work. Towards the end of the pilot, Mark commented: "We have shown it works. We can train nurses to take family histories and undertake genetic testing—it doesn't need to be done by specialist genetics or cancer services and can be integrated into mainstream healthcare." Perhaps even more tellingly, as the process of organizational change unfolded, one of the nurses commented: "It's been exciting to be allowed into the world

of genetics and for us to be seen as credible practitioners."

Florence, the Primary Care Nurse

Florence was a senior nurse located in primary care who had recently moved into a more managerial role responsible for the planning of, and contracting for, primary care services (that is, she was a commissioner of services). She enjoyed a wide range of relationships within primary care, engendered by her role as a nurse working across professions and organizations. Her recent move into a commissioning role widened her network of relationships further within primary care, meaning that she would now "interact not just with healthcare professionals, but managers too."

In contrast to Ruth and Mark, Florence had no prior experience of cancer genetics, but became involved because of her interest in public health, which she developed through nursing practice (rather than formal professional education) in the course of her career. From the start, she understood that moving from her public health role into one focused upon cancer genetics was a "new area" for her: "[P]revention has always taken quite a low profile really . . . Public Health Departments have tackled areas like smoking, exercise, obesity, but nothing as large as cancer or heart disease."

From the outset, Florence commented that "I see this [mainstreaming cancer genetics] as a public health target . . . [because] I sit in modernization doing commissioning and development." Her commissioning role was significant because it enabled her to understand the commissioning process and to develop relationships with those funding the service, including follow-on funding for the pilot cancer genetics project. She commented that, "As a nurse, I think it's fantastic that you should look at prevention and not disease management." Her view was that the NHS spent too much time and money on disease management, and that it would be much more cost-effective to reallocate some resources towards disease prevention. Her role was to promote that agenda through service reform and modernization in the NHS.

Florence admitted that she "couldn't see what we needed to develop because I hadn't worked in cancer genetics. I was taking it on 'hearsay." Further, working in primary care, she was disconnected from the clinical teams that traditionally delivered cancer genetics, which were located in secondary and tertiary care. Even—as planned under the change initiative—when cancer genetics services were delivered in primary care, she outlined that "clinical teams aren't managed within our department. I've no managerial responsibility. I don't manage the team even though I manage the project." Consequently, Florence characterized herself as lacking a "real relationship" with those delivering cancer genetics services.

Being from a nursing background, Florence was acutely aware of the status differentials between doctors and nurses. From the start, she had "found it hard coming from a nursing background," because she viewed herself (and nurses in general) as having limited influence over doctors (including not only those in secondary and tertiary care, but also those in primary care), not wanting to "tread on their toes." Hence Florence perceived that she had limited autonomy to push through changes to service delivery, commenting that "I feel they [powerful doctors] would want to link with somebody who knows a lot about cancer genetics, not somebody who was managing the project." She suggested that a nurse trying to "sell" a new service to doctors was always going to find it difficult.

Florence's sensitivity to the power of specialist doctors was reflected in her naming of the new genetics service: she told of the need to remove the term "genetics" from the title of the new service, instead labeling the service a "cancer family history service," to make it clear that it was not a "genetic service," and thereby to placate the geneticists in the region who may have perceived the initiative as a threat to their professional jurisdiction and autonomy. In addition, early in the development of the project, Florence engaged a nurse, who led on cancer care, and a "friendly" primary care doctor, the rationale for which was that "the GP knew how to access her [primary care] colleagues. Meanwhile, the lead nurse knew how to get straight in and access cancer specialists in secondary care." Notwithstanding their engagement, Florence perceived that crossing professional and organizational boundaries was likely to remain challenging.

She commented that:

> Some of the GPs [primary care doctors] think they're too busy to acknowledge that there's new services out there, so just then don't refer, and they just keep going as they always have done and don't move with the times really. . . . A doctor won't always refer to a nurse if they think it's a nurse-led service, but they will refer to a fellow professional at the same level as they are.

Furthermore, Florence realized that even if she were successful at engaging doctors in primary care, "the problem in primary care . . . is linking all the departments together when it's a project that crosses all boundaries." Over time, she became increasingly aware that she faced real difficulties in developing a new service. Recognizing the limits of her power over doctors meant that Florence scaled down her ambition for the new service regarding the integration of primary, secondary, and tertiary care, and the involvement of doctors.

Rather than impact on doctors' jurisdiction, Florence's vision of change was to develop a public-health-focused, family history service within primary care, with the aim of enhancing the patient experience, congruent with existing professional and organizational arrangements. This enabled her to remain in her "comfort zone." Her approach was to avoid confronting doctors and to focus her efforts where she had good existing relationships, such as with fellow nurses in primary care. This was clearly articulated in the end-of-project report: "Throughout the pilot the team were focused on the effectiveness of a primary care based family history service." The new service was to be based around educational events, to encourage patients who considered themselves "at risk" to refer to genetics risk assessment clinics, which comprised face-to-face meetings lasting 45 minutes. Primary care nurses used an evidence-based decision-support software package to make referral decisions to the tertiary care unit, but this was an arm's-length relationship that did not encompass secondary care. The difficulties that Florence faced in enacting change were summed up well in her comment that:

> I think the awareness of genetics family history screening is just not very high in the whole NHS population really. People working in the NHS are just surviving managing disease still and if these projects can raise the profile we've achieved something.

As the primary care doctor who was involved in the pilot commented, "[I]t's all about prevention really and raising awareness, rather than offering a service."

SECOND-ORDER CROSS-CASE ANALYSIS

Our second-order analysis and theorizing about the relationship between social position and sensemaking about organizational change is summarized in Table 5 and Figure 1.

Capital

Across all three cases, we found that cultural and social capital were the most influential forms of capital in shaping sensemaking. Cultural capital was defined in relation to expert knowledge, aligning with inter- and intraprofessional grouping membership (see Harrison & Ahmad, 2000; Martin, Currie, & Finn, 2009; Sanders & Harrison, 2008; Zetka, 2001). In a healthcare context, knowledge— and jurisdiction over knowledge—equates to power and autonomy. Ruth had the most valuable cultural capital, as the knowledge-producing academic, followed by Mark, the practice-facing doctor. Furthermore, cultural capital can be readily translated into economic capital, because commissioners are typically nonspecialists, who rely on specialists for advice (Mays et al., 2001). Commissioners therefore may be best characterized as adhering to longstanding arrangements in professional bureaucracies, whereby managers merely "administer" decisions made by powerful professionals (Mintzberg, 1979). In the case of Florence, even though she had performed a commissioning role, her nursing background meant that she faced a status imbalance when interacting with doctors, because she relied on doctors for specialist knowledge in commissioning decisions. Hence we suggest that economic capital aligns with the high-status cultural capital.

Social capital was important in relation to the extent to which an actor's social capital spanned inter- and intraprofessional boundaries. For Bourdieu (1977), social capital could play an important role in socializing actors into norms of behavior. When an actor's social capital is homogeneous (that is, when relations are largely within inter- and intraprofessional group boundaries), he or she is more likely to be socialized to accept the norms of behavior associated with that group. In contrast, when an actor's social capital is heterogeneous (spanning inter- and intraprofessional boundaries), he or she is less likely to be socialized into the norms of behavior of a particular group (Coleman, 1988; Nahapiet & Ghoshal, 1998), and so will be more aware of other groups' norms and behaviors.

Our three cases highlight that we need to move beyond thinking of the effects of each capital source in isolation and consider their interaction. We found three distinct configurations of cultural and social capital that shaped actors' sensemaking.

Ruth had the highest status cultural capital as a research-active academic doctor located in tertiary

TABLE 5
Cross-Case Comparison

Aggregate theoretical dimensions	Theoretical categories	Ruth	Mark	Florence
Social position	Economic capital	Relatively strong owing to location in prestigious tertiary center	Relatively weak because a service provider and so at the behest of commissioners	Some power within primary care, but limited beyond
	Cultural capital	Strong as a high-status, research-active, academic doctor: the knowledge creator	Relatively high as a doctor in secondary care: the knowledge applier	Relatively weak as a nurse in primary care
	Social capital	Homogeneous because largely within own inter- and intraprofessional group	Heterogeneous owing to well-developed relationships across inter- and intraprofessional groups	Well-developed relationships across inter- and intraprofessional groups, but within primary care only
Disposition	Profession-centrism	Oriented toward research and knowledge creation	Orientation towards practice and the innovation of practice	Oriented towards public health and the preventative health agenda
	Allocentrism	Low levels: was inward-looking to own professional group and perceived herself to be able to act autonomously	Allocentric because he understood the interests and perspectives of other inter- and intraprofessional groups, but was also aware that he could "afford" to act as a doctor	Allocentric because she understood the interests and perspectives of others inter- and intraprofessional groups, but viewed herself as not being able to "afford" to act because she lacked status as a nurse
Schema of change	Opportunity construction	To "test her model of service innovation"; to screen out less interesting cases; to delegate to nonspecialist labor	To "mainstream" genetics knowledge across the region to reduce inequality in service provision	To "promote" genetics knowledge in support of a public health agenda
	Opportunity problematizing	Limited, focusing on whether or not she could provide robust evidence, to "prove" her model	Understood success was dependent on getting buy-in across inter- and intraprofessional groups	Understood success was dependent on getting buy-in across inter- and intraprofessional groups—primarily doctors
	Vision of change	(i) A more efficient, telephone-based, genetics counselling service that focused on connecting primary and tertiary care (ii) No distribution of genetics knowledge	(i) A unified care pathway across primary, secondary, and tertiary care (ii) Genetics knowledge mainstreamed across organizational and professional boundaries	(i) A family history clinic that acted as a pathway from primary care into tertiary care, but not a unified pathway (ii) No distribution of genetics knowledge

care, with homogeneous social capital that largely derived from her own professional, more academically oriented, group. Hence Ruth was oriented towards the primacy of knowledge creation, which was reinforced by her homogeneous social capital.

Mark was a practice-facing doctor located in secondary care and so had lower status cultural capital than Ruth, but he had more heterogeneous social capital that spanned inter- and intraprofessional group boundaries. Hence Mark was oriented towards the importance of practice and improving service delivery.

As a nurse, Florence had the lowest status cultural capital, but owing to the nature of clinical practice focused upon public health, which encompassed many organizational and professional domains, she was able to develop a relatively heterogeneous social capital—only, however, within primary care.

Disposition

For Bourdieu, capital defines an actor's social position representing embodied labor, which in turn determines the conditions that shape his or

FIGURE 1
Influence of Social Position on Sensemaking about Organizational Change
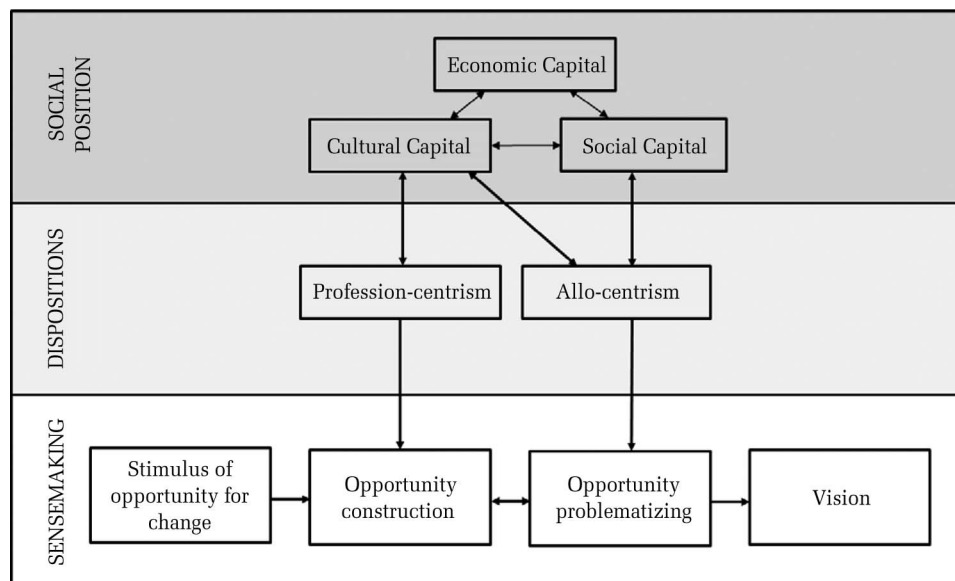
her life experiences and thus dispositions (Crossley, 2001). Although dispositions are durable, they are also shaped and reshaped through an actor's lived history.

Cultural capital promotes a disposition towards profession-centrism (Brennan et al., 2002; Shamir, 1995), which operates across both inter- and intraprofessional groups.[4] Cultural capital works through two mechanisms: (a) socialization, through education, training, and professional development, orients individuals to look at the world in a particular way, including professional values; and (b) the nature of status competition within the professional subfield orients agency towards professional self-interest (Freidson, 1984).

The disposition of profession-centrism manifests itself in actors' sensemaking, the latter shaped by their professional group's cultural capital. All three actors exhibited a disposition towards profession-centrism, but the nature of the disposition was dependent on the nature of cultural capital as aligned to inter- and intraprofessional group membership. Ruth's profession-centric disposition, as a knowledge-producing doctor, was toward the primacy of academic research activities. Mark's profession-centric disposition, being a practice-facing doctor,

was toward service delivery and innovation of service delivery. Being a nurse and a manager located in primary care, Florence's profession-centric disposition was toward public health.

The configuration of the heterogeneity of social capital and cultural capital shapes an actor's disposition towards allocentrism. First, the heterogeneity of social capital promotes a disposition toward allocentrism through "interaction," a mechanism of sensemaking highlighted by Balogun and Johnson (2004) and Maitlis (2005). As an actor engages with a diverse range of stakeholders, he or she becomes more aware of others' perspectives. Where social capital spans inter- and intraprofessional group boundaries, an actor will be better able to view existing practice from the position of other actors in the field.

Second, cultural capital sets limits on action, because actors "can only do what they can afford to do" (Crossley, 2001: 87). Consequently, actors with high-status cultural capital will be more likely to believe that they are able to enact change in an individualistic manner. In contrast, actors with lower status cultural capital, in the terms of Crossley (2001), will be less able to "afford" to act change in an individualistic manner. It is the interaction of the two capital forms that shape the extent to which an actor realizes that his or her ability to enact change is contingent on the thoughts and actions of others.

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[4] See Shamir (1995) for a discussion of the status competition between different specialisms within the legal profession.

Ruth had homogeneous social capital, which, allied to her high-status cultural capital, promoted a low level of allocentrism. In essence, Ruth had a limited insight into the interests and perspectives of other inter- and intraprofessional groups, and viewed herself as being able to act in an autonomous fashion.

Mark had heterogeneous social capital, and so was aware of the interests and perspectives of others, but his cultural capital as a doctor meant that he did not view himself as being powerless in terms of being able to "afford" to promote change. His allocentrism is perhaps best described as being aware of others' interests and perspectives, but not feeling captured by them.

Florence had heterogeneous social capital, but focused on primary care, which was reinforced by the limits of her nursing cultural capital. In contrast to Mark, Florence understood others' interests and perspectives, but, as a nurse with limited cultural capital, she felt relatively powerless because she could not "afford" to promote change (Crossley, 2001).

Schemata of Change

We now examine how actor's dispositions shape their sensemaking about opportunity construction, opportunity problematizing, and their vision of change. In assessing actors' visions of change, we focused on the two dimensions of schema change promoted by the initiative: (a) the joining up of primary, secondary, and tertiary care into an integrated pathway; and (b) the distribution of genetics knowledge, beyond tertiary care, to primary and secondary care. Both dimensions have implications for existing organizational and professional roles and relationships, and whether the vision of change sought to reproduce or reconfigure existing schemata.

Ruth's sensemaking about opportunity construction was shaped by her profession-centric disposition, viewing the initiative as an opportunity to further her research interests and, in so doing, reinforce her own cultural capital. Her sensemaking about opportunity problematizing was shaped by her low level of allocentrism, so that she viewed the opportunity as being unproblematic to capitalize on. For Ruth, the service either worked or it did not; it was akin to running an experiment. Consequently, the way in which Ruth constructed the opportunity translated directly through into her vision of change: a telephone-based model of triage to link up primary with tertiary care. The vision of change was one that largely excluded secondary care and did not involve the distribution of genetics knowledge beyond the tertiary center. Based on the two criteria of organizational change outlined above, Ruth's vision was largely to reproduce existing organizational schemata.

Mark's sensemaking about opportunity construction was shaped by his profession-centric disposition, which promoted him to think of the pilot as an opportunity to innovate the way in which cancer genetics services were to be delivered. Mark's sensemaking about opportunity problematizing was shaped by his disposition toward allocentrism, because he understood that enacting the change would be challenging, but thought that, as a doctor, he would be able to build the necessary relationships to overcome the potential problems of enacting change. Hence Mark's vision of change was very similar to the opportunity that he had constructed. The vision was to develop a fully integrated pathway across primary, secondary, and tertiary care; distributing genetics knowledge across all areas of care and, in so doing, changing existing organizational schemata.

Florence, consistent with her profession-centric disposition, constructed the opportunity as being able to promote a public health agenda in her region. Similar to Mark, Florence had a disposition toward allocentrism, but, in contrast to Mark, she was less positive about her ability to achieve change. As a nurse located in primary care, even though she was positioned as a commissioner of health care, Florence knew that she lacked the cultural capital to influence doctors' behavior. Over time, this led to a scaling back of the scope of the project, to remain within primary care and with a public health focus, because Florence was aware of the difficulty of enacting organizational change, even when aligned with existing organizational schemata. Hence Florence's vision of change was less bold than the opportunity that she originally constructed, which resulted in her largely reproducing existing organizational schemata. Her vision was to develop a public-health-focused family history service that would focus only on primary care, and so there was no real attempt to link up primary, secondary, and tertiary care, other than in terms of the traditional pathway of patients being referred to the tertiary center based on their risk.

Postscript

To link sensemaking to organizational change, we discuss the outcomes at the end of the pilot initiative. Mark's pilot had the most referrals and was deemed to be the most cost-effective, even with a 45-minute face-to-face consultation, owing to the high uptake of the service. Florence's pilot had the fewest referrals (under one fifth of Mark's pilot) and was the least cost-effective, based on a 45-minute face-to-face consultation. Ruth's pilot was based on a 15-minute telephone consultation, which initially proved to be less cost-effective than Mark's pilot (but more cost-effective than Florence's pilot) owing to the relatively low initial uptake of the service. Beyond the scope of the initial projects, the sustaining of the new services was dependent on convincing primary care commissioners to pay for the new service, which was pump-primed through the initiative. All three services were sustained as follows, but in quite different ways.

Ruth was able to drive increased referrals over time and so the cost-effectiveness of the new service increased. With increased referrals, Ruth was able to show that the telephone-based model became 40% less costly than conducting the face-to-face consultations in another neighboring genetics center, which was encompassed within her research study. This enabled Ruth to convince local managers making commissioning decisions to sustain the service. In essence, the telephone-based service led to savings and, interestingly, it became clear that the service could be employed for more than risk assessment of cancer genetics; it was consequently rolled out into other mainstream clinical areas.

Mark was able to win the support of key stakeholders in his area, through networking and providing an evidence-based approach. He commented on his success in developing a networked service towards the end of the project:

> I went back and presented the audit findings . . . and [the senior doctor] said at the end—and this is one of those things that keeps you going really—'We were very privileged to have [Mark] here today because he is probably the only clinician . . . who has developed a proper networked service.'

Based on the evidence generated by the pilot, Mark was able to convince a regional consortium of commissioning managers to continue funding his service—that is, the service had wider geographical coverage than Ruth's pilot. The clear distribution of genetics knowledge was exemplified when the lead nurse took over Mark's leadership role, as he became involved in other related projects.

Finally, Florence positioned the new service as a public health educational initiative—a domain in which she could present herself as expert. She drew upon her background and contacts as a commissioner in primary care to convince other local commissioners to fund the new service for a further 12 months. The service continued, but did so only with considerable uncertainty as to its funding in the longer term because of its lack of a secure evidence base.

CONTRIBUTION AND IMPLICATIONS

The objective of our study was to explore how individual actors' unique contexts shape their sensemaking about organizational change. To date, scholars have examined a limited number of contextual features and have neglected the role of actors' individual histories. Although individuals' positions, histories, and backgrounds are considered to be important influences on sensemaking (Dutton & Dukerich, 1991; Gephart, 1993; Weick, 1995), how this context acts as an antecedent of actors' sensemaking remains largely unexplored and under-theorized in sensemaking studies. To help to conceptualize actors' unique contexts, we drew on field theorists' concepts of social position; to explain how actors' social positions shape sensemaking about organizational change, we drew on Bourdieu's theory of practice. In so doing, we were able to explore how actors' individual contexts provide actors with a "manual or set of raw materials for disciplined imagination" when sensemaking about organizational change (Weick, 1995: 18).

Cultural Capital, Profession-Centrism, and Sensemaking

Consistent with existing studies, our research demonstrates that actors' sensemaking varies between organizational groups (e.g., Balogun & Johnson, 2004; Bushe & Kassam, 2005; Bushe & Marshak, 2009; Huy, 2002; Sonenshein, 2010; Thomas et al., 2011). However, we contribute to the literature by explaining how the varied distribution of cultural capital, both within and between professional groups, serves to shape actors' dispositions toward profession-centrism, which in turn framed actors' sensemaking about opportunity construction. We argue, therefore, that it is important to look beyond group membership to understand how

actors' social positions shape their sensemaking. Our research shows that actors within a professional group may sensemake in different ways, which are shaped by their individual endowments of cultural capital.

As outlined above, two members of the same professional group (such as doctors) may draw on different forms of cultural capital in sensemaking about opportunity construction. The doctor at the apex of the professional hierarchy (Ruth), whose cultural capital was based on being a knowledge producer, had a profession-centrism oriented towards the primacy of academic research. Hence Ruth's sensemaking about the mainstreaming cancer genetics initiative was that it presented her with an opportunity to maintain and further enhance her own dominant status, through outsourcing the more routine cases and increasing the number of more complex, high-risk (that is, interesting) cases with which she dealt. The more practice-facing doctor (Mark) derived his cultural capital from his expertise at innovating service delivery, with his profession-centrism oriented accordingly. Mark's sensemaking about the mainstreaming cancer genetics initiative was that it presented him with an opportunity to redesign the whole service to try to eliminate service inequalities. Finally, the disposition of the nurse (Florence) was oriented toward caring and prevention, because her cultural capital stemmed from her background in nursing in primary care and public health. Florence's sensemaking about the mainstreaming cancer genetics initiative was that it presented her with an opportunity to promote a public health agenda around cancer genetics. Hence we show that both inter- and intraprofessional group membership matters, and, in highlighting that we cannot view doctors as a homogeneous group, we identified the importance of intraprofessional heterogeneity.

We argue, consistent with Labianca et al. (2000), that actors' sensemaking about the development of new organizational schemata occurs at the level of the individual. However, in contrast to Labianca et al. (2000), who focused on the role of existing organizational schemata as cognitive barriers to actors' sensemaking about new organizational schemata, we highlight how actors' cultural capital may promote the creation of new organizational schemata. Based on the discussion above, we argue that cultural capital, beyond economic capital or social capital, influences actors' sensemaking about opportunity construction and that actors' sensemaking about opportunity construction will be oriented towards promoting schemata that will protect or enhance their own cultural capital.

The following hypotheses summarize how cultural capital shapes actors' sensemaking through the disposition of profession-centrism:

Hypothesis 1a. Actors' cultural capital, beyond economic capital and social capital, shapes their sensemaking about opportunity construction.

Hypothesis 1b. Actors' cultural capital operates via the disposition of profession-centrism in shaping their sensemaking about opportunity construction.

Rather than acting as a constraint on sensemaking, cultural capital acts as the "raw material" of an actor's sensemaking, which shapes his or her capacity to construct opportunities for organizational change in ways that deviate from existing schemata. By considering the influence of individual actors' unique social positions on sensemaking, we suggest that actors may be able to sensemake about new organizational schemata in a wider range of ways than has been accounted for in the existing literature. In so doing, our work builds on the work of Balogun and Johnson (2004) and Labianca et al. (2000), who argue that actors work to resolve tensions between new and existing schemata, showing the legacy of old schemata in shaping the implementation of new schemata. All actors were engaged in sensemaking about opportunity construction, as shaped by their dispositions toward profession-centrism, but the nature of their profession-centric dispositions varied according to each actor's underlying cultural capital. Furthermore, the extent to which an actor's disposition of profession-centrism shaped his or her sensemaking about opportunity construction in a manner that promoted the development of new organizational schemata was influenced by the extent to which his or her cultural capital was privileged under existing organizational schemata.

The following hypothesis summarizes our theorizing of the relationships between cultural capital, profession-centrism, and actors' sensemaking about organizational change:

Hypothesis 2. The more an actor's cultural capital is privileged by existing organizational schemata, the more likely it is that his or her disposition toward profession-centrism will promote sensemaking about organizational

change that will not disrupt existing organizational schemata.

In examining the relationship between actors' social positions and their sensemaking about opportunity construction, we heed the call of Battilana (2011: 832) for scholars to dig deeper into the differences between actors' social positions to enable us to better "understand how actors can break with the institutional status quo." Our work highlights the unique social positions in which actors sensemake to construct a vision of change that deviates from existing organizational schemata. We suggest that actors' cultural capital may provide the "raw material" for sensemaking about new organizational schemata, but that it is the interaction between cultural and social capital that shapes how ideas from opportunity construction may be scaled back, or translated directly through, into actors' visions of change, which we explore next.

Social Capital, Cultural Capital, Allocentrism, and Sensemaking

Actors' sensemaking about opportunity problematizing was jointly shaped by the heterogeneity of their social capital and the extent to which their cultural capital was privileged by existing organizational schemata. The heterogeneity of actors' social capital shapes the resulting disposition toward allocentrism, in terms of their awareness and understanding of the interests and perspectives of other professional groups. The extent to which actors' cultural capital is privileged by existing organizational schemata shapes their disposition toward allocentrism, in terms of the recognition that their ability to enact change is contingent on the thoughts and actions of others. We expand below.

Existing studies highlight that patterns of interaction across different stakeholders shape the social processes of sensemaking (e.g., Balogun & Johnson, 2004; Bartunek, 1984; Bartunek et al., 2006; Labianca et al., 2000; Maitlis, 2005; Maitlis & Sonenshein, 2010; Sonenshein, 2010). However, the influence of actors' historical patterns of social interaction is not explicit in studies of sensemaking. We contribute to the literature by demonstrating that actors' patterns of historical interaction, as reflected in their social capital, are an important antecedent of sensemaking.

Our research suggests that actors in our study with heterogeneous social capital (Mark and Florence) exhibited a disposition toward allocentrism, in terms of awareness and understanding of the interests and perspectives of other professional groups. In contrast, the actor in our study with homogeneous social capital (Ruth) exhibited a low level of allocentrism, being largely unaware of the interests and perspectives of other professional groups. We argue that, rather than patterns of interaction across group boundaries leading to conflict in ongoing sensemaking processes (Balogun & Johnson, 2004; Bartunek, 1984; Maitlis, 2005), historical patterns of interaction across group boundaries may be an antecedent that promotes more consensual sensemaking processes. The disposition toward allocentrism, in terms of the awareness and understanding of the interests and perspectives of other professional groups, will enable actors to sensemake about organizational change with a greater awareness of the issues surrounding opportunity problematizing.

The following hypothesis summarizes our theorizing about the relationship between the heterogeneity of an actor's social capital and the extent to which he or she will have a disposition toward allocentrism:

Hypothesis 3. The greater the heterogeneity of an actor's social capital, the more likely it is that he or she will have a disposition toward allocentrism, in terms of an awareness and understanding of the interests and perspectives of others.

The extent to which an actor's cultural capital is privileged by existing organizational schemata shapes his or her disposition toward allocentrism, in terms of the extent to which actors perceive that their ability to enact change is contingent on the thoughts and actions of others. Cultural capital provides actors with "currency," because they "can only do what they can afford to do" (Crossley, 2001: 87).

Among our three actors, we identified important differences in perceptions of the extent to which their ability to enact change was contingent on the thoughts and actions of others, which was related to their cultural capital. Ruth had high-status cultural capital, being positioned at the apex of the medical hierarchy, which manifested in her having a low degree of allocentrism, perceiving that she was able to enact organizational change in a relatively autonomous fashion. Mark, the practice-oriented doctor, had lower status cultural capital, which led him to being allocentric in terms of his understanding that he could not enact change without the support and help of others. Florence, the public health nurse, had the lowest status cultural capital of the three actors, which promoted a dis-

position toward allocentrism that was particularly fatalistic in nature, because she perceived that she had little ability to enact change.

The following hypothesis summarizes our theorizing about the relationship between actors' cultural capital and their disposition toward allocentrism:

Hypothesis 4. The more an actor's cultural capital is privileged by existing organizational schemata, the less likely it is that he or she will have a disposition toward allocentrism, in terms of recognizing that his or her ability to enact change is contingent on the thoughts and actions of others.

As outlined above, actors' dispositions toward allocentrism are jointly shaped by the heterogeneity of their social capital and the extent to which their cultural capital is privileged by existing organizational schemata. We now examine the joint effect of social capital and cultural capital on the disposition toward allocentrism, and—relating our findings to Balogun and Johnson (2004) and Maitlis (2005)—argue that the disposition toward allocentrism will shape actors' propensity to engage in conscious sensemaking processes about opportunity problematizing.

The knowledge-producing doctor (Ruth) had homogeneous social capital, which meant that she was relatively unaware of the interests and perspectives of others, and which, allied to her valuable cultural capital, resulted in her perceiving that she was able to enact organizational change in an autonomous fashion. Her weak disposition toward allocentrism meant that Ruth, in the terms of Maitlis (2005), enacted low levels of sensemaking behavior about opportunity problematizing. Furthermore, her lack of sensemaking about opportunity problematizing, in the terms of Balogun and Johnson (2004), arguably promoted continued conflict between groups and reduced the possibility of a negotiated form of sensemaking across different groups being achieved.

The practice-facing doctor (Mark) had heterogeneous social capital, and so was aware of the interests and perspectives of others, but his cultural capital from being a doctor meant that he felt he had greater agency in being able to overcome such issues. In the terms of Maitlis (2005), Mark's allocentrism promoted high levels of sensemaking behavior about opportunity problematizing. In turn, his high levels of sensemaking about opportunity problematizing, in the terms of Balogun and Johnson (2004), enabled Mark to reduce the potential for

sensemaking conflict between different actors and to promote a more negotiated form of sensemaking. We suggest that Mark is a particularly illuminating case from a theory perspective, because his heterogeneous social capital enabled him to sensemake about the problems of enacting change, but, buttressed by his cultural capital, he viewed himself as being able to develop the relationships necessary to overcome the potential problems of enacting change.

Similarly to Mark, Florence understood others' interests and perspectives, but, as a nurse with limited cultural capital, her sensemaking about opportunity problematizing was rather fatalistic in nature. In the terms of Maitlis (2005), Florence's allocentrism promoted high levels of sensemaking behavior about opportunity problematizing, but her perception that she had low levels of agency to enact change meant that she avoided potential conflict with other stakeholders. In the terms of Balogun and Johnson (2004), Florence reduced the potential for sensemaking conflict by scaling back her vision of change so as to not "tread on the toes" of more powerful stakeholders.

Based on the above discussion, we contend that our work explains why, in the terms of Maitlis (2005), actors engage to a greater or lesser extent in sensemaking. Specifically, actors' dispositions toward allocentrism are an important antecedent of sensemaking that shapes the extent to which an actor will engage in sensemaking processes. We suggest that the greater an actor's disposition toward allocentrism, the higher will be his or her level of engagement in sensemaking about opportunity problematizing. Furthermore, in relation to Balogun and Johnson (2004), we suggest that actors' dispositions toward allocentrism may lead to lower levels of conflict in collective sensemaking across group boundaries and a greater likelihood that actors will be able to sensemake to achieve a negotiated outcome.

The relationship between an actors' disposition toward allocentrism and sensemaking can consequently be summarized as follows:

Hypothesis 5a. The greater an actor's disposition toward allocentrism, the higher his or her level of engagement will be in sensemaking about opportunity problematizing.

Hypothesis 5b. Higher levels of sensemaking about opportunity problematizing will lead to lower levels of conflict in sensemaking about organizational change.

Implications for Practice

Our work suggests that senior management and policymakers need to pay close attention to the social positions of actors whom they engage as change agents. The different social positions will be characterized by unique capital endowments, which will shape actors' resulting dispositions toward profession-centrism and allocentrism, and in turn their sensemaking about opportunity construction and opportunity problematizing.

Within the specific context of health care, actors' inter- and intraprofessional group status is of particular importance, because it shapes the nature of profession-centric dispositions. All actors will exhibit a disposition of profession-centrism, but profession-centrism manifests itself in different ways. Actors in high-status social positions, as defined by inter- and intraprofessional boundaries, are more likely to sensemake about organizational change in a manner that reproduces existing organizational schemata. They do so because existing organizational schemata are more likely to align with their profession-centric disposition. If senior management and policymakers are focused on enabling change through the development of new organizational schemata, they should look beyond actors located in high-status social positions as agents of change.

In our study, we suggest that the actors who are most likely to develop new organizational schemata will be doctors (interprofessionally an elite group in health care) located in social positions not at the apex of the medical hierarchy. The profession-centric dispositions of practice-facing doctors is less likely to be aligned with existing organizational schemata, as compared to elite actors, which will promote a greater agency for change. In addition, their allocentrism will orient them toward being more aware of the interests and perspectives of others (through their heterogeneous social capital), and their cultural capital will mean that, in the terms of Battilana (2011), they will sense that change is possible because they will be able to influence the change outcome. The focus on non-elite doctors as change agents is reflected in global attempts to draw doctors more into transformation of healthcare systems and organizations as hybrid managers (Denis, Lamothe, & Langley, 2001; Doolin, 2002; Hoff, 2000; Iedema, Degeling, Braithwaite, & White, 2004; Kurunmaki, 2004; Llewellyn, 2001). Finally, in contrast to doctors, our work suggests that nurses are likely to be aware—and even acutely aware, if they are allocentric—of the limits of their influence over higher status actors. Consequently, nurses are more likely to sensemake about organizational change in a conservative manner, aligned with existing organizational schemata.

If policymakers wish to focus on the role of elite actors as change agents, then they need to be aware of how their cultural capital will frame their sensemaking about opportunity construction. In addition, policymakers may want to encourage elite actors to develop a more allocentric disposition, which may help to mediate their profession-centric disposition towards the status quo. We suggest that encouraging actors in elite social positions to become more allocentric will enable them to understand better the problems of enacting organizational change. Even if not leading change, actors in elite social positions are subject to change and, by developing dispositions toward allocentrism, they may be better able to engage in more consensual forms of sensemaking about organizational change. A first step in promoting allocentrism may be to expose actors to other organizational and professional perspectives. Currie and White (2012), in their study of knowledge brokering in a hospital, note that education and socialization of doctors on entry to the workplace, and international work experiences as progress their careers, engenders allocentrism. More generally, encouraging doctors to work closely with different inter- and intraprofessional groups, through the use of multidisciplinary teams, may help in enhancing actors' dispositions toward allocentrism (Lave & Wenger, 1991).

Future Research

In this paper, we have explored the influence of context on sensemaking, the reverse of traditional accounts of sensemaking and organizational change, which examine the influence of actors' sensemaking on context (Bartunek, 1984; Labianca et al., 2000; Maitlis, 2005; Nigam & Ocasio, 2010). In so doing, our research opens up the possibility for exploring the recursive relationship between an actor's context and sensemaking, with dispositions a key mechanism operating in both a structured and structuring manner (Bourdieu, 1977, 1990). To explore the recursive relationship between an actor's context and sensemaking, we suggest that scholars should draw on Bourdieu's related, yet underexplored, concept of "position taking." For Bourdieu (1993), "position taking" encompasses an actor's strategies and the actions undertaken to adjust the

balance of power in a field, and is inseparable from the social position occupied by the actor as a result of his or her capital endowments.

Finally, our study is located in a healthcare setting, which has historically provided an exemplary site for the development of organization theory (Pettigrew, Ferlie, & McKee, 1992), but raises issues of generalizability across contexts. We suggest that our insights may be particularly relevant to other professionalized organizations and fields in which significant power differentials exist between actors, and we encourage researchers to carry out further empirical studies to assess the generalizability of our analysis.

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