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Incomplete but Useful? Professional Responses to Cost-Containment Constructs

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ABSTRACT

Adopting an institutional logics lens, this study examines how different professional groups interpret and respond to incompleteness during the development of an accounting construct in a U.S. teaching hospital. Using an interventionist research design, we co-developed the construct by integrating financial and clinical data to identify and reduce unwarranted cost variations. Drawing on 28 interviews conducted in winter 2018 and spring 2023, alongside field observations, our findings reveal distinct professional responses. Frontline clinicians recognized the construct's incompleteness but saw value in it as a discussion aid. Guided by a hybrid logic of professional autonomy and patient-centered care, they adopted a reflexive change response, selectively using the construct to enhance decision-making. Hospital managers, operating within a segmentation logic of performance and compliance, viewed incompleteness as a manageable limitation. Their pragmatic negotiation response balanced internal support for the construct with external reporting requirements. Clinician-managers, positioned between clinical and managerial logics, experienced tension when the construct failed to satisfy either. Reflecting a dominance logic where clinical concerns prevailed, they ultimately adopted an active resistance response. We contribute to accounting research by demonstrating how institutional logics shape the performative effects of accounting incompleteness. Although incompleteness is widely recognized as socially constructed and interpretively flexible, our study explains why professionals respond to the same incomplete construct in different ways. We show that institutional logics influence the performative capacity of accounting constructs by shaping how professionals interpret and respond to perceived incompleteness—either enabling uptake, redefining purpose, or undermining legitimacy—depending on how that incompleteness aligns with or challenges dominant logics.

1 | Introduction

Healthcare is undergoing rapid transformation. The landscape has been fundamentally reshaped by regulatory reforms, economic turbulence, and accelerated digitization (Agostino et al. 2021). A key challenge is the rising cost of healthcare delivery, driven by inflation, increased utilization, and advancements in medicine and medical technology, with global healthcare costs reaching their highest projected increase in 15 years (Organisation for Economic Co-operation and Development 2023). As these escalating costs become unsustainable, implementing novel cost-containment efforts is increasingly urgent (Gibbs et al. 2025; Macassa and Tomaselli 2020).

Research on cost containment in healthcare highlights its challenges, shaped by system complexity (Cardinaels and Soderstrom 2013), institutional logics (Rautiainen et al. 2022), and the contested role of accounting in decision-making (Lehtonen 2007).

Much of this work focuses on cost containment efforts led by healthcare managers (e.g., Carr and Beck 2022; Heberle et al. 2024), emphasizing their attempts to address accounting incompleteness through refinements. As a result, research has largely overlooked clinicians' role in initiating and shaping accounting information. Instead, cost containment is typically framed as manager-led, with studies focusing on how clinicians respond to management-driven initiatives (Carr and Beck 2023; Conceição et al. 2023; Gebreiter and Ferry 2016). Studies also suggest clinicians often resist or disengage from accounting information when they perceive it as incomplete, inaccurate, or misaligned with clinical decision-making and patient care (Begkos and Antonopoulou 2022; Carr and Beck 2020; Kurunmäki 2004; Malmmose and Pflueger 2025). This resistance is not merely a rejection of financial constraints but reflects concerns over the legitimacy and applicability of accounting data in clinical contexts (Llewellyn 2001; Nyland and Pettersen 2004). Consequently, this distrust limits their engagement in cost containment initiatives, reinforcing the divide between cost and clinical priorities (Rautiainen and Järvenpää 2012; Rautiainen et al. 2022).

Research beyond healthcare challenges the view of accounting incompleteness as merely a limitation, suggesting instead that it is a constitutive feature that shapes professional interactions, trust dynamics, and decision-making (Ahrens and Chapman 2007; Busco and Quattrone 2015; Jordan and Messner 2012). This literature examines how managers actively interpret and respond to incompleteness in situated ways. For instance, Jordan and Messner (2012, 545) discuss how managers tend not to rely "blindly" on accounting information. They instead seek to contextualize or complement it by drawing upon other inscriptions or forms of knowledge (Jordan and Messner 2012, 545). From this perspective, accounting is not a neutral representation of reality but rather an evolving mechanism that shapes how professionals engage with accounting information (Yu and Mouritsen 2020). Accounting incompleteness, rather than being a flaw, therefore can foster flexibility, negotiation, and professional discretion in managerial decision-making (Dambrin and Robson 2011; Lillis 2002).

By bridging two perspectives—one that highlights resistance to accounting due to data quality concerns, and another that views incompleteness as inherent and potentially productive—this study advances our understanding of why cost containment efforts grounded in accounting information remain persistently challenging in healthcare. We examine these dynamics through the research question: *How does the perceived incompleteness of accounting information shape professional responses to frontline-initiated cost-containment efforts?*

To investigate this, we adopt an interventionist research design (Jönsson and Lukka 2006; Lukka and Wouters 2022) and co-develop a novel accounting construct aimed at enhancing clinician-level efficiency in a U.S. teaching hospital. Specifically, we seek to co-develop an accounting construct that addresses the issue of unwarranted variation among frontline clinicians—differences in costs that cannot be explained by patient needs or evidence-based guidelines (Wennberg 2002). To explore how the construct was enacted, and to assess its relevance, as a weak market test (Kasanen et al. 1993), we conducted 28 interviews across two periods (winter 2018 and spring 2023) with clinicians, clinician-managers, and hospital managers. In addition, we maintained detailed field notes throughout the intervention to document its unfolding utility.

To examine *professional responses*, in particular, we adopt an institutional logics perspective (Thornton et al. 2012). Institutional logics act as shared guiding principles that shape decision-making within organizations. Rooted in broader institutional contexts, they influence how rules and routines are created and maintained across organizational settings (Lounsbury 2002). In complex organizations such as healthcare, multiple and often competing institutional logics can coexist (Reay and Hinings 2009). From an institutional logics' perspective, clinicians are typically guided by a logic of care, prioritizing patient wellbeing. At the same time, hospital managers operate under a logic of cost containment, focused on budgets and efficiency (Fischer and Ferlie 2013). Clinician-managers, situated at the intersection of these logics, are expected to mediate between clinical and financial priorities (Kurunmäki 2004). This perspective has been instrumental in explaining how institutional logics shape healthcare cost management (Oppi et al. 2019; Shi et al. 2025). However, recent work by Lounsbury et al. (2021, 274) argues that logics should be studied as "complex phenomena that are ever-changing, making their cohesion and durability a problem to investigate". This highlights the need for more nuanced explorations of how institutional logics are enacted, contested, and transformed in everyday practice (Schildt and Kodeih 2025).

The findings of this study reveal that the perceived incompleteness of accounting information shaped distinct patterns of engagement across professional groupings, reflecting the institutional logics each group embodied. Frontline clinicians recognized the construct's incompleteness but did not view this as a barrier to engagement. Operating within a hybrid logic that balanced professional autonomy and patient-centered care, they adopted a reflexive change response—using the construct as a discussion aid to enhance clinical reasoning rather than as a prescriptive decision-making tool. Hospital managers, guided by a segmentation logic of organizational performance and compliance, viewed the construct's incompleteness as a manageable limitation. Their pragmatic negotiation response sought to support the construct's internal development while maintaining external legitimacy, enabling controlled innovation within reporting and governance boundaries. Clinician-managers, positioned at the intersection of clinical and managerial logics, experienced the greatest strain. Over time, they came to see the construct's incompleteness as a fundamental flaw. Reflecting a dominance logic, in which clinical concerns ultimately prevailed, they adopted an active resistance response—rejecting the construct as incompatible with both clinical and managerial expectations.

The paper contributes to the research on accounting in healthcare by demonstrating how the socially constructed and interpretively flexible nature of accounting incompleteness (Busco and Quattrone 2015; Jordan and Messner 2012; Malmmose and Pflueger 2025; Yu and Mouritsen 2020) shapes professional responses to cost containment. The paper explains why clinicians, managers, and clinician-managers respond differently to perceived incompleteness. Specifically, we show that institutional logics influence the performative capacity of accounting constructs by shaping how professionals interpret and respond to perceived

incompleteness—either enabling uptake, redefining purpose, or undermining legitimacy—depending on how that incompleteness aligns with or challenges dominant logics. We advance understanding of performativity as institutionally conditioned, showing that the incompleteness of accounting constructs means they do not uniformly generate calculative effects whenever they are introduced. The study also complements prior literature suggesting that incompleteness is not merely a design flaw by showing how incompleteness can serve as a generative space in which institutional logics negotiate meaning and authority. These insights are crucial for designing accounting constructs that are institutionally resonant in complex settings like healthcare (Carr and Beck 2022; Conceição et al. 2023; Heberle et al. 2024; Rautiainen et al. 2022), where professional collaboration (van Elten and van der Kolk 2025) and compromise (Robbins et al. 2022) are essential.

The paper proceeds as follows: The subsequent section presents the literature related to our study. Section 3 describes the research approach employed. Section 4 presents the data and reports the findings. Section 5 discusses our findings. Finally, Section 6 outlines the study's contributions and opportunities for future research.

2 | Theoretical Development

2.1 | Incomplete Accounting Information

The notion of accounting incompleteness has been widely debated, often seen as an inherent characteristic implicitly understood by managers and decision-makers. As Dambrin and Robson (2011) argue, incompleteness emerges when accounting numbers fail to capture the activities, they seek to represent fully. Prior research on accounting incompleteness offers two contrasting views on how managers engage with it. One perspective views accounting incompleteness as a challenge that managers need to overcome. This perspective focuses on the repair work undertaken to enhance the reliability of accounting systems, making them more precise and useful for decision-making (Ahrens and Chapman 2004; Hall 2010). Here, incompleteness is seen as a limitation that managers strive to mitigate through adjustments, supplementary data, or alternative measures. The underlying assumption is that more complete accounting information improves decision-making, thereby driving efforts to refine financial metrics and enhance their relevance in organizational contexts. For example, Wouters and Wilderom (2008) suggest that by participating in the development and experimenting with design, managers can improve both the validity and acceptance of accounting information. This process allows them to "reduce perceived incompleteness before full implementation, increasing its effectiveness in practice" (Wouters and Wilderom 2008, 512).

In contrast, another line of research suggests that incompleteness is not inherently problematic but can be a productive feature in decision-making. Instead of eliminating gaps, managers may work with accounting's limitations, using it as a flexible tool that guides action rather than providing definitive answers (Busco and Quattrone 2018; Dambrin and Robson 2011). Jordan and Messner (2012) identify conditions where managers deliberately engage with incomplete data, recognizing its role in fostering negotiation, adaptability, and professional discretion. From this standpoint, incompleteness does not weaken control; rather, it enables professionals to interpret and apply financial information in ways that align with evolving organizational priorities. Thus, while both perspectives acknowledge the presence of incompleteness in accounting, one views it as a challenge to be resolved, while the other sees it as an inherent and even beneficial feature of accounting systems (Yu and Mouritsen 2020).

Prior research has primarily focused on how managers perceive and respond to accounting incompleteness, with limited attention to how professionals in different roles interpret, navigate, and mobilize incomplete information. This gap is particularly salient in healthcare, where hospital managers, clinicians, and clinician-managers operate under overlapping but often conflicting logics of financial control and patient care (Carr and Beck 2022; Kurunmäki 1999; Rautiainen et al. 2022). Clinicians disengage from accounting information, perceiving it as incomplete, inaccurate, or misaligned with clinical decision-making (Carr and Beck 2020; Jones and Dewing 1997; Labro 2006). This disengagement reflects concerns over its legitimacy and relevance rather than outright rejection of cost containment (Llewellyn 2001; Malmmose and Pflueger 2025; Nyland and Pettersen 2004). Outside healthcare, research shows managers can engage with incompleteness as a resource for negotiation and adaptation (Busco and Quattrone 2015; Jordan and Messner 2012). Therefore, while prior research has focused mainly on managerial frameworks, opportunities remain to advance understanding of how different professional groups within the same setting engage with incomplete accounting information, particularly when such information arises from frontline initiatives rather than top-down managerial processes (Jordan and Messner 2012; Yu and Mouritsen 2020).

2.2 | Institutional Logics and Professional Responses to Incomplete Accounting Information

To examine *professional responses* to incomplete accounting information associated with frontline-initiated cost containment efforts, we draw on theoretical insights from the institutional logics perspective (Thornton et al. 2012). Institutional logics are "the socially constructed historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton and Ocasio 1999, 804). Early empirical research on institutional logics focuses on temporal shifts in prevailing logics (e.g., Lounsbury 2002; Thornton and Ocasio 1999). These foundational studies demonstrate the efficacy of adopting a logics perspective as a means of explanation and as a generative theoretical perspective for examining how the prevalence of changing logics gives rise to variations in professional responses (Greenwood et al. 2011; Thornton and Ocasio 1999).

Building on these studies, Thornton et al. (2012) propose that competing logics emerge when multiple institutional logics coexist within an organization, leading to either tension and contradictions, change and evolution, or compromise. Conflict and resistance arise when irreconcilable logics lead to tensions, pushback, ethical dilemmas, and potential regulatory intervention. Alternatively, institutional change and evolution emerge

when professionals navigate these tensions over time, shaping new norms, regulations, and industry standards, such as the increasing integration of cost containment into decision-making. Compromise may occur in several ways such as by conforming to the minimum standards expected, by crafting new behaviors to navigate tensions, or by selectively attending to conflicting demands (Pache and Santos 2013).

Professionals navigate these tensions in four key ways: (i) Logic dominance or replacement— professionals adopt one dominant logic while marginalizing or rejecting others, aligning their professional decisions and actions with the prevailing norms or expectations (Thornton et al. 2012); (ii) hybridization—professionals blend elements from multiple logics to develop a balanced or integrative approach in their work, combining, for example, ethical considerations with commercial imperatives (Pache and Santos 2013); (iii) segmentation or compartmentalization—professionals apply different logics in distinct professional contexts, maintaining separate approaches depending on the situation; and (v) situational adaptation—professionals switch between logics based on external pressures, stakeholder expectations, or contextual demands, demonstrating flexibility but potentially facing internal conflicts or ethical dilemmas (Smets et al. 2015).

The vast institutional logics literature highlights the complexity of healthcare organizations, demonstrating that costing information and cost control are not merely technical issues but deeply social ones, shaped by how logics drive behavioral responses (Scott 2015). For example, Pettersen (1995, 212) described hospital budgeting in Norway as "ritual rhetorics and rationalized myths"—while budgets were prepared to comply with government mandates, a gap often existed between plans and actions, as clinicians continued to prioritize patient care over budget targets. In such cases, budgeting functioned more as a symbolic accountability measure than a genuine tool for decision-making. This reflects how a dominant professional logic can lead to decoupling, where cost control measures are formally adopted but not deeply integrated into practice when seen as incompatible with clinical priorities.

Not all responses result in decoupling or resistance. Institutional theory also documents adaptation and negotiation. Rautiainen and Järvenpää (2012) found that how costing information is used depends not only on external pressures but also on organizational context and individual professionals' backgrounds. Hospitals led by managers sympathetic to cost control were more likely to integrate financial data into decision-making. In contrast, clinician-dominated settings tended to engage with cost control measures more superficially. This suggests that logics are negotiated at the micro level, where situational factors, such as leadership that bridges managerial and professional interests, determine whether cost information is embraced or ignored.

A recurring theme in the literature is that, over time, healthcare organizations strive for compromise, allowing cost control practices to function without undermining clinical professional values. Rather than one logic displacing the other, research often finds a coexistence of logics. Conceição et al. (2023) provide a notable example in their study of an Activity-Based Costing (ABC) Project, introduced under austerity measures. Initially driven by managerial logic, the system was reframed to emphasize that improving efficiency could also enhance care quality. By positioning cost savings to improve treatment, ABC became relevant to both logics. Clinicians engaged with the system when it helped identify inefficiencies deemed nonessential to patient care, redirecting resources toward quality improvements. The study found that once "actors' interests and motivations were aligned, ABC was able to offer professional clinicians value", improving communication between clinicians and administrators (Conceição et al. 2023, 592). In this case, the costing system became a boundary object, bridging the logics of care and business.

This study is grounded in the institutional logics perspective as it provides us a lens for understanding how professionals interpret, negotiate, and act upon incomplete accounting information in the context of cost-control measures (Thornton et al. 2012). Incomplete accounting information creates ambiguity, which requires professional interpretation (Jordan and Messner 2012; Yu and Mouritsen 2020). However, how professionals engage with this ambiguity depends on the institutional logics that structure their work (Kurunmäki 2004). Kurunmäki (2004, 328) suggests "that greater attention should be paid to the roles of [accounting] techniques, and their mobility between professional groups, rather than focusing almost exclusively on abstract knowledge". Our conceptual framework (see Figure 1) illustrates how institutional logics shape professional negotiations around cost-containment efforts, emphasizing four interconnected components: (i) Cost-containment initiatives initiated by frontline clinicians; (ii) the development of novel yet (in)complete accounting constructs; (iii) tensions between institutional logics and the incompleteness of accounting information; and (iv) professional responses, including resistance and conflict, change and evolution, or compromise and negotiation.

3 | Research Approach

3.1 | The Case Hospital: A Constructive Intervention

The study was conducted at a publicly funded, 500-bed teaching hospital located in a Midwestern U.S. city with a population of approximately 2.5 million. The hospital provides a broad spectrum of services—from routine primary care to specialized trauma and rehabilitation—and maintains Level I trauma verification. With an annual occupancy rate of around 65% and over 25,000 patient discharges per year, it also operates formal training programs in Internal Medicine, Surgery, Anesthesiology, Pediatrics, and various subspecialties. The hospital serves a socioeconomically diverse and predominantly publicly insured or uninsured patient population. With over 80% of healthcare costs covered by Medicare or Medicaid, and a significant portion of patients lacking insurance altogether, cost containment is a strategic imperative. At the same time, the hospital's social mission—to deliver equitable care regardless of financial means creates persistent tensions between cost control and clinical priorities.

The initial impetus for our intervention stemmed from an international benchmarking project in which both a clinician (from

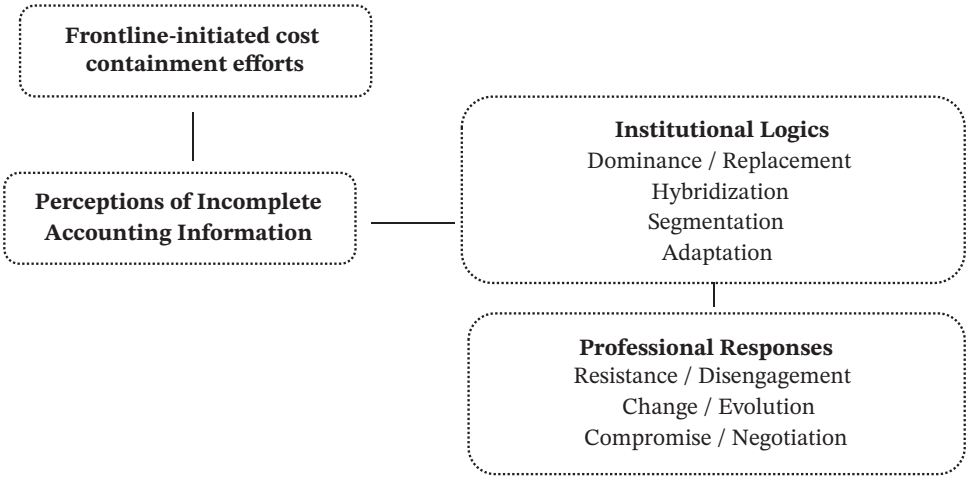

FIGURE 1 | Professional responses to incomplete accounting information: An institutional logic lens.

the case hospital) and members of our research team participated. This initiative compared resource usage across multiple hospitals in different countries, revealing that not all cost variations were medically justified. Intrigued by these findings, the clinician invited us to collaborate on designing an accounting construct to identify and mitigate unwarranted cost variation at his home institution. The opportunity to address a real and pressing issue—within a hospital dedicated to serving vulnerable populations—made the site a particularly relevant setting for our constructive research approach. Importantly, the project emerged not as a top-down hospital management mandate but as a frontline clinician-driven initiative. By embedding ourselves in this bottom-up intervention, we explored how perceptions of accounting incompleteness intersect with competing institutional logics—shaping the enactment of the accounting construct.

To support this, we adopted a constructive, interventionist research design (Kasanen et al. 1993; Labro and Tuomela 2003; Rautiainen et al. 2017) to co-develop an accounting construct. Following the constructive approach, our aim was twofold: To develop a practical solution to a pressing organizational issue and to generate theoretical insights. From the outset, the research team combined conceptual and practical expertise in co-developing the accounting construct. We moved iteratively from problem diagnosis to the design and assessment of its use, engaging closely with a diverse range of professionals. This form of user engagement provided valuable feedback on the construct's practical viability and informed iterative refinements. One researcher (the field author) was embedded on-site and collaborated closely with the clinician "champion"—participating in phone conferences, workshops, and prototype demonstrations. This hands-on involvement allowed for iterative refinement of the construct's design, particularly in tailoring data visualizations and cost calculations to clinical concerns and allowed for sensing the initial attitudes towards the accounting construct among different professional groups. This active collaboration reflects interventionist research principles (Jönsson and Lukka 2006), enabling us to examine how accounting constructs are shaped through institutional logics (Lukka and Wouters 2022). At the same time, other members of the research team maintained critical distance, engaging with the project primarily through theoretical reflection and peer debriefing. This strategic separation helped mitigate the risk of "going native" (Jönsson and Lukka 2006) and ensured that emerging insights were subjected to analytical scrutiny. The dynamic between close engagement and reflective distance was central to maintaining both practical relevance and theoretical rigor throughout the intervention. Further details of the construct's development are provided in the empirical findings.

3.2 | Data Collection and Analysis

Data collection was conducted in two phases to capture the development and use of the accounting construct. Phase one involved semi-structured interviews conducted in winter 2018, while phase two was carried out in spring 2023. In total, 28 participants were interviewed (see Appendix for a detailed list of interviewees). In line with the study's central research question, we collected data from three key professional groups within the case hospital: Frontline clinicians, clinician-managers, and hospital managers. The initial interviews conducted in winter 2018 closely followed the launch of the construct, providing an opportunity to examine the early reactions of different professional groups and their initial perceptions of the construct. The second round of interviews in spring 2023 served to assess the longer-term enactment of the intervention, offering a retrospective view of how the construct had been taken up, adapted, or resisted over time. Taken together, these two phases provided insight into the construct's perceived relevance and legitimacy, as well as its capacity to inform decision-making—key dimensions of market testing (Labro and Tuomela 2003). Specifically, we examined instances where the construct structured clinical reviews (e.g., morbidity and mortality meetings), informed sponsored analyses, or was mobilized in executive discussions—our indicators of weak-form uptake in this hospital.

Across both rounds, interviews were guided by a consistent set of core questions designed to understand their professional backgrounds, how different professional groups perceived unwarranted cost variation, made sense of existing reporting systems, and interpreted the usefulness—and limitations—of the new accounting construct. While relying on this shared framework to ensure comparability, the interviewer allowed conversations

to deviate from the script to probe issues unique to each professional's role or experiences. Interviews lasted between 30 and 60 min. Most were conducted face-to-face, although some follow-up sessions occurred via secure video calls. All interviews were recorded (with prior consent) and professionally transcribed verbatim. Throughout both phases, we kept field notes on informal observations—such as participants' reactions during live demonstrations of the construct—and collected archival materials (e.g., staff memos, board meeting minutes). Institutional review board approval and promises of anonymity encouraged candid participation (Lukka and Modell 2010).

The data analysis proceeded in iterative, abductive cycles consistent with the principles of interventionist research, facilitating the integration of empirical observations with emerging theoretical insights (Jönsson and Lukka 2006). In the initial analysis, the research team conducted open coding of interview transcripts and field notes (Miles and Huberman 2020), identifying recurring references to concepts such as "accuracy", "discussion-oriented usage", and "implementation challenges". These codes served as a foundation for uncovering interpretive patterns across the dataset. Subsequently, codes were consolidated into higher-order themes through comparative analysis within and across professional groupings—frontline clinicians, clinician-managers, and hospital managers. Particular attention was paid to how each group interpreted the incompleteness of the construct's accounting outputs, reconciled competing institutional logics, and enacted distinct forms of engagement, adaptation, or resistance.

4 | Empirical Findings

This section presents the empirical findings of our study, which explores how the perceived incompleteness of accounting information is interpreted and negotiated among professionals. We begin by outlining the collaborative development of the accounting construct, followed by an examination of how it circulated among three professional groups—frontline clinicians, hospital managers, and clinician-managers—each engaging with the construct through the lens of their own institutional logics and professional priorities.

4.1 | The Development of the Accounting Construct

In summer 2015, the research team decided on the case organization. We began with informal observations, a review of organizational documents—including internal financial reports and clinical protocols. During initial meetings with the frontline clinician "champion," a hospitalist, and the Chief of General Medicine, as well as the Director of Short Stay Hospital, the team identified General Medicine as a suitable context of study. In late 2015, the "clinical champion" at the case hospital and the research team initiated an exploratory effort to identify opportunities for cost-containment by examining unwarranted cost variation, focusing specifically on DRG 194 (simple pneumonia with comorbidities), one of the "clinical champion's" medical specialties. They plotted each patient's length of stay (LOS) (*x*-axis) against total treatment costs (*y*-axis), revealing substantial cost variation within each LOS band.

After presenting the findings of this initial analysis to the Director of Short Stay Hospital, the team obtained their first official buy-in, securing initial resources in summer 2016 to proceed with the analysis. In winter 2016, the "clinical champion" and the field researcher presented these findings to the Chief Medical Officer and Chief Financial Officer, who, suspecting inefficiencies, agreed to support a broader investigation. Following Institutional Review Board approval to analyze de-identified patient data and conduct the interventionist study, the team refined their sample to exclude cases involving justified additional services. During further meetings, the research team looked for a way to capture clinical complexity and identified the Pneumonia Severity Index (PSI) to control for illness severity, detecting significant but unexplained cost variation—often attributable to inconsistent use of laboratory tests and imaging procedures (see Figure 2). In spring 2017, building on this approach, the method was extended to three additional Diagnosis-Related Groups (DRGs)—namely, congestive heart failure, acute pancreatitis, and syncope and collapse. Each analysis generated a cost-containment report accompanied by a corresponding Excel file for detailed case-by-case validation.

In summer 2017, these reports were presented to the CEO, who acknowledged the findings but requested clearer insight into the hospital's overall margin impact. In response, a senior management group—comprising several clinician-managers, including the Chief Clinical Officer, Chief Population Officer, and the Chief of General Medicine—commissioned an additional analysis. The "clinical champion" and the field researcher, with the help of a hospital financial analyst, compiled a report illustrating the impact of variation on the hospital's margins, using gross profit as the *y*-axis dimension (see Figure 3).

While the analysis demonstrated that over a third of patient discharges had a significantly negative impact on the hospital's margin—persuading the CEO of its relevance—the gross margin reports were viewed by operational staff as difficult to interpret or act upon. This was due to their reliance on complex and often opaque variables, such as DRG-based compensation, which were perceived as too abstract or removed from day-to-day clinical operations. In spring 2018, coinciding with the allocation of significant resources to a newly founded data analytics division, a data analyst and several clinicians-in-training were appointed to support the intervention. Together with the "clinical champion" and the field researcher, the data abstraction process was standardized, and the Excel file was improved for better usability. In summer 2018, the construct (i.e., the accounting report and the Excel file) was shared with the clinician teams responsible for the identified DRGs within the General Medicine division. Figure 4 presents the timeline of the intervention alongside the corresponding interviews

4.2 | Frontline Clinicians' Engagement With Accounting Incompleteness

In contrast to prior literature, which often frames clinicians as resistant or disengaged when encountering accounting information perceived as incomplete (Carr and Beck 2020; Lehtonen 2007; Rautiainen et al. 2022), clinicians in this study engaged with the accounting information reflexively. Acknowledging

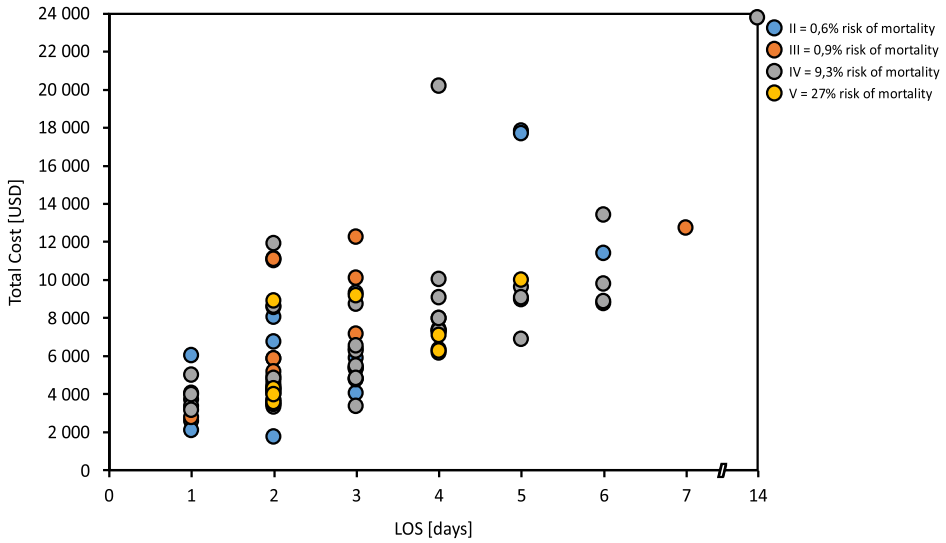

FIGURE 2 | Accounting construct—total costs versus length of stay.
Each dot (n = 88) represents a single patient discharge of DRG 194 (simple pneumonia). The LOS for each individual patient is plotted against the total for that patient. The colour of the dots indicates the severity of illness expressed as the risk of mortality predicted by the pneumonia severity index. The accounting construct was accompanied by a database providing the accounting and clinical source data for understanding and validation purposes by users.
[Colour figure can be viewed at wileyonlinelibrary.com]

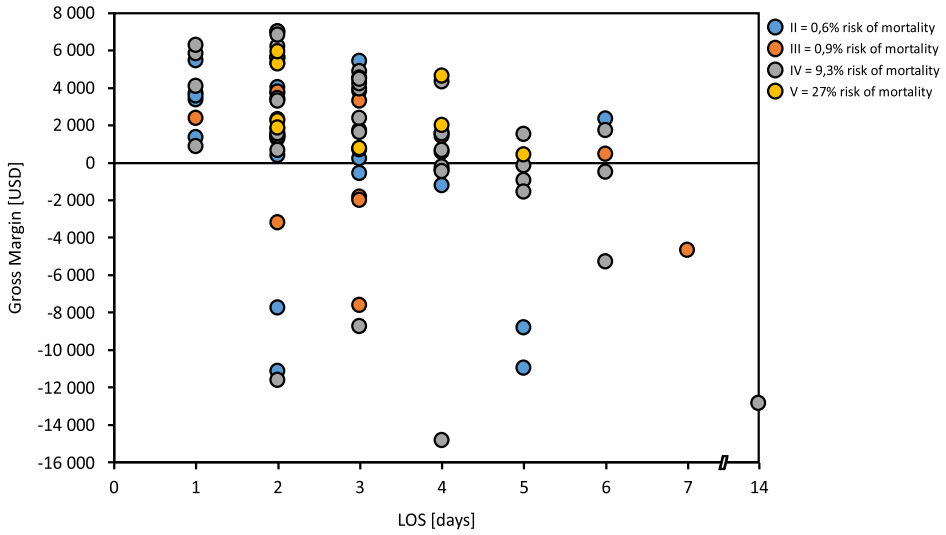

FIGURE 3 | Accounting construct—gross margin versus length of stay.
Each dot (n = 88) represents a single patient discharge of DRG 194 (simple pneumonia). The LOS for each individual patient is plotted against the gross margin for that patient. The colour of the dots indicates the severity of illness expressed as the risk of mortality predicted by the pneumonia severity index. The accounting construct was accompanied by a database providing the accounting and clinical source data for understanding and validation purposes by users.
[Colour figure can be viewed at wileyonlinelibrary.com]

that complete information was unattainable, they used the construct as a discussion aid to foster cost awareness without compromising patient care. This mode of engagement illustrates a form of hybridization in which cost-consciousness is blended with the dominant clinical logic. A cardiologist, one of the early adopters of the construct, exemplified this reflexive engagement by integrating cost information into clinical decision-making, while emphasizing that such considerations are balanced against, rather than override, clinical priorities.

> Frankly, I'm more interested in whether the CAT scan is appropriate for the patient who's in front of me… If this is patient number 30 and I know I'm going to cross a threshold and I'm going to be identified by getting a CAT scan for this patient, do I want that to be the reason I do not get a CAT scan for this patient? No. […] At our operational level, we always question why we do things the way we're doing them. The numbers help guide the conversation, but they don't dictate the decision (ID 14).

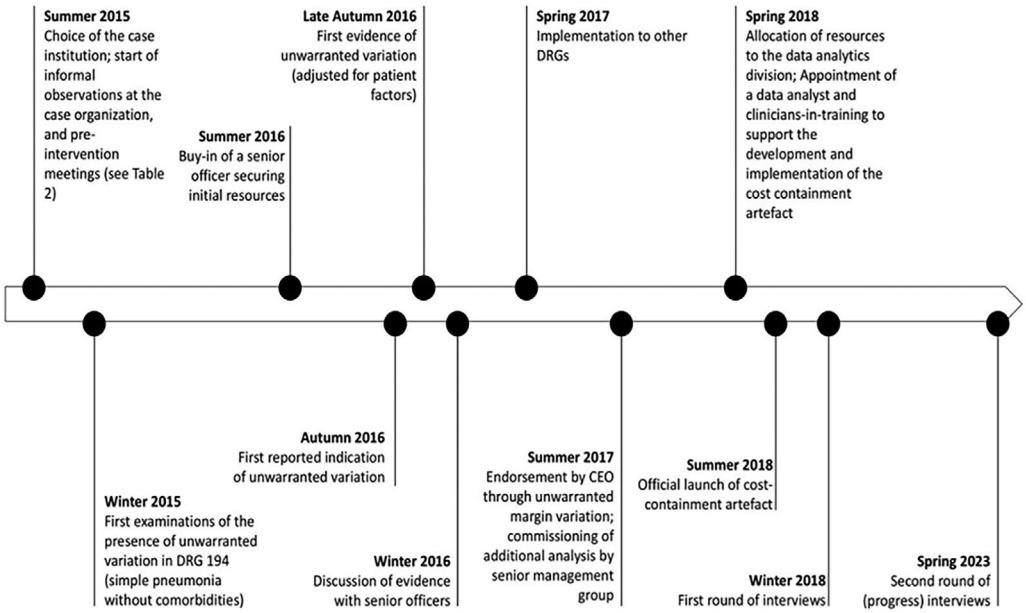

FIGURE 4 | Research project—events and timeline.

Clinicians viewed the accounting information primarily as a discussion aid, in which numerical incompleteness was subordinated to contextual clinical expertise. As one cardiologist explained:

> We support the concept of decision support to help us evaluate in a more evidence-based fashion the ordering of each CAT scan.… (ID 14)

This illustrates a hybridization orientation wherein the accounting construct functioned not as a rigid tool for compliance but as a catalyst for clinical deliberation and responsible resource use. Clinicians were particularly attuned to the evidence-based underpinnings of medical practice, recognizing that informed, evidence-driven decisions naturally entail a degree of financial mindfulness. This integration, they suggested, could enhance both patient outcomes and system efficiency. As one experienced educator observed:

> Physicians are convinced by data, but it must be presented in a very digestible way. […] They would be interested to know that some variation in cost correlates with mortality or length of stay (ID 27).

This comment illustrates how frontline clinicians linked scientific legitimacy to cost awareness, extending their reflexive orientation from individual cases to collective learning. Their engagement with the construct—including through scholarly inquiry—demonstrates an active response to accounting incompleteness. For example, one of the clinician teams that used the accounting construct together with the field researcher published some of their findings in a medical journal. However, the VP Data Analytics noted the ongoing challenge of transforming this scientific curiosity into practice:

> It's been our challenge… how to lift basically this scientific curiosity and transform it into action. In science, you write the paper, and then it's off your desk… so how do you go beyond this scientific curiosity and incorporate it into the clinical routine? (ID 9)

At the same time, clinicians displayed an intrinsic motivation for more cost-conscious clinical practice and conducting research in this area. A clinician in training noted:

> Both sides [medical and cost-focused research] are obviously important. […] We can't just all be aloof academics who sit in our labs and think about how this certain cell type secretes a certain surfactant in the lung or something (ID 25).

A cardiologist emphasized that cost management is becoming increasingly important in clinical practice, citing a range of contributing factors:

> The general interest is in saving the health system, because the way costs and the health system are structured in the United States is not sustainable at this point. But it gets a higher level of importance when you're dealing with an individual patient, where the cost is not going to their insurance company or to the government but is going to their mailbox (ID 14).

Further reflecting on this, a clinician in training, who co-developed and used the construct, recognized generational shifts that are helping to normalize the integration of cost considerations into clinician practice.

> I think younger clinicians are a little more open to needing to be more cost-conscious [. . .] younger clinicians are a little more open to that message than older clinicians. (ID 8)

A cardiologist also observed that such generational shifts face resistance from more senior colleagues:

> There is a big bunch of old schoolers who have been here for many, many years [. . .] but not all of them are open to innovation and changing the way they do things. Some of them just say: 'I've done it this way. This is how I trained. I feel like I'm successful in what I do. Why would I want to listen to a new schooler? (ID 14)

When the field researcher asked about patient cases that the accounting construct had mistakenly flagged as unwarranted variation, one of its early adopters reflected on their familiarity with working under conditions of incomplete information in clinical decision-making:

> Guidelines for these diseases are often a collection of expert opinions and ad hoc recommendations—ones you can easily disagree with. That creates a lot of variation in clinical management, because my expert opinion might be different than yours (ID 14).

However, clinicians also identified structural barriers that reinforced the need for their reflective perception—most notably the practice of defensive medicine driven by concerns over potential litigation:

> Hospitalists are scared of discharging unless everything is done, and even then, they are like OK, am I missing something? That fear of malpractice is, I think, driving costs a lot (ID 28).

Despite these persistent challenges, frontline clinicians exhibited a reflexive approach. Rather than rejecting the construct's incompleteness, they engaged with it through scientific inquiry, evidence-based dialogue, and reflexive reasoning. In doing so, they contributed to a subtle yet meaningful recalibration of clinical practice, gradually integrating cost-consciousness into clinical decision-making.

4.3 | Hospital Managers' Engagement With Accounting Incompleteness

Hospital managers in this study adopted a pragmatic stance—viewing incompleteness not as a flaw to be eliminated, but as a manageable limitation to be worked around. Their response was characterized by segmentation, selectively engaging with the construct to address internal clinical challenges while managing external financial demands. Internally, hospital managers invested in refining the accounting construct by directing resources toward strengthening the organization's data analytics infrastructure. During interviews, the Chief Financial Officer articulated a clear commitment to building internal data capabilities to align clinical and financial decision-making better:

> Making sure that we're getting the right science in the people's hands—that's so they have the right information to make the appropriate decisions (ID 19).

The CEO echoed this commitment, highlighting the hospitals' broader investment in centralizing disparate data systems to establish a more unified foundation for decision-making:

> Everybody's got different data, and they believe what they want to believe, and now this is our attempt at bringing all the disparate systems together and making a central source of truth (ID 11).

Notably, however, the construct remained outside this "central source of truth." While endorsed by hospital managers, its position at the margins of formal data infrastructure signals a potential ambivalence. This reveals a core tension in managerial segmentation. On one hand, hospital managers promoted the construct internally as a tool to support evidence-based clinical engagement. On the other hand, they consciously excluded it from external reporting frameworks, which remained focused on established revenue and compliance metrics. As the Chief Operating Officer acknowledged, the construct had limited relevance in communications with external stakeholders, where legitimacy continued to hinge on traditional financial and quality indicators.

> We have a lot of reports, most of which are revenue oriented. They show how we are performing, how we are tracking. There are cost reports in our budgeting system that track how we are doing versus the budget and where the costs are. But the revenue reports get far more attention. Far more—I call airtime—amongst the executive team discussing because we are still in that growth mode. And not as much as we should be in a cost-of-awareness type mode (ID 18).

This segmented logic represents both a strategic response to institutional complexity and a cautious mode of engagement, enabling hospital managers to facilitate local experimentation while maintaining established reporting norms. The external emphasis on revenue reporting was explained to reflect deeply entrenched incentives embedded in the fee-for-service reimbursement model, an approach fundamentally at odds with the construct being developed. As one interviewee noted:

> Fee for service is an inherent conflict of interest. The more you do, the more you get paid. The surgeons take those kinds of decisions, and the institution is run by surgeons (ID 18).

In addition to financial incentives, the Chief Operating Officer pointed to the role of litigation risk in shaping external positioning, reinforcing a cautious and defensive managerial stance toward cost management:

> This incredible fear, including our people here in the executive suite, constrains how aggressively we push cost containment [externally] (ID 18).

Externally, revenue logics remained dominant, completing the outward-facing dimension of segmentation, while litigation concerns further reinforced this cautious stance. In response, hospital management engaged in pragmatic adaptation—treating accounting incompleteness as a flexible resource to navigate institutional tensions. Internally, they promoted incremental clinical integration by investing in enhanced data infrastructure and reporting capabilities. As the CEO explained:

> The buy-in will come as we continue to produce high-quality information that people can use, that can then go ahead and change (ID 11).

Similarly, the Short Stay Hospital Director described how the construct supported morbidity and mortality meetings, framing it as "powerful culture changing mechanism [allowing the group to] come together and look at the problem and all learn from it [including looking at] high value care cases" (ID 15). Yet externally, hospital managers continued to rely on established compliance and revenue-oriented mechanisms to preserve organizational legitimacy and minimize institutional conflict. This segmented approach was further reinforced by insights from the Vice President of Data Analytics, who emphasized the importance of clarifying internal data usage without striving for externally validated completeness:

> We have thousands of reports and never really knew how people were using them. Centralizing this allows us to see clearer internal usage patterns (ID 9).

Ultimately, hospital managers' response to accounting incompleteness reflected a pragmatic balancing act. Through the segmentation of institutional logics—promoting internal clinical engagement while maintaining external compliance with financial and regulatory expectations—they navigated competing demands. In doing so, they leveraged the construct's incompleteness as a resource, enabling internal innovation without jeopardizing external legitimacy.

4.4 | Clinician-Managers' Engagement With Accounting Incompleteness

Professionals who straddle both clinical and managerial roles are structurally positioned to hybridize competing logics and bridge organizational boundaries (Reay and Hinings 2009). However, the clinician-managers in our study did not consistently enact this hybridizing role. When faced with cost data they perceived as inherently incomplete—particularly due to its disconnection from external accounting practices and reimbursement structures—they reaffirmed the primacy of clinical judgment. They noted that U.S. hospitals operate within a fragmented, multi-payer environment in which complex coding systems, insurer-specific reimbursement rules, and negotiated rates shape financial data. As such, clinician-managers questioned the broader utility of novel accounting information, such as the construct developed in this case, arguing that while these may help identify unwarranted variations in care at a local level, they fall short of addressing the systemic challenges embedded in the wider healthcare financing landscape. As the Chief Quality Officer explained:

> We're not ignoring cost, but you must understand the data we're given—it's just not built for the way we deliver care. It reflects billing logic, not clinical logic. So yes, we'll look at it, maybe even use it to start a conversation, but at the end of the day, our decisions are grounded in what's right for the patient, not what fits the spreadsheet (ID 32).

Clinician-managers initially engaged in selective adaptation, shifting between financial and clinical logics depending on situational demands. Importantly, this pragmatic toggling revealed persistent skepticism about the alignment of cost, quality, and external pressures. Positioned within a hybrid logic, their ongoing struggle to reconcile the construct's epistemic incompleteness with clinical standards produced role strain—undermining their ability to sustain dual commitments and contributing to eventual disengagement.

> One problem was the cases [the clinical champion] picked to try to sell to the clinician leaders who were working with the hospitalists. When those people opened those cases, they were not good examples, and then they dismissed everything. [They] said: see, this was a simple pneumonia. It should never have been admitted. [. . .] And when the clinician leaders looked at it, they concluded that pneumonia was [the patient's] littlest problem (ID 12).

The Chief Quality Officer echoed similar sentiments, expressing a fundamental disconnect between the accounting construct and clinical decision-making:

> I met with the team, but I could not relate to the way they had broken down the information. It did not match with anything that made sense to me from a clinical perspective. You cannot say you spent too much money on [patient] cases, etc. It is not holistic, and it is difficult to translate down to a particular patient level (ID 32).

Moreover, the Chair of Community and Population Health highlighted structural incentives within healthcare that discouraged prioritizing cost efficiency:

> You know, there is no bonus for being cost-efficient and cost-effective. In fact, it is just the opposite. We get rewarded for generating our revenues. So yes, demand driven. And that is the heart of the fee-for-service system [. . .] Right now, in a fee-for-service environment, frankly, the cost is somebody else's problem, right? (ID 7)

These structural misalignments supplied material reinforcement for logic dominance, as financial efficiency ran counter to prevailing revenue-generating norms. Resistance was intensified significantly by the broader external litigation environment. The Operations Director, Emergency Medicine, captured this tension:

> We have so little idea how much anything costs… everybody's worried about getting sued. So, I think those two interests play against each other (ID 20).

The Medical Director of Population Health further reinforced this viewpoint:

> People over-respond to a pushback. In other words, if you or one of your colleagues almost got sued because they did not do a CAT scan for a headache, that doctor and all their peers order more CAT scans for quite a while [after] (ID 12).

Ultimately, clinician-managers disengaged from the construct, concluding that its limited practical utility did not warrant continued development. This resistance was vividly illustrated during an interview with the Chief Quality Officer, who expressed strong skepticism about framing decisions through the lens of the construct. The discussion escalated into a heated exchange, culminating in the abrupt termination of the meeting. The Chief Quality Officer instructed both the field researcher and the clinician champion to leave, stating:

> Cost is NEVER the right way to frame decisions taken at this hospital. Good care is the right framing of any measure that should be deployed. […] The physician is the last line between bureaucracy and the patient (ID 10).

The persistence of clinician-managers' skepticism toward integrating cost and quality was noted by the CEO, emphasizing the cultural shift required:

> People question whether you can deliver good or excellent quality at a lower cost… It is a very slow and cumbersome process… There aren't enough people who believe it today for it to seep into the general psyche of the institution (ID 11).

Taken together, persistent skepticism, external structural constraints, and deeply embedded professional values reveal that clinician-managers—though structurally positioned at the intersection of competing institutional logics—ultimately reinforced the divide rather than bridged it. Their cautious engagement, and in some cases disengagement, stemmed from fundamental concerns about the construct's incompleteness and its perceived inability to capture the complexity of clinical decision-making within a fragmented and revenue-driven healthcare system.

5 | Discussion

What our interventionist study demonstrates is that the socially constructed and interpretively flexible nature of accounting incompleteness shapes professional responses to cost containment, and these professional responses are influenced by institutional logics. The co-development of an accounting construct in this study revealed how different professional groups interpreted and acted upon incompleteness in divergent ways. Its perceived meaning and practical utility were shaped by the institutional logics and identities of these groups, resulting in varied patterns of engagement, adaptation, or resistance. These patterns—summarized in Table 1—highlight that professional responses are rooted in each group's embeddedness within distinct institutional logics, sometimes in ways that are counterintuitive.

Hospital managers approached accounting incompleteness pragmatically, viewing it as a manageable limitation within a segmentation logic oriented toward performance and compliance. Consistent with the pragmatic negotiation response, managers used the construct primarily to facilitate cost-related dialogue with clinicians, balancing internal innovation with the need to maintain external legitimacy. For them, the construct's value lay in supporting internal communication rather than directly informing decision-making. This highlights that the perceived completeness of accounting information is relative to its institutional purpose, extending prior work suggesting that accounting incompleteness is not inherently problematic (Dambrin and Robson 2011; Yu and Mouritsen 2020).

In contrast, clinician-managers, situated between clinical and managerial logics, initially supported but later resisted the construct's development. Their active resistance reflected a dominance logic, in which clinical concerns ultimately prevailed when the construct failed to meet professional standards. Over time, they reframed the construct as another incomplete and distracting construct—one that diverted attention from core clinical priorities. This dual positioning heightened their sensitivity to the construct's limitations, contributing to a deliberate withdrawal from the initiative (Dambrin and Robson 2011).

Finally, frontline clinicians viewed accounting incompleteness as inherent to clinical practice. Operating within a hybrid logic that balanced cost awareness and patient care, they adopted a reflexive change response, adapting the construct as a discussion aid rather than a prescriptive tool. This reflexive engagement fostered cost consciousness without undermining clinical reasoning, supporting previous findings that involvement in accounting design enhances legitimacy and use (Wouters and Wilderom 2008). Our co-development approach embedded clinicians in this process, showing how participatory design can enhance the performative potential of incomplete accounting constructs (Dambrin and Robson 2011; Wouters and Wilderom 2008).

Viewed through a constructive research lens, these patterns represent a weak market test. The construct's use in sponsored analyses, executive discussions, and morbidity and mortality meetings indicates that it was taken up as a means of organizing problem-solving and case review. However, its features of incompleteness—such as limitations in capturing clinical complexity, the contestability of "unwarranted" variation, its

TABLE 1 | Professional responses to the accounting construct.

Professional grouping	Perceptions of accounting incompleteness	Institutional logics	Professional response
Hospital managers	Viewed the construct as inherently incomplete but saw this as a manageable limitation.	**Segmentation**—engagement reflected a logic of organizational performance and compliance, with a focus on preserving legitimacy across internal and external audiences.	**Pragmatic Negotiation** maintained a balance between supporting the construct internally and upholding external reporting requirements, enabling controlled innovation while preserving legitimacy across different constituencies.
Clinician managers	Perceived the construct as promising initially, but over time came to see it as flawed and inadequate.	**Dominance**—engagement reflected an attempt to reconcile both logics, but experienced strain when the construct failed to satisfy/fully align with either. Adopts clinical concerns as dominant logic.	**Active Resistance** positioned within a hybrid logic, their inability to reconcile the construct's incompleteness with professional standard led to role strain and eventual withdrawal.
Frontline clinicians	Recognized the construct's incompleteness but did not consider this a barrier to dialogue.	**Hybridization**—engagement reflected professional autonomy, and a logic centered on patient-centered care and experiential knowledge of cost concerns.	**Reflexive Change** moved towards pragmatic engagement. They used scientific curiosity and reflective discussion to legitimize the construct within clinical reasoning. Rather than seeking completeness, they embraced the construct selectively to enhance decision-making, blending financial awareness with patient-centered care.

peripheral data position, and its disconnection from reimbursement—channeled its application toward dialogic forums rather than prescriptive controls.

6 | Conclusion

Accounting constructs can be used in healthcare to support cost control. Not much is known, however, about the extent to which incompleteness in these constructs shapes professional responses to cost containment efforts. Given that rising healthcare costs have reached unsustainable levels globally, it is increasingly important to understand how different professional groups act upon—and react to—accounting information. Using an interventionist research design and a longitudinal dataset comprising interviews and field observations, this study examines how perceived incompleteness in accounting information shapes engagement, resistance, and adaptation among healthcare professionals, and how their institutional logics shape these responses.

This study contributes to the literature by demonstrating how institutional logics shape the performative effects of accounting incompleteness. Although incompleteness is widely recognized as socially constructed and interpretively flexible, our study explains why professionals respond to the same incomplete construct in different ways. In doing so, we observe three distinct professional responses to accounting incompleteness: (i) reflexive change by frontline clinicians, (ii) pragmatic negotiation by hospital managers, and (iii) active resistance by clinician-managers. This perspective allows us to show that institutional logics influence the performative capacity of accounting constructs by shaping how professionals interpret and respond to perceived incompleteness—either enabling uptake, redefining purpose, or undermining legitimacy—depending on how that incompleteness aligns with or challenges dominant logics.

The study also contributes to the healthcare accounting literature by problematizing the issue of incompleteness (Carr and Beck 2022; Conceição et al. 2023; Heberle et al. 2024; Rautiainen et al. 2022). We argue that hybrid professionals (e.g., clinician-managers) may experience role strain and moral tension, leading to disillusionment and resistance to novel accounting constructs, due to issue of incompleteness. We suggest that (perhaps in contrast to hospital managers) clinician-managers—because they inhabit both clinical and managerial logics—were more attuned to the construct's limitations. This dual perspective may have made them particularly sensitive to its incompleteness, contributing to their eventual resistance. We also show that such challenges of incompleteness and engagement can be mitigated through the active involvement in the development and testing of accounting tools (van Elten and van der Kolk 2025; Robbins et al. 2022; Kurunmäki 2004; Heberle et al. 2024). Extending work on co-production and dialogic engagement (Begkos and Antonopoulou 2022), our study illustrates how frontline clinician involvement helped bridge institutional logics by aligning cost-containment goals with logics of care.

Future research could increase our understanding of how institutional logics may be affected by incomplete accounting constructs. Although institutional logics theory is widely used

in accounting research to explain how professional groups—clinicians, hospital managers, and clinician-managers—interpret and enact accounting practices, it often treats logics as relatively stable background structures that guide interpretation (Conceição et al. 2023). A performativity perspective (Yu and Mouritsen 2020), by contrast, foregrounds how accounting constructs act as productive devices that provoke, constitute, and reshape organizational realities through calculative practices and inscriptions. By bringing these perspectives together, future research could examine how accounting constructs are both shaped by, and shaping of, institutional logics (Schildt and Kodeih 2025). As interpretation of incompleteness may vary according to the logic invoked, it may also exert performative effects that can reinforce, hybridize, or destabilize those same logics.

Future research could also critically examine whether the apparent dominance of clinical logic among clinician-managers—and their disengagement with frontline codeveloped accounting construct—should be seen as inherently problematic. While this disengagement may raise concerns, it is worth asking whether these constructs were ever intended to guide decision-making. As others have argued, they may function more usefully as tools for provocation and dialogue—stimulating reflection rather than prescribing action (Quattrone 2016; Yu and Mouritsen 2020). Yet, in the context of mounting cost pressures, a critical question emerges: To what extent should limited resources continue to be invested in the development of local accounting constructs aimed at fostering professional dialogue, as opposed to being directed toward a more systematic interrogation of existing accounting constructs—particularly those underpinning macro-level, external decision-making, where issues of incompleteness may be more consequential. This tension invites a broader reflection: Can accounting constructs in healthcare continue to operate at the margins as symbolic or facilitative devices, or must they now evolve into more central, integrative instruments of control and coordination? Addressing this challenge may require rethinking how fragmented, localized practices align—or fail to align—with broader performance and accountability constructs shaped by governments, providers, and insurers. Future research could also explore the conditions under which such engagement is fostered and sustained (Bedford and Malmi 2015). Specifically, researchers could examine how externally imposed systems, and locally developed constructs act as complementary, substitutive, conflicting, or enabling mechanisms in addressing cost containment (Bedford 2020). To do so, future research could build on van der Kolk et al.'s (2020) work on tension complexity, to investigate how professionals navigate competing internal and external cost control/revenue generation imperatives, and what control constructs help reconcile these tensions most effectively.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Appendix

Interviewee details

ID	Designation	
	Field notes	**150 pages**
	Pre-intervention: Meetings 2015–2016	**Number of meetings**
ID 1	Hospitalist, General Medicine[a]	5
ID 2	Chief, General Medicine[b]	5
ID 3	Short Stay Hospital Director[c]	4
ID 4	CEO[c]	6
ID 5	Senior Clinician Pulmonologist[d]	20
Interview length	**Winter—2018**	**Interview length**
ID 6	Hospitalist, General Medicine[a]	94 min
ID 7	Chair of Community and Population Health[b]	31 min
ID 8	Clinician in Training, Pulmonary & Critical Care[a]	60 min
ID 9	VP Data Analytics[c]	94 min
ID 10	Chief Quality Officer[b]	30 min
ID 11	CEO[c]	23 min
ID 12	Medical Director Population Health[b]	37 min
ID 13	Clinician in Training, Cardiology[a]	34 min
ID 14	Cardiologist, Cardiology[a]	36 min
ID 15	Short Stay Hospital and Satellite Inpatient Units Director[c]	50 min
ID 16	Business Intelligence Analyst[c]	46 min
ID 17	Chief of Medicine[b]	63 min
ID 18	Chief Operating Officer[c]	63 min
ID 19	CFO[c]	55 min
ID 20	Operations Director, Emergency Medicine[b]	31 min
ID 21	Chief Medical Officer[b]	60 min
ID 22	Director of Business Analytics[c]	23 min
ID 23	VP Data Analytics[c]	49 min
ID 24	Chief, General Medicine[b]	60 min
ID 25	Clinician in Training, Gastroenterology[a]	40 min
ID 26	Chief Medical Informatics Officer[b]	44 min
ID 27	Educator[a]	57 min
ID 28	Clinician, Gastroenterology[a]	46 min
	Spring—2023	
ID 29	Chair, Department of Medicine[b]	89 min
ID 30	Chief Operating Officer[c]	50 min
ID 31	Chair, Department of Emergency Medicine[b]	34 min
ID 32	Chief Quality Officer[b]	28 min
ID 33	Cardiologist[a]	40 min

[a]Frontline clinicians (e.g., clinicians focused on delivering direct patient care).

[b]Clinician-managers (e.g., clinicians with management responsibilities).

[c]Hospital managers (e.g., non-clinical staff overseeing operations and resources).

[d]Frontline clinician "clinical champion".