Professions and the Pursuit of Transparency: Two Cases of Professional Involvement

Charlotta Levay and Caroline Waks

Uppsala University
Department of Business Studies
Box 513, SE-751 20 Uppsala, Sweden
Charlotta.Levay@fek.uu.se
Caroline.Waks@fek.uu.se

Paper for presentation at Royal Holloway, University of London
Centre for Public Services Organisations Seminar
Wednesday 14th November 2007

Work in Progress

Professions and the Pursuit of Transparency: Two Cases of Professional Involvement

Abstract

Health care and other professional services are increasingly pressured to open up to outside scrutiny through public performance indicators, audits, and other transparency techniques that challenge professional autonomy. Earlier research is focused on professional resistance and sometimes decoupling in response to such reforms. This paper is focused on a different type of response which implies that professionals get actively involved in examining and representing their own activities, despite initial reluctance. It explores how and why professionals can get actively involved in transparency technologies and analyses the consequences to professional autonomy. Two cases from Swedish health care – accreditation at a hospital medical laboratory and the national quality registries – were investigated with interviews, document studies, and observations. In both cases, professional involvement took the form of translation and negotiation in expert networks. It was restrained by a remaining resistance towards external monitoring and driven by an interest in legitimising and developing professional practices. The resulting situation was somewhat paradoxical, combining professionals' internalisation of originally non-professional auditing ideas with maintained professional control over evaluation criteria. This process of increasing involvement can be understood as one of professionals making themselves auditable.

Keywords: professions; transparency; health care services; audit society

Introduction

Current day health care is marked by an intensified pursuit of transparency, manifested in the increased importance of quality assessments, performance indicators, rankings, clinical audits, etc (Finkelstein, 2000; Blomgren, 2007; Blomgren and Sahlin, 2007). In earlier research, such demands for external monitoring are largely depicted as a challenge to professionals and their autonomy (e.g. Power, 1997; Tsoukas, 1997; Strathern, 2000a). Professionals, not the least in health care, have been noted to respond to transparency efforts with scepticism. They have attempted to resist scrutiny or to deflect it by decoupling formal representations from everyday activities (e.g. Power, 1997; Hoque et al., 2004; McGivern and Ferlie, 2007).

This paper is devoted to a different type of professional response to transparency reforms, one of active involvement. There are some examples of this type of response in previous research on health care reforms (Laughlin et al., 1992; Pollitt, 1993; Robelet, 2001; Castel and Merle, 2002). Here, it is further explored on the basis of two

empirical cases from Swedish health care. The purpose is to describe and analyse how and why the professional groups in the two cases got involved in transparency technologies and what the results were in terms of their autonomy and influence. Inspired by Scandinavian institutionalism and its emphasis on translation of ideas between different institutional and organisational settings (Czarniawska and Sevón, 1996), the paper describes how professionals operating through expert networks got engaged in translating standards and procedures. It highlights the mixed fallout for professionals, who internalised auditing ideas and got increasingly locked into a system of external scrutiny at the same time as they remained in control of the basic criteria used to evaluate their work.

Theoretical Framework

In contemporary health care, there are several different kinds of efforts to make central processes and outcomes more clearly visible and intelligible to different audiences. These efforts can take the form of rankings, performance indicators, evaluations, etc. Largely fuelled by New Public Management reforms, they also signal new priorities, with a focus on medical core processes, democracy, and patient rights rather than markets, management, and cost-control (Blomgren and Sahlin, 2007). There are also new types of actors driving transparency reforms, i.e. the mass media, patient organisations, buyer associations, and international bodies such as the clinical research publishing organisation Cochrane Collaboration (Blomgren, 2007).

This quest for transparency represents a potential threat to the autonomy of health care professions. A profession's control of its own work, especially with regards to how work is assessed and evaluated, is central to professional authority and independence (Freidson, 1994: 71-72; Pollitt, 1990: 435). Transparency efforts such as clinical guidelines and medical audits make the work of doctors and other health professionals more accessible to outside scrutiny and potentially to external control. Other actors become involved in defining quality and good practice. If a profession is to maintain its jurisdictional claims in relation to other professional groups – including other specialties within the medical profession – it is important that work results can be measured and proven; however, they should not bee too easily measurable, since that would open up for easy evaluation from the outside, and ultimately for loss of jurisdictional control (Abbott, 1988: 46). This reminds that transparency is largely a matter of power; to make something visible is a fist step to control it (Foucault, 1980).

Furthermore, the widespread pursuit of societal transparency appears to imply a reductionist conception of knowledge, assuming that all knowledge can be treated as

objective, codified, and abstract information. But expert systems such as medicine are closely tied to practice and cannot be completely articulated or understood by non-professionals that are not themselves engaged in practice. Hence, decontextualised medical information does not lead to a better understanding of health care on the part of the public; rather, it can undermine trust between patients and doctors (Tsoukas, 1997). Some efforts to increase transparency also involve a standardisation of professional work. This seems to be the case with Evidence Based Medicine, a standardising and visualising technique that has provoked much debate within medicine about the diminished role of individual professional judgment (Lundbäck, 2003; Weisz, 2005).

In line with this conception of professional work, earlier research mostly presents transparency efforts as something intrusive and menacing to professional identities and values. Inspired by Tsoukas (1997), Strathern (2000a; 2000b) warns that what really makes professional organisations work, e.g. the pattern of social interaction, is difficult to capture in formal performance measures. So, 'there is nothing innocent about making the invisible visible' (Strathern, 2000a: 1). In the same line, Shore and Wright (2000) describe the rise of an audit culture as a basically political, neo-liberal project that engenders a 'coercive accountability', with harmful consequences for professionals, including insecurity and undermined professional norms and collegiality. For anthropology, they recommend a resistance strategy combining scrutiny of the effectiveness of audits, reappropriation of concepts such as 'quality', and improved understanding of the logic of audits. Transparency reforms have been described as creating a 'paranoic system', with mutual peer surveillance and internalisation of imposed definitions of accountability (Webb, 2005: 202).

In empirical research, professionals have often been found to respond with suspicion, resistance and/or attempts to evade scrutiny. In health care, there are several reports of professionals reacting negatively to transparency reforms. When medical audits were first made mandatory in the British NHS in 1989, many doctors were doubtful, suspecting underlying motives of cost containment and worrying that the reform would mean standardisation and loss of valuable time (Laughlin et al., 1992: 136; Black and Thompson, 1993). Studies of public release of performance data in American health care show that doctors are often sceptical to that type of data and tend not to make use of it themselves (Marshall et al., 2000). Similarly, in a study of the much-debated star rating of UK hospitals, clinician managers at one hospital characterised the indicators used as meaningless, questionable, and bureaucracy-inducing (Hoque et al., 2004: 369).

Power (1997: 94-98) discusses two possible consequences of the rising audit culture in public service management. One is ‘colonisation’, meaning that auditing permeates the organisations, transforming core professional practices, which is precisely what some professionals fear. The other is ‘decoupling’, meaning that adaptation to auditing demands is superficial and ritualistic, while core activities are sealed off and remain unchanged. In the context of transparency reforms in health care, there are several telling examples of decoupling. When General Practitioners’ experienced a number of NHS reforms demanding new types of reporting and inspections, they found ways to absorb the changes, at least initially, so that ‘real work’ and its underlying values could go on as before (Laughlin et al., 1992: 146). Similarly, when a quality assurance program was implemented at two Swedish hospital departments, work at the departments was quite unaffected, even if the program was prioritised by the hospital management. The actual work was guided by already existing written routines and professional norms (Erlingsdóttir, 1999: 87-100). Likewise, when a system of clinical appraisal for senior medical professionals was introduced in the NHS, most consultants experienced it as a mock-ritual and responded by playing tick-box games to create the impression of effective audit, but continued to practice as before (McGivern and Ferlie, 2007).

However, reforms that open up health care to outside scrutiny are not invariably perceived as threats by health professionals. Transparency efforts made by the authorities often take the form of soft regulation, elaborated in cooperation with professional elites and flexible enough for professionals to adapt recommendations to local circumstances (Blomgren and Sahlin, 2007; cf Jacobsson, 2000; Mörth, 2004). Some transparency techniques have even been initiated by health professionals themselves, such as Evidence Based Medicine, which has been contested by some segments of the medical profession, but which was originally instigated and promoted by other segments. Later on, health care authorities and international expert organisations have taken part in issuing evidence reviews, in cooperation with medical researchers, thus making medical treatment principles more accessible to outside observation and new rounds of regulation (Lundbäck, 2003; Weisz, 2005). This exemplifies Freidson’s (1994: 128-146) observation that standardisation of professional work is usually carried out by professional elites standardising the work of rank-and-file professionals; thus it is not necessarily a threat to the autonomy of the profession as a whole.

There are also a few empirical cases of professionals who were at first resistant to demands for increased transparency, but then become actively involved in the design and workings of monitor systems. In the case of medical audits in the UK, the medical

profession managed to regain the initiative, creating its own model of medical audit and getting it established, so that medical audits were carried out by doctors exclusively (Laughlin et al., 1992: 136-137; Pollitt, 1993: 163). In a study of accreditation in French health care, Robelet (2001) shows that new accreditation programs seemed to be a threat to doctors' professional autonomy by regulating their core activities. However, less powerful segments of the medical profession managed to reposition themselves in a competitive environment by getting actively involved in the elaboration of new quality assurance manuals. By participating in the definition and practical elaboration of assessment criteria, different professional segments tried to further the interests of a particular organisational form (i.e. multidisciplinary cancer treatment centers), a subspecialty (i.e. lung medicine), or a specific medical service (i.e. resuscitation). Likewise, when clinical guidelines were introduced into French oncology, doctors participated actively in developing the guidelines (Castel and Merle, 2002). Despite initial hesitation among some doctors, the guidelines were vague enough not to evoke resistance and to be adaptable to local circumstances. In general, the guidelines were perceived as useful tools in everyday practice. In contrast to Freidson's (1994: 128-146) notes on professional stratification quoted above, with professional elites standardising the practice of rank-and-file members of the profession, Castel and Merle found that guidelines were popular among ordinary practitioners. In fact, by following the norms and procedures specified in the clinical guidelines, practitioners became less systematically dependent on advice from university specialists and immediate colleagues.

To summarise the reasoning this far, there are several systematic attempts to make health care more transparent in contemporary health care, initiated by different social actors, including health care authorities, the mass media, and health care professions. In previous research, such attempts are primarily presented as challenges to professional autonomy, and there are several reports of health professionals' negative responses, ranging from suspicion and resistance to decoupling. However, there are also examples of professionals participating in such reforms, either by initiating new visualising techniques, or by getting actively involved in techniques initiated by others and using them to promote their own professional interests.

In this paper, we look closer at what happens when professionals start participating in making health care transparent. In addition to the notions of professional control, transparency, and auditing, we use the concepts of translation and network to describe and analyse these processes. We draw on Scandinavian institutionalism in recognising that the use of general organisational models and principles – in this case auditing, accreditation, clinical guidelines, quality standards, and measurements – does not

mean exact copying of invariable organisational modes, but rather continuous translations that comprise considerable change and editing (Czarniawska and Joerges, 1996; Czarniawska and Sevón, 1996, 2005; Sahlin-Andersson, 1996). In order to travel from one context to another, a model or idea first has to be decontextualised and stripped of the specificities related to its original organisational setting and institutional logic, then repackaged and expressed in general – and generally appealing – terms, and finally recontextualised in order to make sense to actors in a new setting. This implies that the models are not only created by their original or ascribed inventors but also by the many actors, individual and organisational, that are involved in translating and editing it on the way, such as standardising bodies, advisors, scholars, and, of course, members of the organisations that take them up. Regarding networks, Garpenby (1999) and Sheaff et al. (2003) have pointed at the importance of professional networks when it comes to contemporary public governance efforts directed to knowledge-intensive sectors such as health care. Such efforts are instances of 'soft regulation' (Jacobsson, 2000; Mörth, 2004), as explicated above, and 'soft bureacracy' (Courpasson, 2000), which means that instead of using hierarchical and coercive control measures, authorities or managers engage professional experts and representatives in implementing reforms. As suggested by the terms, to professionals, this means a combination of external control and opportunity to influence.

Design and Method

The study is based on two empirical cases from Swedish health care, each representing an instance of the pursuit of transparency. The first case treats the accreditation of medical laboratories and focuses on a round of inspection at a large hospital medical laboratory. The other case treats the Swedish national quality registries, a kind of medical databases that monitor quality and outcomes of different treatments and health care providers. The study of this case focuses on recent demands to make registry data public, especially as regards the quality of different providers. The dual design allows us to cover all of the main arenas for professional ambitions and strategies – the legal, the public, and the everyday work arenas (Abbott, 1988). Both cases concern the legal arena, and more specifically the soft regulation that is typical for transparency efforts. The laboratory case has an emphasis on the level of local, everyday work, while the quality registry case has an emphasis on the level of public representation and legitimacy.

The focused hospital laboratory was a division of a big university hospital and consists of eight departments, employing approximately 950 persons. It offered

services such as laboratory analysis, consultation, and education to the health sector within the county. In Swedish healthcare, accreditation is mainly performed within laboratory medicine. It is not mandatory by law, but all of the larger County Councils, i.e. the local authorities that organize health care in Sweden, demand that the laboratories they consult are accredited. An accreditation provides soft regulation of the organization, through application of international and European standards. Once the laboratory applies for accreditation it undertakes to follow a defined description of work. For medical laboratories this implies keeping an extended documentation describing its quality system and verification of how work is performed in practice. Swedac, the Swedish Board for Accreditation and Conformity Assessment, which is a national authority, controls that standards are followed through annual inspections. At the same time, each laboratory reviews itself through internal auditing. Regular participation in external test and calibration comparisons is also mandatory (Swedac, 2007).

The Swedish national quality registries are a type of databanks that contain information about diagnoses, treatments, and outcomes for different patient groups, e.g. stroke, heart surgery, or schizophrenia. They are primarily used for development of medical treatments and local quality improvement. Health care providers participate on a voluntary basis, registering data and receiving summaries where results for other participants are normally anonymised. However, in the past decade, there has been growing pressures to report public quality comparisons of identified hospital departments and healthcare centres, which several quality registries have started to do. The case study focuses on the evolving professional response to these external demands for increased transparency. Medical specialty associations and individual enthusiasts within the profession play an important role in creating and operating the quality registries. Today, there are 56 wholly recognized registries. They are managed under the auspices of the Swedish Association of Local Authorities and Regions and the National Board of Health and Welfare. Just as the national professional associations of doctors and nurses, they appoint members to an Executive Committee, which assigns funds to individual registries on a yearly basis to registries that apply and conform to certain criteria, such as reliable reporting and sufficient coverage among relevant health care units. Each registry also has a steering committee and a registry manager.

The empirical material consists of semi-structured interviews, public documents and participant observations. The accreditation case draws on nine interviews with doctors, quality coordinators, and managers at the focused department, and with medical and biomedical assessors from the accreditation board. Information was also collected from reports from the accreditation board and other inspecting organisations, e.g.

newsletters, online presentations, etc. Observation, including several conversations, was carried out at two occasions. One occasion was the entire first day of an annual, two-day assessment round at the laboratory, carried out by the central accreditation board. The other observation was a one-day national quality conference, organised by the accreditation board and other health authorities.

The quality registry case uses data from 23 interviews with 20 health professionals, administrators, politicians, interest group representatives, and other well-placed informants who answered questions about different aspects of the pursuit of transparency in Swedish health care. Eleven interviews concerned the quality registries specifically and the others treated the registries in more or less detail, conveying specific information as well as purposes and attitudes of different actors. Information about the registries was collected from the vast public documentation that exists about the registries, e.g. annual reports, health economic evaluations, strategy documents, media reports, newspaper articles, opinion pieces, etc. In addition, the case study is based on participant observation, including strings of brief, informative conversations with relevant actors. Observations were conducted at the 2004 two-day national conference on quality registries, 'The Quality Registry Days', at a half-day's regional meeting among health care professionals and administrators working with the registries, and at a smaller, one-day conference for quality registry work.

Professional Involvement in Transparency Technologies: The Two Cases

Forms of Involvement: Translation and Negotiation in Networks

In the two cases, professionals contributed to the transparency technologies of accreditation and quality registries in a number of ways. They administered systems of data collection, carried out much of the everyday collection and registration of data, and were members of teams that did inspections or decided about evaluation criteria. Most of these activities can be characterised as a work of *translation* between different social contexts – translation of general guidelines into specific recommendations and local routines, of local realities into aggregated data reports, and of everyday practice into measurable quality indicators. There was a certain division of labour between managers and experts, who designed quality systems and decided about assessment criteria, and ordinary practitioners, who filled in forms and were required to adhere to recommendations. However, decisions about criteria and procedures were not made in strictly hierarchical systems, but rather by experts, professional associations, and

representatives of local health care providers, who were all part of the same professional *network*. The elaboration of quality standards and common rules within these networks was characterised by continuous discussions and *negotiations*, and it included participation of managers at relatively low levels.

The Accreditation Case

In the accreditation case, a number of professionals participated in the continuous work with quality systems and inspections that was required for accreditation. The main professional groups involved were laboratory doctors, biomedical laboratory scientists, and biomedical scientists. At the hospital laboratory focused here, several professionals worked full time with quality systems: eight quality coordinators, one for each sub-department, who were biomedical laboratory scientists, and the general quality manager, who had a PhD in a biomedical science. They were responsible for internal audit systems, and they prepared the laboratory for the yearly inspection for renewed accreditation by the accreditation board, Swedac. In preparation for the inspection, they gathered and scrutinised documentation, went through routines and needs for adjustment, and considered whether to include any new activities in the application for accreditation. The two days of inspection included rounds at all sub-departments. Any employee could be approached and asked to explain routines. At the end of the day, Swedac's inspection team had meetings and discussed their findings with the quality coordinators, the head of the laboratory division, who was a laboratory doctor, and the departmental managers, who were also doctors. During the inspection as a whole, the most active role was played by the quality manager and the coordinators, and by the external assessment team, which was made up of technical assessors who were laboratory doctors and biomedical scientists from other Swedish hospitals. The team leader was a microbiologist and lead assessor and from Swedac.

According to Swedac's presentations and interview statements made by the inspection team leader, accreditation means applying general standards uniformly across different sites and without regard to whether it is a medical or an industrial laboratory. At first glance, the observations made of Swedac's inspection round at the medical laboratory appeared to confirm that assessment criteria were quite strict and inflexible, especially when it came to documentation. During the discussion, the team leader noted deviations from the standards, asked for explanations, and gave instructions on how routines and documentation would have to be changed. The quality coordinators gave explanations and justifications, and the quality manager sometimes objected with insistence, but, as it turned out, to no avail, since the head of the team

never changed her mind. The exchanges often had the character of tough negotiations, where the accreditor was fairly rigid and made the actual decisions.

However, the larger picture of what happened before and after the inspection round, when assessment criteria were set and the final decisions about the renewed accreditation of the studied hospital laboratory were made, shows a more flexible rule application and more opportunity for professionals outside of the accreditation board to have an influence. When the assessment team presented their report based on the inspection, the demands for adjustment were negotiable; it had happened before on several occasions that demands had been withdrawn when the hospital laboratory had presented objections, including calculations of what it would cost to make the changes asked for. In interviews, the local professionals also emphasised the degree of freedom in the accreditation process; it was actually the laboratory's own description of its organisation, routines, equipment, etc. that was scrutinised, which gave a certain leeway:

> So, to put it somewhat bluntly, you can actually describe things in a very general manner and then follow that and then, in principle, you can be accredited. Or you can do it in much more detail and with higher quality. But then it is actually more difficult to keep the accreditation. So the level of ambition is not really controlled for. It can vary within the scope of the accreditation.
>
> Departmental manager and laboratory doctor

Similarly, much of the accreditation demands concerned the existence of internal quality control systems, and the local professionals themselves decided the specific set-up of these systems. At the investigated laboratory, the quality coordinators were responsible for continuous quality monitoring, e.g. by making recurrent audits at each other's departments. Accredited laboratories were also required to submit to regular external monitoring by Equalis, the External Quality Assurance in Laboratory Medicine in Sweden – an agency that was actually owned to 49 per cent by the two main professional associations within laboratory medicine, the Swedish Society of Medicine, with laboratory doctors among its members, and the Swedish Institute of Biomedical Laboratory Science, whose members were biomedical scientists and biomedical laboratory scientists.

It should also be noted that the technical assessors in Swedac's inspection teams were laboratory professionals, mainly doctors, from different hospitals in the country who had been appointed on recommendation of their respective professional associations. One of the doctors at the studied laboratory functioned as technical assessors in other inspections. He told that the technical assessors in each laboratory

speciality met regularly in assessment groups to discuss questions regarding how standards should be interpreted and applied in specific situations. Particularly difficult questions were treated at special meetings twice a year with a representative from Swedac present.

> You can be out at a lab and make an observation and wonder if it is a discrepancy and how we have done at other labs. How should we handle this? Much of what is in the standards are questions of interpretation. How should we interpret this? How should we assess it in a Swedish context? And then you can hand in a question to Swedac and you can hand in a question that is taken up in the assessment group.
>
> Senior laboratory doctor and technical assessor

So, in the case of accreditation at the hospital laboratory, professionals participated in a number of ways in preparing and carrying out inspections, designing and operating quality systems, interpreting standards, explaining local systems to outside observers, and making deliberations regarding judgement criteria. As opposed to traditional professional client work, these tasks were not performed individually, but in teams and networks of professionals, often from different organisations, who interpreted and applied rules through recurrent discussions and negotiations. Managers, senior professionals and specialised experts made the most important decisions, but a wider circle of professionals, from all the main professional groups within laboratory medicine, participated in other ways. Notably, the quality coordinators at the studied laboratory, who belonged to the relatively less prestigious occupation group of biomedical laboratory scientists, made internal audits, had regular contacts with Swedac, attended critical meetings during Swedac's inspection, etc.

The National Quality Registry Case

When it comes to the national quality registries, medical professionals played a crucial role in running the registries, both as initiators and managers of registries and as members of health care organisations that reported and retrieved registry data. When demands for public reporting became pressing, it was up to professionals to handle the demands, and, in the case of several registries, to start issuing public quality comparisons between different health care providers. Specialised researchers within the profession led registry activities and exerted much influence over how the registries were designed and operated. However, they also had to mobilise wider support within each speciality or area of activity, in order to keep the registries running with sufficient national coverage and to get clearance for public reporting.

Initially, most registries had been started at the initiative of one or a few medical researchers, often doctors and managers at university hospitals, who, once the registry was established, became registry managers and members of the steering committee. Frequently, such individual enthusiasts carried out considerable amounts of administrative work, such as engaging computer specialists and organising routines for data reporting. Medical specialty associations were important platforms for discussing and supporting new as well as established registries, and they contributed in a number of ways, e.g. by appointing committee members, donating funds, recommending member specialists to participate, and sometimes by administering registries. On the national level, the two main professional associations organising doctors and nurses were represented in the Executive Committee for National Quality Registries.

Within the professional networks underpinning each quality registries, the registry manager and the members of the steering committee occupied central positions and had influence regarding questions large and small, such as the character and frequency of feed-back reports to participant health care units, or the choice of software supplier. The managers of larger registries also had a say in decisions concerning national regulation and funding of the quality registry system as a whole. However, these experts acted less as hierarchical superiors or supervisors and more as initiators, coordinators and external representatives of collegial networks. Registry participation on the part of individual hospital departments and health care centres was voluntary, except for a few county councils where it was required of all providers. Furthermore, each registry had to achieve national coverage, with as many participant units as possible. Not all registries succeeded; there were reports of intraprofessional rivalries, criticisms, and disagreement over relevant quality measures in some struggling or failed registries, and especially for psychiatric diagnoses there had been difficulties to achieve full participation and consensus. Since no registry could start or survive if it was not perceived as meaningful by the professionals within the concerned discipline, each registry management had to rally support among colleagues in the rest of the country. At each participant unit, the responsible manager also had to secure enough support among local professionals for them to report conscientiously and to make use of the data in local quality development. A previous administrator at the National Board of Health and Welfare described the process of starting a registry in this way:

Many times, there has been a driving enthusiast somewhere, who has gathered others, received support in the speciality association to start this registry. It can take quite a lot of time just to agree on what is important to follow up. Then you have perhaps agreed on a number of parameters, and then it takes time before you can get good quality of that data.

Administrator, previously at the National Board of Health and Welfare

So, within each medical speciality or area of activity, which could also include allied professional groups, agreement had to be reached over which measures and criteria to include. Joint collaboration was also required to develop the registries when it came to securing data validity, elaborating new applications, etc. In summary, there were no given quality criteria, but a labour of joint translation and negotiation within professional networks that had to be carried out for each registry.

When demands for public reporting on the part of the registries mounted and sharpened towards the end of the 1990s, it was medical professionals working with targeted registries who had to answer and who, after initial resistance, started issuing public reports of quality differences between identified health care providers. Since before, there had been a general discussion on the degree of openness of the registries, but the actual change set off when investigative reporters directed demands to specific registries to hand out full data on all participant hospital departments. The first response of these registry managers was to refuse, since the data had been gathered under conditions of anonymity. However, they also initiated internal discussions among the participants in the registries, which later made public reporting possible.

The registry that was first targeted by journalists was one of the oldest and most recognised, the National Hip Arthroplasty Register. In 1997, reporters from the Swedish investigative TV program ‘Striptease’ demanded data on individual hospital departments. The registry manager declined, since the departments participating in the registry had reported data on conditions of anonymity. The TV program then sued the manager, but lost the case in court, since the information requested would have demanded additional rounds of data retrieval. However, the manager also initiated a discussion about public reporting among colleagues at participant hospital departments and within the speciality as a whole, and the registry embarked on a process towards increased openness. As one of the first registries, it started publicising outcome measures for identified hospital departments. At first, only a small selected number of measures considered valid were made public, but the number of variables was gradually expanded from year to year. By 2007, the registry worked actively with public reporting, for instance by testing a new website with sections designed particularly for

patients and health care decision-makers. So, the publication of sensitive data was achieved gradually, after external pressures, and through a process of collegial discussions, professional deliberations of different measures, and efforts to clarify the information to outside audiences.

The National Quality Registry for Gynecological Surgery was started in 1997, and the question of public, non-anonymised reporting was discussed in meetings with member departments already in the spring of 2000. The registry management was positive, but in a round of voting, 70 per cent of the representatives of participant units voted against. The question was then raised again in every half-year meeting, and more and more representatives turned positive. In the autumn of 2001, only two of around 30 hospital departments voted against.

Whereupon I had a personal dialogue with the two department managers, and said that we would not start open reporting before everyone agreed about it. Then they accepted it, and we had the mandate to arrange open reporting.
Gynaecologist and manager of the National Quality Registry for Gynecological Surgery

In 2007, several registries operated with different degrees of open reporting of comparable data, and this was also formally demanded by the national Executive Committee for National Quality Registries. However, each registry made its own decisions about the timing, pace, and form of open reporting, which meant continued negotiations and translations in professional networks.

Forces Restraining Involvement: Defending Professional Autonomy

In each of the two cases, there was suspicion and resistance from professionals towards transparency technologies, both initially when the technologies were introduced and later, when they were well established. Some resistance faded away, and some reflected dissatisfaction with specific forms of monitoring and a will to improve them rather than critique towards monitoring as such. However, there also appears to have been an underlying professional reluctance to lose control of the handling and interpretation of core quality issues. So, even of these cases display an active professional involvement in transparency techniques, there are also components of the defence of professional autonomy against external scrutiny which has been noted so often in previous research.

The Accreditation Case

When accreditation was first introduced at Swedish hospitals, it was at the initiative of Swedac, the national accreditation board. Swedac's initial intention was to start accreditation within health care in general, but it succeeded only in laboratory medicine (Garpenby, 1999). The medical profession was not favourable, including laboratory doctors, who at first resented accreditation because it meant inspection from the outside (Erlingsdóttir, 1999: 118-120). However, in the early 1990s, the doctor-manager of a large medical laboratory, who wished to improve routine descriptions and work organisation, initiated cooperation with Swedac. The chairman of the Swedish National Association of Hospital Laboratories agreed to join the group of professional referees which elaborated a model for accreditation, even if the association as such took its distance. Once this laboratory had started accreditation, others soon followed, keen to obtain a quality stamp in public procurement processes and to be a step ahead if accreditation would become compulsory (Erlingsdóttir, 1999: 121-122).

At the time of this study, laboratory professionals, the doctors and their associations included, were actively involved in accreditation, as described in the previous section. Within pathology and cytology, however, which had relatively more doctors than laboratory medicine in general, many doctors were still sceptical, and several laboratories were not accredited. Even the professionals at the accredited laboratory focused here often expressed frustration with the way accreditation was carried out, in interviews and in conversations during observations. They complained that accreditation only verified minimal requirements that were challenging in the beginning but could not be used to develop quality further, or to compare quality nationally or internationally. Accreditation was seen as expensive, and every year, laboratory management discussed whether to apply again or not. What were lacking, according to the quality manager, who was particularly critical, were tools to monitor effectiveness and not just efficiency.

> It is much more important [to the inspectors] that we do it the right way than that we do the right things. But for the labs today, the emphasis is just the opposite – to us it is much more important to do the right things. Of course we should do them the right way too, but we don't get any help with it, so to say. We are kept stuck in this millimetre-analytical assessment, and in my opinion, they must begin giving us credit for the quality maturity that we have reached.
>
> Biomedical scientist and quality manager at hospital laboratory

These complaints were not necessarily directed to accreditation in general; they could be taken as signs of an active approach and a will to participate in developing accrediting procedures. However, they were also signs of irritation with the detailed

demands of an outside inspector and of a certain interest in returning to a model where professionals in the organisation had the main responsibility for quality monitoring and development.

The National Quality Registry Case

Even if the national quality registries were developed from within the medical profession, not all doctors were equally positive. Before the turn of the century, suspicions that the registries would be used by authorities for control purposes used to be raised at virtually every meeting with doctors in the audience, according to a central administrator at the Swedish Association of Local Authorities and Regions. In the early 2000s, however, this happened only rarely. There were also recurrent difficulties with sufficient local involvement and complaints from participant units that registration was to cumbersome and time-consuming. This criticism did not go away, but it was mostly directed to perceived deficiencies of less successful registries and not to quality registries as such.

Most of all, many medical professionals were reluctant to publicising quality indicators of identified hospital departments or health care centres. This reluctance had been publicly expressed in different contexts and was well known in Swedish health care (Blomgren, 2007). In a survey among the holders of the 29 existing registries in the beginning of 1996, only around 20 per cent were prepared to open the quality registries for full public view (Garpenby and Carlsson, 1996: 28). In a survey in 2001 among representatives for organisational units participating in the registries, 26 per cent were favourable to open reports of the results of identified hospitals, and 20 per cent to open reports of identified county councils. 42 per cents thought that open reporting with identified hospitals would jeopardise the registries in their present form (National Board of Health and Welfare, 2002: 38). The reasons for their reluctance could be seen in the anonymous comments added by respondents, evoking themes that also appear in the interviews, articles, and other documents examined for this study, notably the risk that hospitals would be exposed publicly and unjustly, since comparisons of crude quality measures can be misleading.

> [T]his type of quality registry data becomes so difficult to interpret. I assume that if you look at a heart surgeon for instance, it is probably the surgeon who is considered the best who has the worse results, I would suspect, since the best one gets the most difficult cases. If that should somehow be used to help patients to find the best care, it is of no use.
>
> Kidney doctor

In the view of these professionals, only the medical profession had the right competence and perspective to interpret medical outcome data that could easily be misunderstood by politicians, administrators, the media, and the public.

> A seemingly relevant comparison between different hospitals can be totally irrelevant […] good results for high risk patients – that others avoid to operate on – give seemingly bad operation results and vice versa […]. Such factors that are well known to us in the field *inevitably* tend to be distorted more and more on the way up to higher administrative levels – and finally the press.
>
> Anonymous doctor and representative of a unit participating in a quality registry (National Board of Health and Welfare, 2002: 24)

Only a few years later, several registries were reporting public quality comparisons between identified health care providers. However, there was still a professional reluctance. For instance, a representative of the first registry to start public reporting, the National Hip Arthroplasty Register, still saw difficulties with public reporting in 2004, and said that the media only wanted to report about problems and not about positive results.

Forces Driving Involvement: Legitimising and Developing Professional Work

As is clear from the description this far, professional involvement in transparency technologies in the two cases developed despite initial resistance, largely in response to outside pressures. Professionals perceived the need to *legitimise* their work in the face of external questioning and information demands, in order to acquire resources and, ultimately, to secure the survival of their organisational units. However, it does not seem to be a question of only strategic moves in order to get material and other advantages. The transparency techniques also seem to correspond to professionals' own conceptions of how to assure and develop quality in modern health care organisations. Despite dissatisfaction with existing deficiencies, accreditation and national quality registries – public reporting included – came to be seen as meaningful tools for *developing* professional work. They could be used both to assure minimal quality levels and standardised procedures and to develop new ways of organising work; both to promote general awareness of quality and to offer practical tools to improve it. This was not clear from the start to all professionals involved. Rather, the advantages were discovered and developed under way, stimulated by the networks and the continuous interaction with professional colleagues and experts.

The accreditation case

Ever since Swedish hospital laboratories started with accreditation, professionals were driven by a mix of motives related to both legitimacy and development of work practice. As related above, the first hospital laboratory to apply for accreditation had a doctor-manager who looked for a way to develop local quality. The hospital laboratories that followed wanted to improve their positions in public bidding and in case accreditation became compulsory. The laboratory focused here was one of the early adopters, and according to one of the laboratory doctors involved at the time, there was both a will to improve routines and to get a competitive advantage in public bidding. Later, accreditation became a minimal requirement for public bidding, and in stead of an advantage, it became a necessary way to maintain legitimacy. Other costumers, such as pharmaceuticals purchasing services or blood plasma, also began to demand accreditation of provider laboratories.

Accreditation was also in accordance with the professionals' own conceptions of how to secure and raise quality. At the focused laboratory, even those who were critical to several aspects of accreditation believed that it had improved quality of services.

> [I]n this development, accreditation has made the degree of awareness of every step in the process, so that perhaps you think a little sharper about it. Especially that you need to reduce the risk of mistakes, there is a demand for traceability in a different way, a discussion that did not really occur earlier in the lab world. It is an awareness that is created in all development and accreditation is a contributing factor. It creates a way of thinking, so to say.
>
> Biomedical laboratory scientists and quality coordinator for clinical chemistry

Several professionals noted that the formalised procedures typical for accreditation harmonised with their culture as laboratory professionals, which favoured orderliness and strict methods. Without accreditation, one of them said, they would have had to instigate another, similar system. Some professionals also told of experiences of mutual learning when carrying out internal audits of other laboratory units within the hospital, which was demanded for accreditation, or when inspecting laboratories at other hospitals as part of their accreditation.

> All this cooperation with a joint accreditation has given me a lot. You broaden your views. You meet others with the same problems, ideas, and experiences. And then we look at the activities of other labs [at the hospital] – that is useful. You can bring suggestions home and you can give suggestions.
>
> Biomedical laboratory scientists and quality coordinator for bacteriology

You bring back home the ideas that you get [when you assess other laboratories] and you have them with you in your ordinary routine job. It can be the organisation, ways of writing things in the manual that you think “that is good!”.

Laboratory doctor in transfusion medicine and technical assessor for Swedac

As these quotations illustrate, the professionals at the hospital laboratory appeared to have internalised the assessment procedures and quality standards involved in accreditation, despite their often critical remarks. When engaging in accreditation, they were not just seeking outward legitimacy, but also legitimacy according to professional criteria. The motives of legitimising and developing professional work were connected; as professionals, they saw accreditation as a way to secure quality, to learn, and to improve their work.

The quality registry case

Since the start of the quality registries, their main purpose had been to develop professional knowledge and practice, by monitoring treatment effects and complications, by investigating access to care for different regions and demographical groups, and by making comparisons over time and between providers that were initially anonymised. Several registries also offered more direct support, for instance by providing assistance in the meeting with the patient. The use of the registries to maintain outward legitimacy came later, when the media started to request detailed information, and when some country councils started to demand participation from all health care providers. As we have seen above, the registries approached by the media were pressured to start public reporting, which later became the norm for all registries, even if many continued to publish anonymised results. So, for health care providers to participate in relevant registries and for registry managers to promote public reporting became a question of legitimacy towards different audiences – the media, the general public, administrators, and politicians.

Professionals involved in making registry data public also discovered benefits with such publicity, in terms of strategic advantages and reinforced participant involvement in using the registries to improve quality of care. As one of the earlier registries, the Register for Cardiac Intensive Care started publishing outcome measures for identified hospital departments in 2004, after pressures from an investigative TV program. The ensuing media coverage was fierce, and according to the registry manager, it unfortunately focused on the least reliable outcome measure, i.e. one-year mortality. However, on the whole, the manager was positive to public reporting. In a talk at the 2004 Quality Registry Days, he acknowledged a number of positive consequences, notably improved quality of data, enhanced mutual learning, and stronger motivation for

improvement efforts. He saw public quality comparisons as a way to take advantage of participants' competitive spirit and said that it was not until now that some departments really started to pay attention.

The manager of the National Quality Registry for Gynecological Surgery had similar, positive experiences from public quality comparisons. Participant units became much more interested in the registry reports, and as long as they were well prepared, they could handle the media attention.

> My experience of the press corps is that you can make any number of mistakes, as long as you stand for it. [---] And poor those who have good results, they do not have as much use of the registry. It is those who have the worst results that have most use of it.
>
> Gynaecologist and manager of the National Quality Registry for Gynecological Surgery

There are even examples of hospital departments that have been pointed out in the media as bad performers, following publication of registry data, but have then managed to turn the attention into their own advantage. At the 2004 Quality Registry Days, the manager of the department of internal medicine at Halmstad Hospital, which was denounced in the media for its comparatively high mortality rates, told the happy ending story of how the department handled the situation (see also Hallandsposten, 2004). The department publicly admitted an unfortunate lag with regards to new diagnostic and medical methods and presented their efforts to improve quality of care. Cardiac care came into focus of the entire county organisation and was granted increased funding. In a follow-up coverage of the initial reporting, 'Uppdrag granskning' lauded Halmstad Hospital as an example showing that it is possible to turn a negative development and to improve quality of care. Similarly, the department of orthopaedics at Sundsvall Hospital had bad results in a report from the National Hip Arthroplasty Register. At a conference for quality registry work, the registry manager told of the successful local improvement program that was initiated immediately at the department. New surgical routines were introduced, and critical discussions, which had previously not occurred during radiology rounds, were encouraged. According to the registry manager, this lead to improved results at the department; for instance, there had been no more luxations.

So, the process of increasing public transparency was a learning process with unexpectedly positive experiences for professionals. They told about these experiences at different meetings, and the conception of public reports gained more and more legitimacy among those involved. New practices and ideas developed spread and were reinforced in professional networks. The policy of the Executive Committee

for National Quality Registries, which included professional representatives, was that all registries should include measures for identified hospital departments in their annual reports, starting in 2007. All in all, the public reporting was thus driven by a mix of need for legitimacy, gradually increasing support in professional circles, and professional involvement in improving professional work.

Result of Involvement: Internalised Auditing and Professional Control

In both cases described here, the rising importance of transparency technologies and professionals' active involvement had a twofold and somewhat paradoxical impact on the autonomy and standing of the professional groups concerned. On the one hand, several professionals appeared to have *internalised* ideas of quality control that originated from outside the health care professions and to have embarked on a process that became irreversible. On the other hand, they maintained a significant degree of *control* over important evaluation criteria and thus retained their basic professional autonomy.

At least the professionals who got actively involved in the transparency technologies showed signs of having internalised central auditing ideas that had initially met with resistance in professional circles and that they themselves could also be sceptical about. In the accreditation case, as described above, the professionals who worked with accreditation had a firm belief in the value and potential of continuous quality monitoring, including manuals, detailed routine specifications, and external and internal auditing. They put considerable efforts into making these activities beneficial to the organisation. They could be critical to specific evaluations and decisions made by the accrediting board, but they did not seriously question the idea of accreditation as such, only the specific way it was carried out. Even their criticism was often expressed in suggestions on how to adjust and improve accreditation procedures. And under way, some of their initial critique turned into understanding and appreciation.

> In this world of accreditation […] you are not allowed to do anything if you are not authorised. And much of that felt very alien when it was introduced, and partly it still feels a bit overdone today. That you are authorised for this and that and that you sign lists here and there. The point is that you should have the competence for what you do and you should have the traceability. […] If something happens, it is not because I should be able to go back and say "This is where you did wrong" but rather because I should be able to go back and say "What happened? How can we avoid this the next time?"
>
> Biomedical laboratory scientists and quality coordinator for bacteriology

When it comes to the national quality registries, we have seen how the notion of publicly reported quality comparisons gained at first reluctant resistance and then support among registry managers and representatives of hospital departments and other units that participated in registries. Open quality reporting gradually became the norm, and even if many registries still did not publish quality comparisons at the level of identified hospital departments, that was not something they wanted to brandish. When a national overview of the registries was prepared for 2005, several registry representatives did not want their lack of public reporting to appear in the catalogue, according to the administrator who prepared the report. In stead, it was noted that the registries planned open reports for a particular year, or that they would introduce it gradually. The internalisation of public reporting was also clear from an interview with a cardiologist who worked at a hospital department that participated in the Register for Cardiac Intensive Care, which was about to start publicise outcome data.

I think that we just have to start showing results in this way.
Interviewer: So you think it is good?
Yes, I think it is great, because you can use it in a very constructive way. If you think at your own hospital that we do not have the resources to do this as well as they do it at another hospital, then you can use this registry result to talk with your politicians.
Cardiologist

In both cases, the process was, by all appearances, largely irreversible. Once professionals had begun to devote time and efforts to accreditation and publicly reported quality registries, and once these transparency technologies had gained ground within and without the professions, there was no real possibility of interrupting the development and going back to a state with less intense scrutiny.

In the accreditation case, the professionals at the focused medical laboratory, including the management group, actually discussed the possibility of not applying for renewed accreditation when they were particularly discontented. However, this seemed be a hypothetical discussion; the county council, which was their main costumer, demanded accreditation from all providing laboratories, and even if the laboratory had managed to get acceptance for abandoning accreditation, it is probable that it would have to be replaced with another quality system, with similar elements of quality manuals, inspection rounds, and adherence to external standards. Besides, considerable investments of time and resources had been made to enable accreditation – procedures had been changed, internal control systems set up, and much energy and dialogue had been spent to establish good working relations with

Swedac, the accreditation body – and probably the professionals would hesitate to undo it.

In the quality registry case, there did not appear to be any way back for registries that had started to divulge quality comparisons. It was one thing for a registry management to indicate that data validity had to be improved or that consensus among participant units had to be reached before outcome data could be made public; it would be quite another to exclude a type of information that had been publicised earlier. Just as in the case of accreditation, professionals had devoted much resources to make each registry work. Several registry managers and participant units had discovered advantages with public reports, the practice had gained increased legitimacy in professional circles, and it seems unlikely that the professionals involved would jeopardise a registry's external legitimacy by interrupting public quality reporting.

So, the health care professionals involved in these cases internalised priorities that were originally non-professional and got involved in transparency practices that it became difficult to withdraw from later on. Still, the resulting situation was actually quite advantageous when it came to professional autonomy. The professional groups, and especially their networks of experts and representatives of organisational units, still had considerable control over evaluation criteria. They deliberated, negotiated, and made crucial decisions about how to translate measures and standards between different contexts.

We have already seen how, in both cases, important decisions concerning the principles of scrutiny were framed and made in professional networks that included medium-level professionals, notably hospital consultants, non-medical professionals, such as biomedical laboratory scientists, and local managers of hospital departments. The crucial role of professionals in deciding standards and criteria can be further exemplified. In the accreditation case, Swedac, the accrediting body, had a need to secure legitimacy among professionals in the field, not just for accreditation in general, but also for specific procedures and applications of general standards. On the subject of decisions that could be questioned by accredited laboratories, the inspection team leader from Swedac talked of the importance of professional clearance.

And these questions we put to the reference group, clinical microbiology in this case, which belongs to the Swedish Society of Medicine, in order to know that the profession is behind us. Otherwise there is not enough weight when we are out there.

The team leader also emphasised that in case of doubt about how to interpret general standards, the professionals had the final say.

[T]here are demands but there is also room for interpretation. How do we adapt this demand to this field of activity? And if we are the least doubtful, again, we toss it back to the profession in question, to see, is this a reasonable demand?

Microbiologist and inspection team leader at Swedac

As concerns the national quality registries, there is no doubt that the professionals involved in each registry, mostly doctors, had the final say about how the quality measures were selected, collected, aggregated, and reported. Despite the strong pressures for public reporting, they could still make their own decisions about the pace and character of the publicity. As one centrally located administrator noted, the general policy decision that all registries should provide public data on identified hospital departments was actually not very coercive.

We [in the executive committee] say that the registries should be open from 2007, but we do not say what to report. Trivial information is not the same as […] good analysis and important variables.

Administrator at the Swedish Association of Local Authorities and Regions

So, even with the high degree of external scrutiny implied in accreditation and public quality registries, the professional groups in the two cases retained substantial prerogatives concerning how the quality of the work was ultimately defined and judged.

Conclusion

We have showed how professionals in the two cases got actively involved in transparency technologies through negotiation and translation in wide-ranging professional networks, despite initial and partly remaining reluctance. By this involvement, they managed to influence and take advantage of transparency techniques. In the accreditation case, all professions concerned, including the once so reluctant doctors, became actively engaged in accreditation procedures. Individual professionals participated both as technical assessors assigned by the accreditation board and as members of the accredited laboratory. In their latter function, they were much more active in forming criteria then one would expect, given that accreditation is supposed to be performed by an external, independent party. In the quality registry case, transparency to the public increased because of outside pressures, in spite of the negative attitudes of many professionals. There were some bad experiences of misleading media coverage, but there were also positive discoveries; interest and involvement on the part of participant health care units increased, and quality of data improved, according to registry managers. Even low-ranking hospital departments that were targeted in critical media coverage managed to turn the bad publicity into a

source of financial support and quality development, by admitting mistakes and introducing local quality improvement programs.

Clearly, in both cases, something happened in the process of professional response. Professionals entered into negotiations with external actors, be it benevolent accreditation bodies or more aggressive media and investigative journalists. They learned to shape evaluation standards and criteria by using arguments that were accessible and acceptable to external audiences. They also learned to visualise their own activities and improvement efforts so that their own priorities gained attention, legitimacy, and support. In both cases, they submitted themselves to the gaze and judgment of others, but in the end, professionals retained considerable control over judgment criteria. In the accreditation case, they made decisions and negotiated on standards of accreditation, in their role of expert advisers to inspection bodies. In the quality registry case, medical professionals continued to decide what processes and outcomes should be measured, and when they were pressured to divulge information, it was still they who decided about the pace and modes of release.

The outcome of the process was twofold and somewhat paradoxical. On the one hand, professionals learned to handle the pressures for external visibility and retain professional control over the basic evaluation criteria. On the other hand, they were gradually caught up in a permanent system of continuous external inspection into professional practice. Voluntariness gradually diminishes during the process, through a mix of increasing formal and normative pressures. Once enrolled, it was difficult for the professions to back-pedal, given the commitments and investments already undertaken. Step by step, soft regulation hardened into required practice.

In a sense, the outcome just described is an instance of professional organisations being colonised by a logic of auditing (Power, 1997, Strathern, 2000b), and the process as one of professionals making themselves auditable (Power, 2005). What points in this direction is how the professionals got to participate actively in the continuous monitoring of their work, how they internalised auditing procedures and priorities, and how they gradually got locked into a system of external scrutiny. However, this was not a powerless position; on the contrary, the professionals still managed to control the premises and criteria of evaluation, and to use them to advance professional interests. So, it appears that the basic professional project to control work with reference to exclusive expert knowledge (Freidson, 1994; Abbott, 1988) is potent even under conditions of auditability and transparency. Even when auditing practices are imposed from the outside, and when professionals are pressured to account for their work to outside observers, it seems difficult to overturn the professional prerogative to ultimately define standards of quality.

References

Abbott, A.
1988 *The system of professions*. Chicago: University of Chicago Press.
Ackroyd, S.
2004 'The national health service' in *The new managerialism and public service professions*. I. Kirkpatrick, S. Ackroyd and R. Walker (eds). London: Palgrave.
Black, N., and E. Thompson
1993 'Obstacles to Medical Audit: British Doctors Speak'. *Social Science and Medicine* 36/7: 849-856.
Blomgren, M.
2007 'The drive for transparency: Organizational field transformations in Swedish healthcare'. *Public Administration* 85/1: 67-82.
Blomgren, M., and K. Sahlin
2007 'Quests for transparency: signs of a new institutional era in the health care field' in *Transcending New Public Management: the transformation of public sector reform.* T. Christensen and P. Laegrid (eds). Aldershot: Ashgate.
Bäsén, A.
2004 'Ny larmrapport: Farligaste sjukhusen för hjärtsjuka'. *Expressen* 17 March.
Castel, P., and I. Merle
2002 'Quand les normes de pratiques deviennent une ressource pour les médecins'. *Sociologie du travail* 44/3 : 337-355.
Courpasson, D
2000 'Managerial strategies of domination: Power in soft bureaucracies. *Organization Studies* 21/1: 141-161.
Czarniawska, B, and B. Joerges
1996 'Travels of ideas' in *Translating organizational change*. B. Czarniawska and G. Sevón (eds.). Berlin: Walter de Gruyter.
Czarniawska, B, and G. Sevón, editors
1996 *Translating organizational change*. Berlin: Walter de Gruyter.
Czarniawska, B, and G. Sevón, editors
2005 *Global ideas: How ideas, objects and practices travel in the global economy*. Malmö: Liber.
Equalis
2005 'External Quality Assurance in Laboratory Medicine in Sweden' at: http://www.equalis.se/engelsk%20version.htm (accessed May 2005)
Erlingsdóttir, G.

1999 *Förförande idéer: Kvalitetssäkring i hälso- och sjukvården.* Lund: Department of Business Studies, Lund University (diss.).
Finkelstein, N.D., editor
2000 *Transparency in public policy: Great Britain and the United States*. Basingstoke: Macmillan.
Foucault, M.
1980 'The eye of power' in *Power/knowledge: Selected interviews and other writings 1972-1977.* Brighton: Harvester Press.
Freidson, E.
1994 *Professionalism reborn: Theory, prophecy and policy.* Oxford: Polity Press.
Garpenby, P.
1999 'Resource dependency, doctors and the state: quality control in Sweden'. *Social Science and Medicine* 49/3: 405-424.
Garpenby, P., & and P. Carlsson
1996 *Nationella kvalitetsregister inom hälso- och sjukvården: en uppföljande studie*. Linköping: CMT.
Hallandsposten
2004 'Svarta rubriker gav mer pengar till vård: 30 miljoner kronor extra trots sparkrav'. *Hallandsposten* 16 October.
Hoque, K., S. Davis, and M. Humphreys
2004 'Freedom to do what you are told: Senior management team autonomy in an NHS acute trust'. *Public Administration* 82/2: 355-375.
Jacobsson, B.
2000 'Standardization and expert knowledge' in *A World of Standards*. Brunsson, N. and B. Jacobsson (eds). Oxford: Oxford University Press.
Laughlin, R., J. Broadbent, and D. Shearn
1992, 'Recent financial and accountability changes in General Practice: An unhealthy intrusion into medical autonomy?'. *Financial Accountability and Management* 8/2: 129-147.
Lundbäck, E.
2003 'Challenging Experts in Medicine: Introducing Evidence-Based Medicine'. Paper presented at the 17th Scandinavian Academy of Management Conference in Reykjavik, Iceland, 14-16 August.
Marshall, M.N., P.G. Shekelle, S. Leatherman and R.H. Brook
2000 'The public release of performance data: What do we expect to gain? A review of the evidence'. *Journal of the American Medical Association* 283/14: 1866-1874.
McGivern, G. and E. Ferlie

2007 ‘Playing tick-box games: Interrelating defences in professional appraisal’. *Human Relations* 60/9: 1361-1385.
Mörth, U., editor
2004 *Soft Law in Governance and Regulation: An Interdisciplinary Analysis*. Cheltenham: Edward Elgar.
National Board of Health and Welfare
2002 ‘Användningen av och nyttan med nationella kvalitetsregister’. Stockholm: Socialstyrelsen.
Pollitt, C.
1990 ‘Doing business in the temple? Managers and quality assurance in the public services’. *Public Administration* 68/4: 435-452.
Pollitt, C.
1993 ‘The Struggle for Quality: The Case of the National Health Service’. *Policy and Politics* 21/3: 161-170.
Power, M.
1997 *The audit society: Rituals of verification*. Oxford: Oxford University Press.
Power, M.
2005 ‘Organizations and auditability: A theory. Paper presented at the SCORE conference ‘Organizing the world’, 13-15 October.
Robelet, M.
2001 ‘La profession médicale face au défi de la qualité: Une comparaison de quatre manuels qualité’. *Sciences Sociales et Santé* 19/2 : 73-98.
Sahlin-Andersson, K.
1996 ‘Imitating by editing success: The construction of organizational fields’ in *Translating organizational change*. B. Czarniawska and G. Sevón (eds.). Berlin: Walter de Gruyter.
Sheaff, R., A. Rogers, S. Pickard, M. Marshall, S. Campbell, B. Sibbald, S. Halliwell, and M. Roland
2003 ‘A subtle governance: ‘Soft’ medical leadership in English primary care’. Sociology of Health & Illness 25/5: 408-428.
Shore, C., and S. Wright
2000 ‘Coercive accountability: The rise of audit culture in higher education’ in *Audit cultures: Anthropological studies in accountability, ethics and the academy*. M. Strathern (ed). London: Routledge.
Strathern, M.
2000a ‘The Tyranny of Transparency’. *British Educational Research Journal* 26/3: 309-21.

2000b, editor, *Audit cultures: Anthropological studies in accountability, ethics and the academy*. London: Routledge.
Swedac
2007 ‘How Accreditation is Performed’ at:
http://www.swedac.se/sdd/System.nsf/(GUIview)/index_eng.html (accessed January 2007)
Swedish Institute of Biomedical Laboratory Science
2005 ‘General Information about IBL’ at:
http://www.ibl-inst.se (accessed May 2005)
Tsoukas, H.
1997 ‘The tyranny of light: The temptations and the paradoxes of the information society’. *Futures* 29/9: 827-843.
Webb, P.T.
2005 ‘The anatomy of accountability’. *Journal of Education Policy* 20/2: 189-208.
Weisz, G.
2005 ‘From clinical counting to evidence-based medicine’ in *Body counts: medical quantification in historical and sociological perspective.* G. Jorland, A. Opinel and G. Weisz (eds). Montreal: McGill-Queen’s University Press.