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How ideas are created and transmitted through the organisation field; Quality assurance in Swedish health care

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We note that today ideas and models regarding both how to perform activities and how to present oneself are generously offered to all organisations. Thus ideas concerning organisational models, management principles and quality assurance travel between countries, fields and organisations (Czarniawska and Sevòn, 1996). Organisations in the public sector, faced with the demand for higher productivity and customisation with reduced resources, will often find solutions to their problems in ideas circulating in their particular organisation field (DiMaggio, 1983; Jacobsson, 1995). In this project, one such idea is studied; the idea of health care quality assurance.

The aim of the project is to build a theoretical frame for the analysis of how ideas are created and transmitted through the organisation field, and what happens when they meet the practice at hand in the organisation in which they are implemented. This will be done by joining parts of the so-called new institutional theory (Meyer and Rowan, 1991; DiMaggio and Powell, 1991; Scott, 1995; Czarniawska and Sevòn, 1996) with theories of creativity (Jeffmar, 1978; Koestler, 1964; Fletcher, 1988; Hofstadter, 1985) and organisational decision-making processes (Cyert and March, 1963/1992; March and Simon, 1958/1993; Simon, 1945/1976).

Two quality assurance models have been observed at three places in the organisation field (the health care sector); in central agencies and at the management level as well as on the "shop floor" in one organisation (the Lund University Hospital). Tracing how these two ideas of quality assurance have spread through the organisation field and observing quality assurance procedures in organisational practice, reveals how new standards are created, passed on, and meet the already existing routines.

Theoretical Framework

Institutional theory

Institutional theory is used by several disciplines such as business administration, sociology, anthropology and political science. Different schools are embraced by the institutional perspective but they all claim that the

institution is manifested by habitual actions and that these actions are controlled by ideas, norms, values, laws or traditions of which the institution consists.

The "new institutionalism"

During the past two decades, there has been a revival of what has been called an institutional perspective in organisation research. This "new institutionalism" seeks a better understanding of the role institutions play in organisations and how organisations react to the demands of institutions of which they are constituted and by which they are surrounded. According to this body of theory, organisational change occurs due to a desire for legitimacy and survival (DiMaggio, 1983). Organisations are dependent on acceptance and legitimacy in the field within which they operate – otherwise they will have difficulty in attracting qualified personnel and other resources. To gain legitimacy, organisations seek congruence with the institutions upon which they are dependent and/or want to be part of. Thus change in organisational processes and structures is explained by the prevailing institutional forces.

It is also stated that this process creates a growing homogeneity as organisations both within and between different fields are influenced by the same institutions. Thus, according to Meyer and Rowan (1991), many organisations base their formal structure on the institutional myths of their environment, rather than on their "true" needs. The fact that organisations are becoming increasingly homogeneous, in lack of innovation and effective management, can therefore be seen as the result of institutional isomorphism (DiMaggio and Powell, 1991).

Theories within the institutional perspective explain standardisation on several different levels. They provide the opportunity of understanding the processes that lead to standardised individual behaviour, as well as how units of measurement are turned into standards. In yet a broader sense, institutional theories clarify why organisations adopt standardised ideas from their organisation field and how they are assimilated into the particular organisation.

It is, however, obvious that not all actions follow the rules of institutions. All variations in organisational structure and behaviour that arise when a standardised idea like quality standards, is implemented in an organisation can not be explained by institutional arguments alone, according to DiMaggio (1988).

Seeking solutions to these theoretical paradoxes, i.e. both the similarities and differences that occur in an organisational field, other authors concerned with new institutionalism explain organisational changes in terms of imitation, translation and organisational fashion (Czarniawska and Sevòn, 1996). Interesting as these analytical concepts may be on a collective level, they offer little help in explaining how ideas are created and passed on from one individual to another. The new institutional theory becomes too vague an instrument to be used on field material which describes in detail a person's way of acting and/or reasoning in a problem-solving situation.

"Expanding" the institutional perspective

In the field material gathered in this study, stories were told and situations were observed of how people would find new solutions to both old and new problems they faced in their work situation. These observations can not be explained through the institutional perspective alone. Even though institutionalists like Berger and Luckmann (1966/1979) point out that institutions enable non-habitual action, they do not deal with this creative behaviour. Therefore, a more nunaced analysis to people's problem solving and decision making might enrich the institutional perspective by providing a wider understanding of the institutionalising processes that are constantly ongoing in an organisational field. Such an analysis may be based on combining the institutional perspective with theories and ideas about the act of creation or, as it is more commonly called, "creativity".

Theorising creativity

The concept of creativity was probably used for the first time in a lecture by Guilford on divergent thinking in the early 1950's (Ekvall, 1983) and has since caused problems in its definition. In my "Oxford Advanced Learners Dictionary of Current English" there is no explanation of the word whilst create, creation and creative are explained. In the Swedish "Norstedts stora lexikon" creativity is not explained in its own terms – but it is given as a synonym for the explanation of the adjective creative: "a person who has the ability to produce new ideas and to realise them (syn. creating): creativity" ((p 634) my translation). I personally would prefer Koestler's terminology of the phenomena "the act of creation" (1964) but in order to deal with theories and other literature the concept "creativity" is inevitable as the largest part of the literature on the subject was written in the 1970's when creativity was a concept in vogue.

The quotation "Man, in his essence is a creative being" (Malec, 1969 as referred to in Rommel, 1974, p 20) gives an idea of how the authors dealing with the concept, mainly behaviourists, look upon creativity; namely as one of the most typical human characteristics (Wengel, 1972; Gutman, 1971). Several authors approach creativity by defining its field of application (Bach, 1971; Guilford, 1971; Ekvall, 1983). Bach (1971), for instance, argues that a fruitful way of finding a definition of creativity might be to see it through different variables, such as the person, the process, the product and the pressure (the interrelation between a person and his/her environment). Bach also points out that most attempts at a definition of the concept creativity contain these variables, one of them often being emphasized.

Guilford (1971) points out the remarkable resemblance between the creative process and descriptions of problem solving. According to these descriptions, the problem-solving process and the creative process differ only in one critical point — namely that the creative process involves a phase of illumination which the problem-solving process does not. Arthur Koestler (1964) and Fletcher

(1988) define the illumination of the creative process as bisociation, i.e. the connection of two previously unconnected facts or ideas to form a new single idea, thus contrasting association which, according to Koestler, refers to previously established connections between ideas. Hofstadter (1985) follows a similar line of reasoning and points out that, in his opinion, creativity and insight are intimately connected with intelligence and problem-solving ability.

Both Koestler and Hofstadter show that creativity is dependent upon an underlying structure of knowledge or skill. Nothing comes from nothing — nor does creativity. In the creative process, facts or ideas that are already known are combined in a new way. Bisociation happens by an abstraction of the known notion of ideas so that they become free from their habitual usage and thereby lend themselves to new and unforeseen combinations. Thus creativity is both dependent on the existence of habits and routines and on breaking these bonds. Creativity can thus be seen as a problem-solving process in which previously unconnected facts or ideas form a new idea. It is my belief that the act of creation is basically the same, whether the outcome is simply a solution for the moment, or a new revolutionary technique.

Institutions and creativity

It has been argued in theories about organisational decision making that existing habits and routines form the frames within which people search and solve problems in organisations. According to this view, routines constitute the major limitation to the rational decision process model (Simon, 1945/1976; March and Simon, 1958/1993). But March and Simon also describe how problem solving can range from the "taken for granted" solutions to problem solving in which the search process is essential but "performance programs" are used to find solutions, to situations where neither solutions nor solution-finding programs are available.

It is therefore advocated here that Simon's description of how memory and problem solving interplay, together with March and Simon's theories of different problem solving responses, may be combined with theories about the creative process, such as bisociation. Performance programs that lead to a totally new combination of previously known facts or ideas by bisociation can then, somewhat paradoxically, be regarded as creativity. This would make it possible to comprehend where and how the institution and its standardisation of behaviour interfere with the creative process and its bond breaking.

There is considerable tension between these two sets of theories. Institutional theories consider collective action, thus primarily dealing with organisational and societal levels of analysis. Theories about creativity, on the other hand, deal almost solely with individual action. The institutional perspective is, in part, a deterministic one – assuming that people will behave according to their institutional frames. Theories on creativity are voluntaristic – they presuppose that people strive to be creative creatures, breaking the bonds of routines.

Institutional theories focusing on stability and on standardised behaviour can only give answers to what can be expected to happen in an organisation due to existing institutional forces. Theories about creativity look one-sidedly upon the creative force focusing on dynamics and on non-standardised behaviour in organisations.

Institutional theories explain how routines and standards are established and spread. Theories about creativity explain how people both create and break these standards and routines. Together, these theories increase our understanding of problem solving, the creation of new ideas and change in organisations and their environments. Combining the institutional perspective with theories about creativity may thus lead to an increased understanding of the impact of institutions and institutionalisation on organisational action.

The field study

The aim of the project was to examine how routines and creativity interact within and between different areas within a field with ongoing standardisation processes, as well as to map out how such standards spread and what happens in an organisation in which they are implemented. There is an ongoing institutionalisation of new control forms in the health care sector in Sweden which takes the shape of quality assurance. Different quality assurance models are being introduced, tested and implemented in different parts of the health care sector. Moving from one central agency to another, these ideas represent an acceptable, and often legitimate, solution to different problems. At the management level, one of these quality assurance ideas is chosen and adapted to fit the particular organisation. On the shop floor (in a hospital ward), these new standards are confronted by the already existing everyday routines. Many of the organisations in this field are, moreover, dependent upon the interplay between routine work on the one hand, and flexibility and creative problem solving on the other. Therefore the idea of quality assurance within the health care sector in Sweden has been studied.

During 1994, when the study was initiated, an intensive implementation was being carried out at the University Hospital of Lund. An Organisational Audit type of quality assurance – the so called Lund model – was being implemented at the same time as other models were to be found out in the clinics. An object of study which was close at hand thus presented itself and I decided to try to find out how the introduction of new standards – those of quality assurance – affected the routines and creativity on the shop floor which, in the case of a hospital, is in the wards.

Direct observations

It was necessary to take part in, or observe, the work in a ward for a continuous period of time to be able to identify and distinguish between the routines and/or creative actions that take place there, and how they interact, as well as to

observe quality assurance procedures in practice. Therefore, observation with emphasis on direct observation was used as a method in the field study. Observation combines several techniques for gathering information, such as; surveys, analysing documents, direct observation and participant observation (Denzin, 1978) and is a method that is well suited to studying action and to interpreting influence. Direct observations were carried out at three clinics at the Lund University Hospital; the Medical Clinic, the Surgical Clinic, and the Clinical Chemical Laboratory. These were chosen to represent different working methods and routines within health care.

The initial intent was to study only the principle quality assurance model being implemented at the University Hospital of Lund, the Organisational Audit model. However, it turned out that in one of the clinics studied a different type of quality assurance model was being implemented. The Clinical Chemical Laboratory had applied to SWEDAC to be accredited. The fact that the observed clinics have used different types of quality assurance models provided an excellent opportunity to follow and compare them both throughout the study.

New questions arose during the direct observations and as continuous reformulation and restructuring of the research during the process of observation is encouraged (Schatzman and Strauss, 1973) material has been gathered in parallel with the direct observations, to enable the work identifying out where these particular quality assurance ideas in health care originate from, and how they have spread through the organisation field. For this purpose, interviews were conducted and written material gathered at both different central agencies and at the management level at the hospital.

Where does quality assurance come from?

The concept of quality assurance within the health care sector is not a new idea at all. It began when The American College of Surgeons introduced a system for the approval of surgical clinics in the USA in 1918. This work expanded and at the beginning of the 1950s The Joint Commission on Accreditation of Hospitals was founded. This primarily American idea has since been adopted amongst other countries, Canada and Australia.

In Sweden, quality within the health care sector has, for a long time, been superintended by educational agencies, legislation, supervision by the Swedish Standing Committee on Social Questions, etc. This supervision has not been carried out in the form of quality assurance or standards, but rather as general recommendations. It was as late as in the mid 1980's that people at Spri (the Swedish Planning and Rationalisation Institute of Health and Social Services), started to discuss different quality assurance models.

Tracing the path of the Organisational Audit model led back to a former employee at Spri who, according to both herself and other people in the field, was the initiator of Spri's work on quality assurance. The woman in question worked at Spri in the 1980s. Spri's main task is to give advice to and provide support for decision makers within the health care sector. In doing this, Spri

maintains a close contact with organisations in the field and, of course, keeps track of the general state of affairs within the health care sector. In the 1980s new demands as well as heavily increased costs led to what has been referred to as the "cost crisis" in Swedish health care (Spri 287, 1990). At the same time, approximately 1986, RRV (The National Audit Bureau) published a report on productivity within the health care sector in Sweden between 1960 and 1980. The report claimed that the productivity within the health care sector in Sweden had decreased during these twenty years. Organisations within the health care sector reacted defensively by claiming that the report was misleading as it did not show and/or give credit to the increase in quality during the same period.

The problem was later formulated in one of Spri's reports as follows; "There seems to be a lack of a system for measuring and evaluating the quality within health care" (Spri 287, 1990). Bearing this in mind, the Spri employee was listening to a lecture, by a professor invited to Spri, on how private companies used quality assurance to both raise their quality and assure customers of the quality of their products and services. She told me *"when I heard him, I suddenly thought of the problems we were having measuring quality within the health care sector, and I thought this is what we should be doing"* (referring to the quality assurance work). From then on, Spri had a group of people working with quality issues. Those who started this work were inspired by both quality assurance in industry and various quality assurance programs in health care in other countries. Quality assurance has, with time, become one of Spri's main domains.

During the past ten years, quality assurance as such has become habitual within the health care sector in Sweden, although the methods and models vary. This variation can be traced to central agencies where everybody seems to agree about the necessity of quality assurance while, at the same time, different authorities promote different models as the optimal one (Erlingsdóttir, 1995). Thus, the Swedish National Board of Health and Welfare has developed a Swedish model similar to the SIQ (Swedish Institute for Quality) model which is called QUL and has the form of a competition, where only one "winner" gets the distinction for best quality. Spri, on the other hand, is monitoring the Organisational Audit model as part of their drive for a national strategy of health care quality assurance in Sweden. Furthermore, a change in the "Health/Medical Services Act" in January 1997 has made it compulsory for anyone (organisation or person) responsible for medical care to have a quality assurance plan.

The Organisational Audit becomes the Lund model

People working with the implementation of the Organisational Audit model at the University Hospital in Lund told me that they had come to learn about the model through their contacts with Spri. The collaboration between the University Hospital of Lund and Spri began as early as 1990, when Spri initiated a study of the quality work being carried out in four hospitals in Sweden. It was thus natural for the Quality Assurance Board of the University

Hospital of Lund to confer with Spri about the choice of a suitable quality assurance model, whereupon Spri recommended the English King's Fund's Organisational Audit model. A delegation from the Quality Assurance Board from the hospital went to England and studied the model in practice. They decided that the Organisational Audit model seemed suitable for implementation in Lund. In December 1992 the work of translating the quality assurance guide into Swedish started. This work took a year since it was necessary to change the structure as well as the formulation of the quality guide. Spri, who brought the quality guide from England, supervised the translation. The Quality Assurance Board, including a representative from all the hospital clinics, worked centrally on the implementation of the Lund model. The representatives from the clinics had the responsibility of informing each at their clinic about the program.

The reasons for implementing a quality assurance model of this kind in Lund were said to be that it was expected to bring benefits to the hospital in relation to the customers, not the patient as such but the municipalities and county councils who were the potential buyers of the hospital services. Another reason was to show others in the field that the hospital in Lund had engaged itself in quality assurance. As somebody commented, *"It's a sort of a trend for the moment, you see. A couple of years ago everything was ethics, now there is no talk of ethics, its all about quality assurance."* At the administrative level, quality assurance was understood as being part of the changes towards market economy within the health care sector.

The SWEDAC model

The Clinical Chemical Laboratory had applied to be accredited by SWEDAC in 1993, and was in the phase of preparing itself for the first real accreditation when the direct observation was carried out during the autumn of 1994. When I met the head physician while preparing this study he told me that the clinic was implementing a different quality assurance model than the overall hospital. He also claimed that the SWEDAC model was so much broader than the organisational audit model that the lab would automatically fulfil the audit model's standards by meeting the SWEDAC acquirements. The initiative to introduce the accreditation model was taken by the head physician himself. Thus the implementation of the accreditation model was not monitored centrally at the hospital. The reason for implementing this quality assurance programme, whose costs were high, was said to be firstly, that it would be a good sales argument for the customers and secondly, that there was some discussion within the branch organisation implying that it might become compulsory for clinical chemical laboratories to be accredited in the near future. As the clinics at the University Hospital of Lund were free to buy their services from whichever laboratory they preferred – the Clinical Chemical Laboratory was literally operating in a marketing economy.

The idea, to be accredited by SWEDAC as a clinical chemical laboratory, came from the Sahlgrenska Hospital in Gothenburg. Their Clinical Chemical

Laboratory was the first ever in Sweden to use SWEDAC's accreditation model. The professor of the clinic was the one who came up with the idea and he told me how and why he got the idea of using the SWEDAC accreditation. The professor felt that the laboratory lacked a system for organising and keeping order in a workplace where both equipment and analyses must be monitored in detail. He said that the issue had been raised in the National Board of Clinical Chemical Laboratories but nothing had been done – mainly, in his opinion, as politicians and administrative decision makers did not want external revision of the enterprise. Being responsible for a laboratory with over 300 employees and quite recently having moved to new facilities, he thought he ought to set new standards to enhance quality. There was some talk about quality assurance in the field and he had seen an American quality assurance guide but found it too complicated and in too detailed. SWEDAC, which at that time mostly controlled water laboratories in Sweden, had the same area of interest and was therefore known to the head physician. One evening, as he sat at home thinking about these things he suddenly thought of SWEDAC *"and I thought why not ask them if they are interested in accrediting the lab – so I wrote a letter and sent it to them"*. The professor claims that it was mainly the need to enhance the quality of everyday routines that triggered his search for a new solution, but he also recognised the changes towards market economy within health care in Sweden as an argument for engaging in quality assurance work.

Until their work with the Sahlgrenska Hospital started, SWEDAC's accreditation only concerned water laboratories. Now it is also used for chemical and physical laboratories within several hospitals in Sweden. SWEDAC is connected with an EU collaboration concerning the development of standards, as well as specific interpretation documents, and thus the accreditation model is linked to European norms.

Quality assurance on the shop floor

Direct observations result in a vast amount of data of which only a few examples can be given in this paper. The wards in the Medical Clinic and in the Surgical Clinic varied in many ways, and a great deal of the material from the observations appears to make comparison possible. Regarding the examples that will be presented here however, the two cases are similar enough to be viewed as variants of the same type of ward. The third case is different since it is a clinical chemical laboratory without any direct contact with patients and with a high degree of automation. The cases are labelled "the Lab" and "the Ward". Each is briefly described below.

The Lab

The Clinical Chemistry Laboratory is a clinic comprising nine sections where analyses are carried out for the Lund University Hospital and also for the majority of the wards close to Lund.

The samples to be analysed at the Lab (mostly either blood or urine) arrive at the reception in test-tubes. Depending on the type of analysis required, the test-tube is channelled to the appropriate section within the Lab. Each section is automated to a degree depending on how standardised the test is. The personnel within each section work at different work-stations according to a rotation scheme. Most of the work-stations involve operating a machine. The work is carried out according to strict regulations and is highly routinised. Clear instructions describe how samples can/shall be handled and how different sub-operations are to be carried out. These systems were quite transparent. Routines and standards were obvious, although the degree of standardisation differed between the different sections as a function of the degree of automation.

The Ward

The Ward can be described as an ordinary ward, where patients are admitted for treatment, for a number of weeks on average. On the Ward, the task of the individual employee was largely defined by his or her staff and shift affiliation. Task assignment was not as strict as at the Lab, and machines were not as common, although small pieces of equipment and tools existed. Manuals guiding the handling of sub-operations were present only in exceptional cases (in connection with machinery and other technical devices).

The administrative tasks were not divided in any particular manner between the personnel. Nobody in particular was assigned to answer the phone, answer questions from either the patients, relatives or staff from other units, or to handle the correspondence with, for instance, social workers and physiotherapists. Nor did nurses or doctors have devoted time or space where they could handle paperwork. This was done in the reception where the risk of being interrupted was substantial.

Preliminary findings

According to the hospital management, a quality assurance model was implemented in the entire hospital in 1994. This quality assurance was however, not that visible in the concrete activities in the organisation on the "shop floor" in the ward. Several routines and quality control activities were carried out in the ward but none of them could be linked directly to the Lund model. The only time the quality assurance model was mentioned by the personnel was during the same week the audit was carried out at the hospital. The personnel believed that the auditors would turn up, which they did not. The reason for not turning up was afterwards stated to be that the auditors had talked to somebody at the administrative level at the clinic, and had hence not visited the department on this specific audit.

In 1994, the Lab applied to be certified in accordance with SWEDAC accreditation standards. The implementation of this particular quality assurance programme was evident. During our observations the Lab went through an internal revision of all sections, preparing themselves for the real SWEDAC

accreditation. Many of the new routines derived from the quality assurance were visible as they required special attention as the staff were still learning them. During the revision, even more new routines emerged, designed to measure the standards and routines already in place.

Both routines and creativity were found at the Lab as well as on the Ward. At the Lab, creativity was especially evident when the equipment caused trouble. In these instances the personnel had to find different solutions such as running the samples on other machines, in a different order or in another section. In most cases, an engineer was available who had the responsibility of mending the malfunctioning equipment. Meanwhile, the laboratory technicians found other temporary solutions. However on several occasions I witnessed the lab assistants devoting themselves mending the equipment. I especially remember a technician who dived into a huge computerised machine one night when the engineer was out of town -*"We have to get it started - one ought to be able to see what is wrong - Look! it's probably that thing that has got stuck - if we just had the tools."* She searched for the right tools without finding them. Finally, she found some other tools which she tried to use, but unsuccessfully. - *"One ought to be able to bend it loose"* she continued, - *"a device this shape is what is needed"* she showed with her fingers the shape she believed to be needed to loosen the stuck device. Thereafter, she went hunting through shelves and drawers, all the way to the staff kitchen and returned in rounds with different things resembling the shape she thought to be correct.

When SWEDAC's guidelines were implemented, the personnel had to apply them themselves. This meant that they had to produce new standards and routines in order to meet the requirements of the accreditation. This was considered quite a creative experience by the staff.

In the Ward, routines and creativity were more intertwined. Many small changes were made continuously, concerning both organisational issues and the treatment of patients. The staff's desire to make the situation as bearable as possible for the patient led to several creative solutions, mostly using existing equipment and/or materials, such as band-aid, for a purpose other than that originally intended. One situation where a new solution was found was when a patient's drip stand broke just as he was to be sent to another department for an examination. The drip stand would not stay in the position it was meant to and several nurses and staff nurses who were present stopped what they are doing and came running to assist – they took turns in trying to "fix" the thing, but without success. Finally one of the nurses said *"doesn't the stand on the bed look almost the same?"*. She than ran with one of the staff nurses to check the bed stand which turned out to fit the rest of the drip stand, and the patient was able to proceed to his examination with a new type of a drip stand. Several creative situations arose from stress - when patients and/or relatives had to be taken care of in times of shortage of staff. Regrouping among the personnel and redefinition of who was to do what, were frequent. Stress situations did not, however, always lead to creative solutions. In the Ward, routines often had to be

interrupted in order for the staff to take care of a more urgent matter. This often led to a chaotic situation when the entire routine had to be re-run at a later time. This created problems and more work.

Analysis of the findings

There is an ongoing institutionalisation of new control forms in the health care sector in Sweden, taking the shape of quality assurance. Different quality assurance models are being introduced, tested and implemented in different parts of the health care sector. The project described here is concerned with the implementation and adaptation of two such quality assurance models in the Swedish health care sector. The two models studied, the Lund Organisational Audit, and the SWEDAC accreditation, have been traced through the organisational field. Hitherto, investigations have been carried out at three places in the field; in central state agencies where ideas flow through networks, on an managerial level of an organisation (a hospital) where one specific model is chosen, and on three shop-floor settings in this specific organisation.

The analysis of the material from the study is still in progress and therefore the results presented here are preliminary. In the analysis, the focus is on the dynamics between processes of standardisation and creativity, both within and between the different places studied. The general idea put forth here is that institutions and creativity can generally be depicted by habitual actions manifested in routinised problem solving, and non-habitual actions manifested in unroutinised problem solving. Further, it is suggested that the relationship between institutions and creativity in an organisation varies both over time and due to different situations and processes. Indeed, when standards meet with practice there is dynamic interaction between standardisation and creativity. Thus when a new idea or solution is institutionalised, creativity can enhance the assimilation of the idea in an early phase, while in a later phase the already established institutions can enhance and/or restrain creativity. Creativity was found in the utmost standardised surroundings and routines and standards were found necessary to enable creativity.

It was further found that in the process of creating, and/or making use of standardising idea (such as a quality assurance model), people in central agencies, at managerial levels in organisations and on the shop floor may react to and utilise standardisation in different ways. So far, the study has shown that people locally, solve problems that are created by quality assurance standards, in a creative manner. In this case, creativity is a direct consequence of attempts at standardisation. On the other hand, the study also shows that people who work with standardisation procedures can be creative in their problem solving, so that their creativity actually leads to standardisation.

Institutional theories usually focus on stability and standardised behaviour. Theories about creativity often look one-sidedly at dynamics and non-standardised behaviour. My ambition is to join the two sets of theories, by enriching the institutional perspective with theories about creativity.

Empirically, this is done by showing how routinised and creative problem solving alternate during standardisation processes in organisations. By viewing standardisation and creativity as two sides of the same coin, we may enrich our understanding of the dynamics of organisational behaviour. While organisational practice can gain from the insight that creativity and standardisation might go hand in hand, organisational theory might similarly become enriched by a dialogue between the institutional theory and creativity theory.

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