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Abstract

This article investigates variations in two professions' adaption of quality reforms. The adaption of reforms is viewed as a part of the professions' legitimacy and identity processes. Literature in the area suggests that the adaption of reforms is influenced by the profession's knowledge base, professional norms, organizational belonging and organizational field. The two cases here on how doctors and auditors adapt to quality reforms show that the influences of these factors are, however, moulded by the professions' strategies and the salience of the different aforementioned factors. A general conclusion is that compatibility between the bases of knowledge and the professional norms are vital for the adaption of reforms and that organizational fields are important for setting the agenda. Organizational belongings, on the other hand, seem of less importance for adaption of quality reforms.

Keywords

Auditing business, health care sector, legitimacy and identity processes, professions, quality reforms

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For some decades now reforms have been one of the main sources of organizational change (Brunsson and Sahlin-Andersson, 2000). In the early 1980s, quality assurance became a fad in the private sector and was introduced together with other New Public Management (NPM) reforms into the Swedish public sector during the 1990s. NPM brought about a number of administrative reforms intended to enhance the efficiency of the public sector. One consequence of these reforms was that market-based and bureaucratic forms for control challenged professional forms for control in both public and private sectors. The reason for reforming and the way that reforms are dealt with by the professionals, however, differ between various professions as diffusion implies reinterpretations and negotiations of the content of the reforms. Actors may thus adapt to the same reform differently depending on the characteristics of the recipient.

In this article we investigate the adaption by two professions, doctors and auditors, to reforms. Earlier research regarding professions' adaption to changes has been performed both at the level of professions as collective (e.g. Ackroyd and Muzio, 2007; Greenwood et al., 2002; Warring and Currie, 2009) and on the level of the individual professional (e.g. Empson, 2004) and has also been salient in the research about the effects of NPM (e.g. Bejerot et al., 2008; Kirkpatrick et al., 2005). Our contribution to this stream of research will be to study the variations in the ways different professions adapt when they meet a similar occurrence and to connect these variations to features important for the profession in their legitimacy and identity processes.

There are several models of profession's legitimacy processes, especially in the research regarding professional boundaries and boundaries processes (e.g. Abbott, 1988; Fournier, 2000; Montgomery and Oliver, 2007). We depart from the model developed by Fournier (1999) where the legitimacy and identity processes are viewed as ongoing processes and manifested in the practice of the professions. Our main focus is upon the professions as collective. As Fournier's model focuses on legitimacy processes we complement this with a discussion of the identity processes.

We have chosen the diffusion and implementation of quality reforms as our case. Quality reforms may be initiated by actors external to the profession, as by professional associations, or by powerful members of the profession. Quality reforms have been widely diffused between countries and professions in different sectors as a part of NPM and the liberalization and globalization of markets (Hasselbladh and Lundgren, 2002). Quality reforms are thereby a suitable case for comparing the actions of different professions. As our focus is on the variations in professions' adaption rather than on quality reform as such, we delimit our presentation of quality reforms to the ones implemented in the Swedish health care sector and audit business.

The article is organized as follows. First, we present the theoretical framework where adaptations to reforms are viewed as legitimacy and identity processes. There after our two cases are presented: the Swedish medical profession and the Swedish audit profession. The cases are analysed in relation to the following dimensions: the profession's knowledge base; norms; the professionals' perceived belonging; and features of the organizational field. The article concludes with a discussion of the variations between the professions in adapting quality assurance.

Actions to gain legitimacy and collective identity

The diffusion of new administrative reforms may be done for several reasons and through different channels. Researchers have described diffusion reforms either as a fashion or fad (Røvik, 2002), or as the 'bandwagon effect' (Andergassen et al., 2006). In both cases legitimacy with regard to the wider environment has a salient role in explaining the implementation of new reforms. This is the case also when professions implement new administrative reforms. Professions' domains are based on 'claim of truth' and that their conduct appears as appropriate. To retain control the profession has to currently meet criteria of legitimacy (Fournier, 1999: 289). If the 'truth' (or knowledge), or the conduct is questioned, so too is the profession's function in society. The way professional competence is exposed is likely to vary depending on the actors that are salient for the legitimacy of the profession. Often it is the function of professional associations to legitimate the profession in the eyes of the public and to retain the professions' claim to truth, as well as the boundaries between different professions (Greenwood et al., 2002). The 'claim of truth' is not static, but malleable and expendable in order to secure the profession's domain (Fournier, 2000) and a profession's legitimacy is not static, but something that may be constantly contested.

The profession's activities in order to legitimate it with regard to other groups in society simultaneously imply a construction of the professional identity (Fournier, 2000; Power, 2003). Identity, as legitimacy, is nothing monolithic or robust (see Alvesson, 2000); instead, an individual identity is constructed and reproduced through everyday social interactions and practice. According to Heggen (2008: 323) professional identity is directly connected to the notion of self and the practice of the individual, while a profession's identity is connected to the collective identity of a profession. Professions' identities are two-sided: one concerns group identity, which is internal for the members of the profession and deals with how individual professionals identify themselves with the profession. The other side is a category identity through which actors outside the social category of the profession identify the profession.

A collective profession's identity is often constructed and maintained by professional associations, as it acts as an arena for members where the content and meaning of the membership in the profession are continuously discussed (Greenwood et al., 2002). It also functions to ensure that the members live up to the collective identity through, for example, ethical codes and standards and disciplinary means directed towards members who do not act accordantly. A foundation for the group identity as a social category is thus created as the professional association acts as the agent for the profession in relation to other groups in society. Identity processes on a collective level are thereby closely interlaced with the processes of legitimacy. Both cases deal with exposing representation of the profession through practice; *identity* regarding what the profession is, *legitimacy* regarding the public good and the truth of the profession.

The processes of legitimacy and identity thereby contain a stream of interconnected activities. Which activities are performed will, however, be connected to how the profession has chosen to meet the criteria of legitimacy, the profession's identity and the salient actors for pursuing the legitimacy. This implies that reforms under a similar label, such as quality reforms, may lead to variations in the way different

professions adapt to the reform. Comparing the implementation of these reforms in different professions therefore will give us insight into the relationship between the salient actors, the claim of truth and the legitimacy criteria of different professions.

Bases for variations in adaption of reforms

A first basis for variation in a profession's implementation of reforms is the organizational field of the profession. Reforms often diffuse between different fields, in the case of NPM, from the business sector to the public sector (Hood, 1995). Features of the reform imply various possibilities and bounds for different professions. According to Fournier (1999: 289) the legitimacy processes of professions are marked off by the actors that are salient for the constitution of the profession's domain. This implies that, sometimes, new reforms may be enforced through 'external forces' rather than initiated by the profession itself. The liberal government is probably a salient part of most professions' (Fournier, 1999), and especially so in Scandinavia and continental Europe where professions traditionally have been closely connected to the state (Evans and Honold, 2007; Svensson and Evetts, 2010). Professions may however be exposed to various types of regulation and dependent on different governmental agencies. Besides the state, professions meet different types of clients, cooperate or wage domain contests with other professions. The organizational field of the profession thereby influences the way that professions adapt to new reforms.

To be a 'carrier of truth' implies building on professional competence, specified by Fournier (1999: 289) as knowledge, the personal conduct of the practitioner and control over practice. These aspects may all be bases for variations in the way a profession adapts to reforms. First, the type of knowledge a profession possesses may differ both in kind and in exclusivity and malleability. Second, the professional conduct is, on a collective level, most often controlled through the development of professional norms and standards. These norms differ between professions and are likely to influence the profession's actions when adopting new reforms. Third, according to Fournier (1999), professional competence includes sustaining control over practice. This may be achieved by an apparent adjustment, but decoupling the practice from the reform (Meyer and Rowan, 1977). In the wake of NPM, we have observed that implemented reforms have had the intention and the effect of rendering professionals manageable and thereby changing the autonomy and the identity of the professions (see Bejerot et al., 2008; Brunsson and Sahlin-Andersson, 2000; Erlingsdóttir, 1999). In some cases, however, the professions have seized the reforms and utilized them in order to enlarge their domain of activity and increase their legitimacy (e.g. Aidemark, 2004; Selander, 2001).

A salient issue related to the application of professional conduct is where a professional finds a point of reference for her/his own identity (Warren and Alzola, 2009). Previously, the collective identity has been the obvious point of reference for most professionals. Today this is not self-evident (Empson, 2004; Gendron and Spira, 2010). Former homogeneous professional workplaces have developed into multi-professional ones and most professionals have become salaried employees in large organizations (Ackroyd and Muzio, 2007; Leicht and Fennell, 1997). The profession's collective identity, thereby, has competition from the identification with the organization.

In summary we expect variations in the way different professions adapt to reforms depending on: the organizational field of the profession; features of the knowledge base of the profession; the collective norms and standards of the profession; and the saliency of the collective or organizational identity for practitioners.

Method

The effect of the implementation of a reform is an empirical issue. In the rest of this article we discuss the implementation of one technique, quality assurance, in the professions of doctors and auditors. The two professions are both well established with defined domains. They are based on professional training including intellectual components as well as skills. They apply professional control through socialization into the profession monitored by their professional organizations, and abide by norms such as autonomy, self-regulation and public service. The content of the training and the norms, however, varies widely. While public service manifests the doctors' aim to save life, the service of the auditors consists of ensuring that companies supply sound financial information to the financial markets. The doctors in Sweden work mostly in the public non-profit sector, whereas auditing is big business dominated by global firms. This variety provides a wide span in which professions' approaches in relation to new reforms may be investigated.

The cases are built on two research projects in health care (Erlingsdóttir, 1999; Erlingsdóttir and Jonnergård, 2006) and one research project in the audit business (Erlingsdóttir and Jonnergård, 2006; Jonnergård, 2003) about implementation of quality reforms in the Swedish health care and audit business up to 2004. The Swedish health care study draws on 30 interviews with practitioners, hospital administrators and representatives of the Swedish Medical Association both locally and nationally. Also observations in three different clinics of the implementation of quality systems in Swedish hospitals were carried out and a substantial archive study of the development of quality reforms within the sector. The study of the audit profession is based on 30 interviews, discourse analysis of the debate about quality reforms within the profession and studies of internal and external documents. We start our investigation by briefly describing the development of the quality reforms in the two fields, and then we discuss the approaches of the professions.

Quality reforms in the Swedish health care and audit business: The background stories

The Swedish National Board of Health and Welfare (Socialstyrelsen) supervises the health care sector. In this function the National Board regulates the sector and carries out the disciplinary function in relation to the professionals. The political governance of the health care sector is divided between the government through the National Board of Health and Welfare and the counties. The counties are responsible for organizing local health care and ensuring the efficient use of public funds.

The doctors in Sweden are organized in two associations: the Swedish Society of Medicine, which has its main interest in supporting research, education and development

within the health care sector, and the Swedish Medical Association, which is the doctors' union and professional organization. The Swedish Society of Medicine is responsible for continuously improving the education and training of doctors, while the Swedish Medical Association develops ethical codes and rules for the profession.

Traditionally, the quality control of doctors has been professional self-regulation. Deviation from good practice, acceptable professional values or conduct may be punished by exclusion from the profession. The ethical code formulated by the Swedish medical associations appears as a strong common norm for all doctors. Even though Swedish doctors do not formally swear an oath, this code functions as a code of honour or best practice for the doctor (Eklöf, 2000). The doctors carry out their work with peer job autonomy, implying that each doctor is responsible for his/her decision regarding diagnosis and treatment. The conduct of doctors is traditionally based on reliable practice and scientifically tested methods. The daily routines have not been regulated in detail but decided on currently by the doctors within each specialist branch. Research is looked upon as a guarantee for continuous quality improvement and development.

In the Swedish health care sector, quality reforms were introduced in the mid-1980s (Erlingsdóttir, 1999; Hasselblad and Lundgren, 2002). The idea behind the reforms emerged as a part of NPM and from popular management discourses such as TQM and ISO9000. Quality assurance was mainly introduced and promoted by policy organizations in the field and was initially seen as a solution to the problem of measuring the quality of health care. This was linked to the government's aim to gain better measures and control of the cost of the public sector. At first the ambition was to find a common national model; however, a number of models were introduced and tried out at different locations in the field. None of these have become permanent however. In order to ensure implementation of quality reforms, self-regulation with regard to quality assurance became a legal requirement for all organizational units in the health sector in 1997. This requirement did not lead to any standardization of the quality models. As a consequence the legal requirement for quality assurance was abandoned in 2005. Nevertheless, the subject keeps resurfacing in discussions about the state of public health care in Sweden.

In contrast to the health care sector, auditing is a big private business. The control of the auditor is thereby realized, first, by governmental supervision of the sector, second by the professional association FAR (the Association for Authorized Public Accountants) responsible for developing the knowledge and ethics of the profession, and third, by the audit firms' traditional managerial control systems. Traditionally, FAR has played the biggest part in control of auditors. The association has had a specific disciplinary committee to which complaints have been reported. In severe cases, the complaints have been taken one step further and reported to the organization that authorized the auditors. In 1973 the government authority, the National Board of Trade, assumed responsibility for the licensing and supervision of auditors. In 1995 a special governmental organization, the Supervisory Board of Public Accountants (Revisorsnämnden), was established. The Supervisory Board took over the disciplinary control of auditors.

Traditionally, auditors have legitimated their activities through legal monopoly and professional standards of ethics and conduct. Since the 1970s the business has been characterized by increased internationalization. Global audit firms have emerged and the market is increasingly becoming an oligopoly. Besides the globalization of the audit

firms, the profession has actively worked for international standardization of accounting and auditing standards. In addition, the EU has issued recommendations and directives regarding audit work processes as well as audit independence and audit quality control.

In the audit business, quality reforms emerged in the US during the 1970s. The reforms were readily imported to Sweden and a standard for a quality assurance programme was developed by FAR. At the beginning of the 1990s FAR addressed the issue once again. In 1997, a decision to implement obligatory quality control was taken by FAR. The decision was influenced by a strong global trend in favour of quality assurance and as the new government authority, the Supervisory Board of Public Accountants, had taken over the control of the audit business.

In November 2000, the EEC Commission issued a recommendation of a minimum requirement for quality control in the audit business. In Sweden, this recommendation led to lengthy negotiations between the two professional audit associations (the other was the Association for Approved Public Accountants) and the Supervisory Board. An agreement was reached that the professional associations should continue to carry out quality control. The result of these controls was to be reported to the Supervisory Board on an annual basis. In addition, the Supervisory Board was to carry out a 'control of the controls', i.e. each year scrutinize a number of quality controls done by the professional associations.

Approaches of the Swedish medical and audit professions

This article's empirical basis is found within the framework of the two stories above. The two professions and their associations have reacted quite differently to quality reforms and these differences can, at least in part, be explained by the professions' urge to use quality reforms as a part of their legitimacy and identity processes. In the material we discovered two phases of the implementation process. For the doctors the phases are disregard and capture, and for the auditors there are the phases of incorporation and boundary setting. We have chosen to structure our material according to these phases.

Doctors' phase I: Disregard

Quality reforms in health care were initiated mainly in order to measure medical quality. As medical quality is hard to measure the first models for quality assurance, for instance ISO9000 Organizational Audit, focused on the organization or structure of the activities rather than on medical quality. The reforms were initiated and promoted through policy organizations and most hospitals and staff thus came into contact with them. Still, doctors more or less ignored these discussions in the beginning. According to the CEO of the Swedish Medical Association in 1994, doctors were of the opinion that quality and quality development was built into their everyday work and routines and that the models presented by the authorities or policy organizations were not contributing to what they themselves regarded as quality. Thus quality assurance rather became an issue for the head nurses (Erlingsdóttir, 1999). Still the Swedish National Board of Health and Welfare issued a recommendation on obligatory quality assurance in the early 1990s. The recommendation did not attract that much attention, and in a

survey held in 1996 many chief doctors claimed no knowledge of it (Rosén, 1995). Neither was much attention paid by the professionals to a change in the Swedish Health and Medical Services Act, which was made public in January 1997, making it compulsory for anyone responsible for medical care (organization or individual) to have a quality assurance plan. For example, no discussion addressing the subject appeared in the Swedish medical journal, the official organ of the Swedish Medical Association, which is the forum for most discussions within the profession and there was no discussion or opposition from the doctors at the public meeting presenting the new law.

To summarize, the doctors profession's approach to the first phase of the quality reforms was characterized by a lack of interest, which can be interpreted in a number of ways:

- Doctors did not experience quality reforms as a threat to their professional autonomy;
- They regarded quality reforms as a temporary fad;
- They did not relate to the models that were trialled, as these did not correspond with the doctors' own professional view of quality development and control.

Probably all three interpretations are valid. As the quality reforms were not experienced as a threat to the doctors' professional autonomy, for most professionals there was no reason to react or get involved. However, the reforms did not fade away.

Doctors' phase 2: Capture

By the turn of the century the Swedish National Board of Health and Welfare showed an increased interest in transparency of and control over medical processes. A shift to quality assurance as a way of controlling the operative medical work therefore seemed to be in process. As Bejerot and Erlingsdóttir (2002: 70) pointed out, at the time: 'The future follow-up systems of health care are thus based on systematised and in many ways translated medical knowledge, processed and made visible by modern information technology.'

Basically there were three main areas of medical quality craving the profession's attention and collaboration. First, gathering and documenting data for the national quality registers; second, development of quality indicators; and third, drawing up guidelines for medical quality audits. In all three areas the tools already existed but were now further developed to meet the requirements of the policy organizations. This has largely been communicated through the Swedish Medical Association's Medical Quality Board that was set up at the beginning of 1990s. The Medical Quality Board has mainly been occupied with questions and demands from the National Board of Quality in Health Care or the Swedish National Board of Health and Welfare. It can thus be seen as reactive rather than being proactive.

The national quality registers have existed for more than 30 years, but the interest in them grew during the 1990s and in 2003 there were roughly 40, more or less nationwide registers. The medical profession mostly used the registers internally in the beginning

but by the late 1990s there were several voices advocating that they should be made open for comparison and public scrutiny.

At the beginning of the 1990s, the Swedish Medical Association and the Swedish Society of Medicine were asked by the national coordination organization for quality assurance in the health care sector, the National Board of Quality in Health Care, to develop indicators in different areas. The first report on the subject, presenting indicators for 11 specialities, was published in 1993 (Svensk Medicin, 1993). Since then indicators for new specialities are developed continuously. Concerning medical quality audits, 'peer reviews' have been conducted locally in different wards or clinics for a long time within the medical profession. As a discussion among the policy organizations about a compulsory medical audit, in all specialities, surfaced around 2000, a sub-unit, the Unit for Medical Quality Audits, was formed to enhance the development and education within quality audits.

The concept of acceptable quality has also been used by the professional association as an argument when lobbying for more resources for the health care sector. The Swedish Medical Association and the Swedish Society of Medicine have abandoned concepts such as 'quality assurance' and 'quality system' in favour of the concept 'quality development'. This, they claim, has always been an integral part of the work of the profession and quality is ensured through continuous scientific development and professional self-regulation. The Medical Quality Board has been moved from the Swedish Medical Association to the Swedish Society of Medicine. This may be interpreted as a way for the profession to pronounce its own position in relation to quality.

The profession's involvement thus has developed over time and varied with the character of the quality reforms. As the quality models more recently have started to involve medical care, the professional associations have formed plans of action and strategies aimed at achieving a certain amount of power over the methods and models as well as attempting to 'redefine' the quality models into more traditional techniques for the doctors to assure quality in their work. In this way the professional associations have captured both the interpretation of quality and forms of quality control.

Auditors' phase I: Incorporation

The tradition of self-regulation within the audit business has implied that the professional association has been highly proactive in implementing quality reforms. The professional association FAR issued in 1981 the first recommendation for a quality control system. This made 'quality' an issue for the profession at large. As some of the auditors questioned the use of the recommendation, its implementation became voluntary. Few smaller audit firms implemented the recommendation and at the beginning of the 1990s the professional association suggested an external quality control in the form of 'peer reviews' as it perceived a need to increase the creditability of the auditors in society. Again, the suggestion was met with mixed reactions from the auditors. The auditors from big audit firms already had firm-internal peer review systems and to participate in an additional quality assurance scheme was considered as expensive. Auditors from small firms either supported profession-wide quality programmes as a way to gain a better

position in competition with the larger firms, or were uninterested or negative, experiencing no need for increased credibility.

In 1996, the issue was raised again. A suggestion of peer reviews was issued and decided on at FAR's general annual meeting in 1997. The auditors from the large firms supported the suggestion, while the small firms' auditors raised a number of objections. The complaint was that FAR had taken on the role of 'quality controller'. In addition, the democratic process leading to the decision, and the proposed division of costs, were criticized. Some auditors expressed concerns that the peer reviews would imply that both the Supervisory Board of Public Accountants (responsible for the governmental control of the profession) and FAR would control the quality of the auditors. This is the point where the differences in opinions were the most obvious. In an answer to these concerns, the chairman of FAR stressed the importance of the reforms as follows: 'It is only by forceful initiative from the profession that we can stress our intention to take responsibility for the development of the profession ourselves' (Thiel, 1997). The suggestion was approved and FAR organized a first round of external quality control.

Hereby the reforms were incorporated into the profession's practice. Quality reforms, however, seemed to have three functions and to be carried out by two types of actors. The first was to increase the credibility of the profession as such. This seems to be the role of the professional association. The second function was as a competitive tool for the large audit firms. These two functions were contradictory, which is probably one reason why there was resistance to profession-wide quality controls. The third function, however, seems to be more unifying. Through 'peer reviews', the profession was able to demonstrate its ability for self-regulation. This function became even more important during the next phase of the implementation of quality reforms.

Auditors' phase 2: Boundary setting

In November 2000 the EU issued a recommendation regarding the quality control of auditors. This allowed either peer review or supervision by government, but demanded public insight into the system and a supervisory board overseeing the control system.

Together with the second professional association in the field, SRS (the Association for Approved Public Accountants), FAR suggested that a 'quality board' be formed consisting of representatives from the Swedish business society to supervise the peer reviews. Issues of poor quality would be reported to the Supervisory Board only in cases where the need for disciplinary action was judged to be substantial. The Supervisory Board of Public Accountants did not agree to the suggested model. According to Swedish legislation, the Supervisory Board is responsible for all supervision of auditors, and this responsibility cannot be delegated. A compromise was reached after three and a half years of negotiations. The professional associations aimed to protect the integrity and anonymity of their members therefore the Supervisory Board's insight into the control system was especially sensitive. In the compromise the Supervisory Board would audit a number of peer reviews each year, but was not allowed to make any report to its disciplinary committee in case of insufficient quality. Instead, an insufficient review would be referred back to the quality board, while the Supervisory

Board would only judge the system for quality assurance. In this way the profession, at least formally, could retain its self-regulation.

The negotiation challenged the traditional boundaries between the self-regulation of the profession and the supervision of the state. The result may be viewed as a way of securing category identity of the profession to the outside world as well as satisfying the internal demands from the profession on a group identity that included respect for the autonomy of the individual auditor.

Variation in approaches to quality reforms

As described above, the approaches of the two professions regarding quality assurance differed substantially. The four approaches – disregard, capture, incorporation and boundary setting – are examples of actions available to professions as new reforms are introduced or new demands are put upon a profession. Capture and incorporation both imply that the reform is grafted onto the professional practice and thereby becomes a part of its legitimacy and identity processes. While the profession, through capture, integrates the reform in its everyday activities in a way that more or less leaves the practice unchanged, incorporation implies adding a function to the profession and thereby giving a new representation of it. Boundary setting presumes that the reform is integrated into the profession and is used to enhance the profession's legitimacy to distinguish the domain of the profession from the domains of other societal actors. Disregard, on the other hand, indicates that the reform is neither perceived as a threat nor a part of the profession's practice. The reform is thereby outside the profession's representation of itself. In the forthcoming comparative analysis we focus on the four aspects discussed earlier in the theory section: the relation between reforms and the *professional knowledge base*; *professional norms*; *organizational belonging*; and *features of the organizational field*.

Quality reform and the professional knowledge base

The medical profession has a strong scientific basis and usually a doctor is both a practitioner and a researcher. Each doctor has a personal relation to the professional knowledge base and responsibility to apply it in his/her work. This knowledge is specific and difficult to gain for actors outside the profession. Transforming this knowledge to practice is one craft that has been internalized through on-the-job training during medical education, mentored by more experienced doctors. The early models for quality assurance in the health care sector dealt with organizing or structuring health care, not the medical treatment. For doctors, therefore, it was difficult to relate to the models and they found no reason to adjust to the reform.

Recently, the National Board of Health and Welfare has pronounced an interest in medical quality. The task of defining medical quality as well as its documentation have, however, been given to the medical professional association. This seems to be viewed as a natural addition to the professional medical work. The perception of quality appears to be unaffected by this addition. In this way the recent introduction of quality devices seem

to be easily integrated into the traditional definition of the doctor's professional knowledge as well as the group identity of the profession.

While medical professional knowledge is based on science and difficult to replicate, the auditors' knowledge is based on regulations for auditing economic transactions. The structural part of auditing, e.g. definitions and processes of auditing, is taught to most students of accounting and not unique to the profession. Auditors, therefore, have an incentive to develop their basis of formal knowledge by creating procedures and processes for audits that are internal to the profession. This development of knowledge may take place either within the audit firm in the form of expert systems, or within the professional associations, national or international, as codes of conduct and work process standards. Quality reforms in the form of documentation and control over work routines are also compatible with the existing knowledge base for the auditors, while it was unfamiliar to the medical profession. Peer reviews may even be viewed as an extension of the auditors' knowledge base. The preconditions for getting involved in the quality reforms are therefore better for the auditors than for the medical profession. At the same time, the threat to the exclusivity of the knowledge base is greater for the auditors than for the doctors should the quality control be performed by a non-professional. The incentive for actively pursuing an incorporation of quality control was thereby greater for the auditors than for the medical profession. In summary, we may conclude that the difference in exclusivity between the different professions' knowledge bases, the character of the knowledge and its importance for the professional identity provides part of the explanation for the different strategies applied by the professions in relation to quality reforms.

Quality assurance and professional norms

Quality reforms in the health sector are related to NPM and the transfer of the management ideals of the private sector to the public sector. Here the logic of economy rules, and quality is measured in relation to price and performance. Efficiency and productivity is measured in monetary, not medical or humanitarian values. The conflict between some of the economic values and the medical ethical code of conduct is one reason why the medical profession at large had difficulty accepting the early quality reforms. The more recent quality measures appear to be more acceptable to the medical profession. It is, namely, not measurement as such that is incommensurable with the identity as doctor, but measurement based on administrative routines (see Aidemark, 2001).

Again the audit profession is a striking contrast to the medical profession. Economy and management are parts of the logic of the audit business. Peer review, on the other hand, is an encroachment into the peer job autonomy of the individual auditor. It also contradicts professional discretion with regard to clients. One argument against the peer review was that the professional association was supposed to support, not to control, the auditors. In the latter part of the development process, the involvement of the professional association, FAR, was based on the intention to retain the self-regulation of the profession, i.e. to guard the category identity of the profession.

In sum, the quality reforms have conflicted with the professional norms for both doctors and auditors. In the case of the medical profession the quality measurements have been captured and developed in accordance with the professional norms. In the case of

the auditors, it was not the quality assurance as such that opposed professional norms, but its implementation that led to a conflict between the norms for peer job autonomy and professional self-regulation. This made prioritization and adjustment between these norms necessary to enable an implementation of quality assurance.

Quality assurance and organizational belonging

Traditionally, the vocational identity of doctors has been connected to the profession, rather than to the hospital. Doctors are socialized into the profession and gain their identity through mentoring during their education. Doctors within the same specialty often have more in common with each other than with the hospital they work in. Professional knowledge and its practice are linked to the individual doctor, rather than to organizational expert systems, even though the role of medical technology is of growing importance. The early models for quality assurance, on the other hand, focused on organizational goals and goal congruence among the organizational members. Also in this regard, quality reforms appeared to be heading for a collision with the traditional identity and loyalty of the doctors.

For auditors, the relation to the profession and/or the audit firm depends partly on the type of firm in which the auditor works. Those working in smaller audit firms are more inclined to emphasize their belonging to the profession (Warren and Alzola, 2009). This affiliation legitimates the auditor in the eyes of the clients and important interest groups. In large audit firms considerable resources have been invested in creating an organizational identity (Dirmsmith et al., 1997; Grey, 1998). Internal education, mentoring and management devices all support a primacy for the organizational identity. Most often, work tasks outside auditing, such as consultancy work, are highly appreciated by the auditors. Given these characteristics of the work within a large audit firm, primacy of the organizational identity might be a natural consequence for the individual auditor. In the large audit firms, quality assurance systems have been implemented for a long time. Profession-wide quality assurance is perhaps one among others, but probably the auditor is hardly aware of this system. In summary, quality reforms seemed to have little influence on the perception of organizational belonging.

Quality assurance and features of the organizational field

Hospitals have been described as arenas rather than organizations (Brunsson and Sahlin-Andersson, 2000) as professional norms control the daily activities and different professions interact in order to solve the needs of the patient. To a large degree the entire health care sector may resemble an arena. Several organizations have an interest in the health activities, and the control of the sector is thus divided between different societal levels as well as between administrators, experts, politicians and professions. This 'multi-levelness' was obvious in the implementation of quality reforms. The profession of doctors did not import the idea; it was the work of expert agencies. Not until the focus of the quality reforms moved from the administrative level to the operational work did it concern the doctors. The reaction from the profession was to capture for themselves the development of the definitions and measures of quality. The receivers of the quality

assurances still seem to be the supervisory levels of the field, the administrators and the expert agencies. In the field of health care, quality reforms are more of a managerial device for transparency (see Levay and Waks, 2006) than information for the customer regarding the quality of the product offered.

The field of the audit business has a hierarchical structure where auditing is carried out by hierarchical firms under the supervision of the government. Many of the initiatives for developing the field originate from international cooperation between auditors within the large firms or within the professional associations. The impulses go often from global to national/local levels of the field. The leading actors in the field are the professionals, even if they are supervised by governmental agencies.

Also, quality reforms seem to be a part of the regulation of the business, an assurance for those (i.e. the government) that have given monopoly to the auditors that the profession is performing its work with care. The legitimacy processes in relation to quality assurance are thereby directed towards the Supervisory Board rather than the clients of the auditors.

Conclusions

One may conclude that while the medical profession initially experienced quality assurance as unfamiliar, something that did not concern them, the auditors experienced it as a possibility from the start. And while the doctors have now transformed quality assurance from something strange into an addition to the traditional knowledge base included in the collective identity, auditors have actively utilized quality assurance to sustain self-regulation. In the short run, this implies that the medical profession has acted for unchanged identity, while the auditors as a collective have acted for enhanced legitimacy. As we discussed earlier in the article, identity and legitimacy processes are interwoven by means of the representation of practice, but the processes that seem salient in the adoption of new reforms appear to depend on (1) the profession's perceived relevance of the reform for the legitimacy of the profession, (2) the profession's perceived compatibility of the reform with the traditional knowledge base and (3) the way in which the reform is compatible with the traditional professional norms.

In our cases, perceived relevance for the legitimacy and compatibility with the knowledge base appear to be interwoven. The main role for the legitimacy processes seems to be to protect the profession's core competence. Any threat to the profession's knowledge base seems to trigger actions to protect its exclusivity. These actions have, in the case of the quality reforms, primarily been carried out by the professional associations and thereby been a part of the collective legitimacy processes.

For the process of identity, compatibility both with the knowledge base and with professional norms appears to be important. One reason why the medical profession decided to capture and redefine the concept of quality assurance was that it was not compatible with the traditional medical conception of quality control and development and the professional norms. For the audit profession, the norms in favour of self-regulation (by implementing quality control) were opposed to the norms of peer job autonomy. As already discussed, this led to a situation where the collective was prioritized over the individual professionals.

The internal processes of the professions appear to be most important in cases when a profession actively initiates an import of a reform or when there are conflicts between the norms of the reform and its application and the traditional norms of the profession. In these cases, not only the professional association but also the members in general have to agree to the reform in order to assure an appropriate implementation. Moreover, a shared understanding must exist among individuals within the profession that the reforms are important for the legitimacy of the profession. For the auditors' professional association the importance of quality assurance to the profession was apparent from the themed-1970s, while it took some time to find the situation (problem) and argument to convince other important actors (most salient: the large firms) that this was the case. For the doctors no common understanding occurred. Neither was it needed. The professional association utilized a defensive strategy of redefining the quality assurance into more traditional terms and seized the power to define different elements of the techniques in use. Quality assurance thus could be incorporated into the already shared understanding among the professionals.

The findings from this study extend Fournier's (2000) conclusion that the malleability of knowledge is used to claim new domains of knowledge. The findings indicate that a reinterpretation of concepts to match the existing knowledge base, as in the case of the doctors, is also a way of securing the identity and legitimacy of the profession. The case also adds to a study of doctors by Warring and Currie (2009) as it shows that capture may be used as an approach to change not only by the individual professional, but by the profession as a collective as well.

In addition, both our cases show that the processes, salient for the actions of the professions for legitimacy or identity, were more or less determined by the field. It is also interesting to note that, even though the studied reforms concern quality, the client was not in focus in either of the cases. Instead it was compliance to the doctors' traditional definition of quality, i.e. the identity of the profession, or to the self-regulation of the auditors, i.e. the legitimacy of the profession, that triggered action from the professional associations. This supports the ideas of Fournier (1999) and Power (2003) that professional practice is a representation of the professions' legitimacy and identity and that these processes are at the core of professional survival.

In our study, contrary to our expectations, the organizational belonging had a minor influence on the adaption of the reforms. This might be due to the level of analysis, i.e. that we focused on the collective level of the professions. Warring and Currie (2009), Kurunmäki (2004; Kurunmäki and Miller, 2006), Gendron and Spira (2010) and Empson (2004) have all pointed to the importance of focusing on the individual professionals' perception of their organization in order to understand the way changes affect the professionals. In the long term it is likely that changes in individuals' perception of their professional identity influence both the group and the category identity of the profession. This might happen in our cases as well, but at present time we do not have material to draw such a conclusion.

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References

- Abbott A (1988) *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.
- Ackroyd S and Muzio D (2007) The reconstructed professional firm: Explaining change in English legal practice. *Organization Studies* 28(5): 729–747.
- Aidemark L-G (2001) The meaning of balance scorecards in the health care organization. *Financial Accountability and Management Journal* 17(1): 23–40.
- Aidemark L-G (2004) *Sjukvård i bolagsform – en studie av Helsingborgs lasarett AB och Ängelholms sjukhus AB* [Health care organized in public limited companies – a study of Helsingborg Hospital Ltd and Ängelholm Hospital Ltd]. Göteborg: Växjö University Press.
- Alvesson M (2000) Social identity and the problem of loyalty in knowledge-intensive companies. *Journal of Management Studies* 37(8): 1101–1123.
- Andergassen R, Nardini F and Riccottilli M (2006) Innovation waves, self-organized criticality and technological convergence. *Journal of Economic Behaviour and Organization* 61(4): 710–728.
- Bejerot E and Erlingsdóttir G (2002) Kvalitetsidéns materialisering i hälso- och sjukvården [The materialization of quality in health care]. In: Bejerot E and Hasselbladh H (eds) *Kvalitet utan gränser* [Borderless quality]. Lund: Academia Adacta, pp. 59–80.
- Bejerot E, Hasselbladh H and Göransson R (2008) *Bortom New Public Management – Institutionell transformation i hälso- och sjukvården* [Beyond New Public Management – Institutional transformation in health care]. Lund: Academica Adacta.
- Brunsson N and Sahlin-Andersson K (2000) Constructing organizations: The example of Swedish public reform. *Organization Studies* 21(4): 131–145.
- Dirmsmith M, Heian J and Covalesski M (1997) Structure and agency in an institutionalized setting: The application and social transformation of control in the big six. *Accounting, Organizations and Society* 22(1): 1–27.
- Eklöf M (2000) *Läkarens Ethos, Studier i den svenska läkarkårens identiteter, intressen och ideal 1890–1960* [The ethos of doctors: Studies in the Swedish medical profession's identities, interests and ideals 1890–1960]. Motala: Kanaltryckeriet.
- Empson L (2004) Organizational identity change: Managerial regulation and member identification in an accounting firm acquisition. *Accounting, Organization and Society* 29(8): 759–781.
- Erlingsdóttir G (1999) *Förförande idéer – kvalitetssäkring i hälso- och sjukvården* [Seductive ideas – quality assurance in health care]. Lund: KFS AB.
- Erlingsdóttir G and Jonnergård K (2006) *Att trola med kvalitetssäkring. En jämförelse mellan hälso- och sjukvården och revisionsbranschen* [To sorcerize with quality assurance: A comparison between health care and the audit industry]. Lund: Studentlitteratur.
- Evans L and Honold K (2007) The division of export labour in the European audit market: The case of Germany. *Critical Perspective on Accounting* 18: 61–88.
- Fournier V (1999) The appeal to 'professionalism' as a disciplinary mechanism. *Sociological Review* 47(2): 280–308.
- Fournier V (2000) Boundary work and the (un)making of the profession. In: Malin N (ed.) *Professional Boundaries and Workplace*. London and New York: Routledge, pp. 67–86.
- Gendron Y and Spira LF (2010) Identity narratives under threat: A study of former members of Arthur Andersen. *Accounting, Organization and Society* 35(3): 275–300.
- Greenwood R, Suddaby R and Hinings CR (2002) Theorizing change: The role of professional associations in the transformation of institutional fields. *Academy of Management Journal* 45(1): 58–80.
- Grey C (1998) On being a professional in a big six firm. *Accounting, Organizations and Society* 23(5–6): 569–587.

- Hasselbladh H and Lundgren R (2002) Kvalitetsrörelsen i Sverige [The quality movement in Sweden]. In: Bejerot E and Hasselbladh H (eds) *Kvalitet utan gränser* [Borderless quality]. Lund: Academia Acta, pp. 40–58.
- Heggen K (2008) Profesjon og identitet [Profession and identity]. In: Molander A and Tenum P (eds) *Profesjonsstudier* [Studies in professions]. Oslo: Universitetsforlaget, pp. 321–332.
- Hood C (1995) The ‘New Public Management’ in the 1980s: Variations on a theme. *Accounting, Organizations and Society* 20(2/3): 93–110.
- Jonnergård K (2003) Quality assurance as venetian blinds: External quality control in the Swedish auditing industry. In: *EASARNET Conference Proceedings*, Manchester.
- Kirkpatrick I, Ackroyd S and Walker R (2005) *New Managerialism and Public Sector Professionalism*. London: Palgrave.
- Kurunmäki L (2004) A hybrid profession: The acquisition of management accounting expertise by medical profession. *Accounting, Organizations and Society* 29(3–4): 327–347.
- Kurunmäki L and Miller P (2006) Modernising government: The calculating self, hybridisation and performance measurement. *Financial Accountability and Management* 22(1): 87–106.
- Leicht K and Fennell ML (1997) The changing organizational context of professional work. *Annual Review of Sociology* 23: 215–231.
- Levy C and Waks C (2006) *Strävan efter transparens, Granskning styrning och organisering i sjukvårdens nätverk* [The strive for transparency: Audit, governance and organizing in the health care network]. Stockholm: SNS Förlag.
- Meyer JW and Rowan B (1977) Institutionalized organizations: Formal structure as myth and ceremony. *American Journal of Sociology* 83(2): 340–363.
- Montgomery K and Oliver AL (2007) A fresh look at how professions take shape: Dual-directed networking dynamics and social boundaries. *Organization Studies* 28(5): 661–687.
- Power MK (2003) Auditing and the production of legitimacy. *Accounting, Organization and Society* 28(4): 379–394.
- Rosén P (1995) *Rapport till Socialstyrelsen om föreskriftens effekter*. Lund: IHE.
- Røvik KA (2002) The secrets of the winners: Management ideas that flow. In: Engwall L and Sahlin-Andersson K (eds) *The Expansion of Management Knowledge, Carriers, Flows and Sources*. Stanford, CA: Stanford Business Books.
- Selander M (2001) *Mångfaldens problematik: om mötet mellan Äldreformen och sjukhemmets verksamhet* [The problems with diversity: About the meeting between the old people reform and the activities in the nursing home]. Göteborg: Bas.
- Svensk Medicin (1993) Report No. 38.
- Svensson LG and Evetts J (2010) Introduction. In: Svensson LG and Evetts J (eds) *Sociology of Professions, Continental and Anglo-Saxon Tradition*. Gothenburg: Diadalos.
- Thiel T (1997) FAR:s ordförande svarar [Reply from FAR’s chairman]. *Balans*, 1.
- Warren ED and Alzola M (2009) Ensuring independent auditors: Increasing the saliency of professional identity. *Group Decision Negotiation* 18(1): 41–56.
- Warring J and Currie G (2009) Managing expert knowledge: Organizational challenges and managerial futures for the UK medical profession. *Organization Studies* 30(7): 755–778.

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Résumé

Dans cet article, on enquête sur les variations de l'adaptation de deux professions à des réformes qualitatives. L'adaptation aux réformes est perçue en tant que composante de la légitimité des professions et des processus identitaires. La littérature sur le domaine suggère que l'adaptation aux réformes est influencée par la base de connaissance de la profession, les normes professionnelles, l'appartenance organisationnelle et le champ organisationnel. Nos cas sur la manière dont les docteurs et auditeurs s'adaptent à des réformes qualitatives, et montrent que les influences de ces facteurs sont toutefois moulées modelées par les stratégies de chaque profession et la prévalence des différents facteurs cités. Une conclusion générale montre que la compatibilité entre les bases des connaissances et les normes professionnelles est vitale pour que l'adaptation aux réformes ait lieu, et que les champs organisationnels sont importants pour définir l'agenda. Les appartenances organisationnelles, de leur côté, semblent avoir une importance mineure dans l'adaptation aux de réformes de qualité.

Mots-clés

professions, légitimité et procès identitaires, réformes qualitatives, secteur de santé, affaires de comptabilité

Resumen

En este trabajo investigamos las variaciones en la adaptación de las reformas cualitativas de dos profesiones. La adaptación de las reformas es considerada como una parte de los procesos de legitimación e identidad de las profesiones. La literatura en el área sugiere que la adaptación de las reformas es influenciada por la base de conocimiento de la profesión, las normas profesionales, la pertenencia organizacional, y el campo organizacional. Nuestros casos sobre cómo los médicos y auditores se adaptan a las reformas cualitativas muestra que las influencias de estos factores son, sin embargo, moldadas por las estrategias profesionales y la relevancia de los diferentes factores mencionados. Una conclusión general es que la compatibilidad entre las bases de conocimiento y las normas profesionales son vitales para la adaptación de reformas y que los campos organizacionales son importantes para establecer la agenda. La pertenencia organizacional, por otro lado, parece menos importante para la adaptación de las reformas cualitativas.

Palabras clave

profesiones, procesos de legitimidad e identidad, reformas cualitativas, sector de cuidado de la salud, auditorías