Does haute couture become Prêt à Porter? A paper on the fashion industry of the Swedish health care sector

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Does Haute Couture become Prêt à Porter?

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When fashion in clothes and accessories is created and spread it usually happens in quite exclusive environments as in the big fashion houses and through the known international fashion magazines or on the catwalks. We are aware that yet other fashions are created amongst people on the street making use of what they have got creating local fashions that can become noticed or discovered by a broader public and spread that way. But let us stay with the metaphor of the big fashion houses and their catwalks. On the catwalk and in the most well known fashion magazines the latest trends are often presented quite vaguely ie not as ready made outfits that can be worn by real people in real situations (many of the designs shown would be quite inconvenient for anything else but a stroll down the catwalk) as they are rather presented as ideas or images of how people should look and dress. They are thus more of an inspirational material hinting the direction or the feeling of the coming trends considering materials, colours and styles. When this "Haute Couture" is spread and lands on the shop-shelves as Prêt à Porter it has been translated into more "user friendly" versions of the original ideas. This transformation is necessary in order to make the latest fashion reachable for a broader public.

Using the metaphors of Haute Couture and Prêt à Porter we would like to examine some of the fashions that have been spread in the Swedish health care sector the past two decades. Who are the fashion makers? Who decides what to import and why? Who are the models demonstrating the latest fashion? Most of all we wonder if the Haute Couture gets transformed into Prêt à Porter so that it suites and becomes useful to the broad masses. And if not, what do people do with fashion? Does it become an issue for some kind of an elite, or does it simply get ignored?

These questions will be reflected upon through and illustrated by material from our own study, of how and why quality assurance came in vogue.

Theoretically we seek inspiration to Czarniawska and Joerges's (1996) "idea-model" as well as the concept of translation (Latour, 1986; Callon, 1986). However the metaphors of fashion will be our main focus in the reflection of the introduction and implementation of quality assurance in the Swedish health care sector.

The fashion metaphor

We primarily base our use of the fashion metaphor on Czarniawska and Joerges' (1996)

description of organisational change due to what they call travelling ideas. According to the authors, ideas that go places, get their velocity mainly from being in vogue in the cense that many people/organisations in different places and over time will "catch on" to fashionable ideas and use them. Fashion can thus explain "many puzzling developments in and between organizations" (p. 24). In other words the metaphor of fashion can be helpful in understanding changes that occur in an organisation field and even how institutions are altered or changed. In Czarniawska and Joerges' words:

> Much as fashionability and institutionalisation seem to be opposites, one standing for temporality and frivolousness and the other for stability and seriousness, it seems mre fruitful to see them as interconnected and interdependent……Similarly, much as fashion seems to sabotage and threaten established institutions, it is also an institutional playfield: new practices can be tried out and disposed of or institutionalized, thus revitalizing the existing institutional order." (1996, p. 25).

In the article "Haute Couture and Prêt-à-Porter: The popular Press and the Diffusion of Management Practices" Carmelo Mazza and José Alvarez (2000) use the fashion metaphor in terms of Haute Couture and Prêt-à-porter to describe the role of the popular press in the production and legitimisation of management ideas and practices. The authors reason that human resource management is made reachable for the broad masses through the popular press, which translates theories and ideas from the academic world into the world of practitioners, by making them more comprehensible. The way we intend to use the metaphor of fashion is a bit different as we by Prêt-à-Porter refer to fashion translated into "user friendly" models, techniques or routines i.e. something that not only can be but is "worn" or used in practise. We find that many of the fashions introduced in health care, as the example of quality assurance will show, are quite bothersome to use, as they do not really fit the users.

If fashion, as in fashion of clothes, is seen as the overall metaphor it contains several "sub" metaphors as of course Haute Couture and Prêt á porter, but even the catwalk, models, designers, fashion houses, fashion magazines and so forth. Our intent is to investigate if these metaphors can be helpful in reflecting upon the quality assurance fashion in Swedish health care.

Quality assurance as fashion

When we write about fashion in health care we are referring to what at any given time would be considered as the latest fashions and fads of how to present oneself as an organisation, which would imply the modes of organising and the various identities that at any specific time would be considered the "right" ones. Being in vogue of course has an inbuilt notion of being modern and "wearing" what might be seen as right at any given time. The idea presented below, that of quality assurance, came in vogue in the Swedish health care sector in the beginning of

the 1990s. It started as a fad in the mid 1980s grew into a fashion and has in fact been institutionalised as a law from 1997. We have "traced" the idea in two studies carried out in the period between 1994 and 2002. The aim of the first study was to map out how the idea of quality assurance has circled within the health care sector since the mid 1980s until it became obligatory in 1997, and to learn what happened when it was implemented in a specific practice in form of a specific model. In the second study the effects of the institutionalisation was in focus. But even that study has shown that the idea is still circling in the health care sector, being reinterpreted and changing "styles".

We start by a brief account of the introduction and implementation of quality assurance in the Swedish health care sector between ca 1985-2002. And then we go on with the reflection based on the fashion metaphor(s).

Quality assurance in health care

The idea of quality control has been circulating within the health care sector since the mid-1980s. In the 1980s new demands as well as greatly increased costs led to a cost crisis in Swedish health care (Spri 287, 1990). This crisis was not an isolated Swedish phenomenon but can be seen as quite typical of the accelerating costs of the public services in the OECD countries at that time. Several West European governments connected the problem with oversized and expensive public sectors. In Sweden the government tried to evaluate the productivity of the different areas of the public sector. The health care sector was one of the fields scrutinised. Around 1986, RRV (The Swedish National Audit Office) released a report on the productivity within the health care sector in Sweden between 1960 and 1980. The report claimed that productivity within the health care sector had decreased in those twenty years at the same time as costs had increased. The comparison was made with the good example - the private sector. Thus, the general public discussion at this time spoke of the public sector as the "ugly sister" and the private sector as the "beautiful sister" and organisations in the public sectors sought inspiration for new identities and management models from the private sector (cf. Czarniawska and Sevón, 1996; Sahlin- Andersson, 1996).

Organisations and professionals within the health care sector reacted defensively by claiming that the report was misleading as it did not show or give credit to the increase in quality during the same period. Large parts of the health care system as we know it today, were built up in the years between 1960-1980. Technical systems and new areas of diagnosis also evolved during this period, leading to better care but also to higher costs.

A search for a national model

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 main task of the Swedish Planning and Rationalisation Institute of Health and Social services, (Spri), was to give advice and support to decision makers within the health care sector. The discussion of whether or not there had been a decrease in the productivity within this sector thus became a matter for Spri to investigate. When they began their survey they discovered that there were no existing methods to measure quality in the health care system. From that time on Spri had a group of people working on finding a solution to the problem of how to measure and compare quality throughout the health care sector. 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, one of Spri’s employees 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. In an interview she recalls: *"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. The group was inspired by, both quality assurance in industry, and various quality assurance programs in health care in other countries. According to our informants the groups work was not that popular by the Spri management from the start but still quality assurance did, with time, become one of Spri's main domains.

One reason for this might be that in the early 1990s, quality assurance as such was becoming an idea in vogue, not only in health care but also in society at large. At this point different authorities showed their interest in engaging in the ongoing discussion about quality assurances. Thus both the Swedish Federation of County Councils (SFCC) and the Swedish National Board of Health and Welfare (SNBHW) participated in formulating and testing the idea of quality assurance. In 1990 The National Board of Quality in Health Care, was formed by Spri, SFCC and SNBHW and as a part of its mission sought a national solution, i.e. a national quality assurance model. The Board published its strategy in a report (Sprirapport 287) where it listed arguments for quality assurance and argued for a national model. The line of reasoning was that due to the "cost crisis" and the indicated measures for reducing costs it would become necessary to safeguard the quality of health care services.

Before the quality assurance discussion started the Swedish health care sector had been superintended by educational agencies, legislation, supervision by the Swedish Standing Committee on Social Questions, etc. This supervision was not conducted in the form of quality assurance or standards, but rather as general recommendations. Daily routines were carried out according to best practice and monitored by the medical staff. The National Board of Quality did not, however, relate to the former regulations in the area when discussing quality, but rather saw them as an example of what quality assurance *was not*. It was thus very important for the Board to present a new solution that differed from the one already used. The members of the board split up its functions and Spri got the assignment to evaluate different quality assurance systems used in other countries. As a part of this assignment the Organisational Audit model was brought in by Spri from England and tested at the Lund University Hospital. This model was based on a concept where all participating units are externally audited once a year by staff from other hospitals. Spri got their inspiration for the model from King's Fund in England, which was inspired by a Canadian model, which was adopted from an Australian model, which in turn had the American model as a pattern.

Thus, at the turn of the 1990s there were three coexisting technologies of how to regulate quality within the health care sector; the general pre-1985 recommendations, the models inspired from the industry (for example ISO 9000) and models inspired by health care in other countries (for example Organisational Audit). An interesting result of this mixture was that the argumentation and the action prescription from the different technologies or models were mixed

with each other as they were translated in the Swedish health care sector. The Organisational Audit model that originated from health care sectors in England was, for example, launched with the argument that it resembled the quality assurance models being used in the private sector at that time, and was associated with the same benefits.

However, the Organisational Audit model was a disappointment and was never used as a national model. The main critique was that the model did not sufficiently engage the hospital board and the chief doctors. Our observations at the hospital in Lund at the time when the model was tested showed no visibility of the model in the concrete activities in the organisation on the wards either. Several routines and quality control activities were carried out in the wards but none of them could be linked directly to the Organisational Audit model.

One reason for implementing a quality assurance model of this kind in Lund was locally said to be that it was expected to benefit the hospital in relation to the customers such as the municipalities and county councils that were the potential buyers of the hospital services. Another reason was to show the field that the hospital in Lund had engaged in quality assurance work. At the administrative level the quality assurance was comprehended as being a part of the changes towards market economy within the health care sector. The interpretations at the local level were thus quite different from the one made by the authorities who connected quality assurance to efficiency, cut costs, measurability and possible comparison between different wards and hospitals.

In the early 1990s the doctors did not pay much attention to the quality assurance discussion apart from a few individuals who acted at their own hospital or clinic as spokesmen for quality assurance. Collectively it was almost as if the discussion did not concern the doctors at all. Or if it did, was seen as an administrative “thing” with nothing to do with the quality of their own work i.e. the medical quality. The chief doctors we interviewed were neither particularly interested nor startled by the fact that quality assurance was spreading in health care organisations. Quality assurance would fall under the administration aspect of their job, which is time-consuming and necessary but not as important or as strong as that of the medical part of their role. Also the chief doctors connected the necessity of having a quality assurance with the introduction of market economy in health care and thus viewed it as one of many ideas in vogue at the time. As one of the doctors commented *"its 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, it’s all about quality assurance."*

The frequent comment on quality assurance that it did not concern medical aspects was probably one reason for the lack of interest from the doctors. Still, the Swedish Medical Association has had a special board, The Medical Quality Board, since the beginning of 1990 dealing with these issues. The board was formed more or less at the request of the National

Quality Board in Health Care, to be a cooperation link to the doctors. The Medical Quality Board has mainly been occupied with questions and demands from the National Quality Board of Health Care or the Swedish National Board of Health and Welfare. It can thus be seen as acting on demand rather than being proactive.

From idea to law

At the beginning of the 1990s it became quite obvious to the National Board of Quality in Health Care that the chief doctors were not paying much attention to quality assurance. This was considered to be one of the main reasons for why quality assurances were spreading slowly and randomly in the health care organisations. The Swedish National Board of Health and Welfare thus decided to formulate a recommendation that was handed out to the practice in the Swedish health care sector. According to the recommendation anyone responsible for medical care (organisation or individual) had to have a quality assurance plan. As it turned out, not even this recommendation attracted that much attention, and in a survey in 1996 many chief doctors claimed no knowledge of the recommendation.

During the summer of 1996 a change in the Swedish Health and Medical Services Act was prepared on commission from the government. The time of preparation was short and there was no official debate about the new law. The change in the Swedish Health and Medical Services Act was made public in January 1997, and it became compulsory for anyone responsible for medical care (organisation or individual) to have a quality assurance plan. However, there was, and still is, no agreement between the authorities and the health organisations, regarding the model or method that was to be used. In fact, this has been the case since the idea of quality assurance was introduced into the Swedish health care sector in the mid 1980s. Instead, different authorities have promoted different methods and models at different times. Thus, Spri launched the Organisational Audit model as part of their drive for a national strategy for health care quality assurance at the beginning of the 1990s, while the Swedish Federation of County Councils developed a leadership and excellence model called QUL inspired by the Malcolm Baldrige National Quality Award. QUL was launched in 1996. Besides these models a number of consultants have carried out various quality projects in different parts of the sector.

Still, the new law remains and there is a continuous search going on within the health care sector for a quality assurance method or model that can fulfil the demands of the law. This has resulted in a vast variety of translations and interpretations of the concept of quality assurance amongst organisations within the health care sector. Often, models or methods are introduced and tried out one after the other, when the previous one has failed and has been abandoned. As a result, several hospital clinics have tested a succession of more than two, even as many as five, different quality assurances methods. During the past ten years or so, quality assurance as such

has become habitual within the health care sector in Sweden, although the methods and models vary. In a survey directed at senior managers in health care organisations about quality assurance in 2000 (Hasselbladh and Bejerot, 2001), nine out of ten managers and eight out of ten chief doctors claimed they were using some kind of quality assurance. The law thus seems to be quite efficient in engaging managers and chief doctors in the matter. At the same time there seems to be a certain degree of confusion about which models or methods are useful for the purpose. When the managers in the above-mentioned study were asked which models or methods they used, several responded "bench marking" or "balanced scorecard" which can hardly be seen as quality assurances but are rather classified as general management tools in the industry where these models come from.

The latest turn of events

Most of the quality assurance methods or techniques used by Swedish health care have not been directed towards medical quality, as medical results are often quite difficult to measure and control. Recently, however, the Swedish National Board of Health and Welfare have clearly formulated an interest in making medical quality open to public scrutiny and control. 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 (Bejerot och Erlingsdóttir, 2002).

There seem to be three main areas of medical quality in which the medical profession is now taking part. The first one is gathering and documenting data for the national quality registers. The second is the development of quality indicators and the third is drawing up guidelines for medical review. The national quality registers have existed for more than 25 years, but the interest in them grew during the 1990s and now in 2003 there are roughly forty, more or less nation-wide registers. At the beginning of the 1990s the Swedish Medical Association and the Swedish Society of Medicine were asked by the National Board of Quality in Health Care to develop quality indicators and measures for health care quality. The first report on the subject, presenting indicators for eleven specialities, was published in 1993 (Svensk Medicin nr 38). Concerning medical quality revision there have been ongoing audits, "peer reviews", locally in different wards or clinics for a long time. These reviews have been conducted and monitored within the medical profession, but since the mid 1990s reviews have become an acknowledged area within the Medical Quality Board and in 2000 a sub-unit, the Unit for Medical Quality Revision was formed to enhance the development and education within quality revision.

On the council level, Stockholm County Council has lately been focusing on medical quality and has put out a quest for medical audits. There is one applicant for the audit, the Unit

for Medical Quality Revision, and they have got all the contracts in the medical specialities they have applied for. The medical specialities that the Unit for Medical Quality Revision have not applied for and have therefore been handed out to consultants, are areas in which the Unit does not consider itself to have sufficient competence. This is surprising as surely it must bee the Unit for Medical Quality Revision that possess the greatest competence in all medical specialities. The Unit for Medical Quality Revision wants to conduct the audits as a kind of peer-review in which experienced doctors in a specific medical field visit and audit a specific organisation. The idea is that the audits will be made by clinically active doctors and not by doctors specially employed for the task. The Unit for Medical Quality Revision sees this as an important criterion as clinically active doctors are continuously updated in knowledge of the field they audit.

Since the turn of the century, the Swedish National Board of Health and Welfare have shown a clearly marked interest in making the medical aspects of the health care sector more visible and open for scrutiny (cf Bejerot and Erlingsdóttir, 2002). The control of medical quality has always been in the hands of the profession, i.e. the doctors, and the process of rendering the medical process more transparent thus has to go through the profession. In line with this, the different authorities have turned to the Swedish Medical Association and their Board on quality issues to involve them in the process. Even though the latest turns in the development of issues in the health care sector can be seen as something that might come to resemble the Peer Review of the auditors, most of the history of quality assurance in the health care sector, as we will see below, differs considerably from the one in the auditing business.

Reflections

The Zeitgeist

According to Czarniawska and Joerges (1996) fashion ideas are often selected because they cohere with what they call the Zeitgeist or the master-ideas of that time. In the 1980s the Zeitgeist was that of scrutinising the public section in terms of, efficiency, new liberation (Thatcher) and cost reduction. This was not a specific Swedish trend but was common for the OECD countries where also the solutions to the problem of to large and costly public sectors would be collectively formulated. The comparison between the public and the private sector, to the benefit of the private sector, was also common at that time. When quality assurance surfaced as an idea in the late 1980s it was connected to the Zeitgeist by the people defining it. It thus was interpreted as a way to cut costs, make “production” more efficient and when it came in vogue in the beginning of 1990ies it was seen as one of the “modern ways” of organising oneself as an organisation. It was also connected to other modern ideas like sell and by and customisation and was thus seen as one of many new ideas that in a kind of a bundle

represented a “new” way of organising not only organisations in the health care sector but more or less the whole public sector. Quality assurance thus became one of many fashionable ideas in the trend of New Public Management that swept over the public sector at that time.

Who is the (role)model?

For the health care sector the private sector has been the “role model” or the fashion leader during the past twenty years or so, introducing and modelling new ideas, fads and fashions. Even if same or similar ideas have existed in the public sector they have somehow not had the same attractiveness as ideas from the private sector. One might say that all designs worn by the private sector were of the right “brand” whilst the designs from the public sector were seen as less “inn” and less exclusive. The way the health care sector had assessed quality until then became out of date compared to the modern quality assurances in the private sector. It is thus not surprising that the Organisational Audit model, that originated from the health care sector in England was launched with the argument that it resembled the quality assurance models being used in the private sector at that time, and was associated with the same benefits. So the private sector can be seen as a fashion leader of that time, or even the “fashion Mecca” towards which everyone in the public sector would turn to find the latest fads or fashion.

Where are the Catwalks?

The fashion metaphor fits nicely with the idea of quality assurance in the health care sector as does the private sector as the fashion leader but where is the catwalk? Where are new ideas shown off in an exclusive setting to a selected audience spread to the broad masses through the lens of media as is the fashion of clothes on the catwalks of the fashion houses? Maybe the large consultancies can be seen as one type of fashion houses where the latest designs are shown off on the catwalk where only the ridge and mighty (read the ones who can pay) get in. The companies that by first are the most modern ones and soon everybody else will follow. This is true for instance for some types of quality assurance, the Balance Score Card, Bench Marking and several other fashionable ideas in the 1990s.

Carmelo Mazza and José Alvarez (2000) view the academic production of management ideas as Haute Couture and the more user-friendly versions of the ideas spread by business magazines as Prêt á Porter, but we cannot really find similarity with the quality assurance idea. Dealing with quality issues in production was in the post war era something that on the contrary was dealt with close to practice and not on higher level of management or academia for that matter and thus had an inferior status (Hasselbladh and Lundgren, 2002). It did not become fashionable on a top management level until in the late 1980s when quality management was formulated as a general management tool. The magical connection was that of customer

satisfaction. To put it differently it rather seems like the idea of quality management went from Prêt á Porter to Haute Couture than the other way around. This of course happens in the fashion industry of clothes too. Designers will be inspired by folklore or other already existing or pre-existing garments that they remake, add to or transform into a new fashion-idea.

We still wonder if it is possible that the quality assurance fashion never has been Haut Couture, but rather a fashion that was inspired by the practice but in the process of generalisation became something in between Haute Couture and Prêt á Porter?

Spreading fashion

Another type of spreading is done by the type of organisations like the Malcolm Baldrige National Quality Award and the Swedish version of it Utmärkelsen Svensk Kvalitet (USK) and the special health care version Qvalitet Utveckling Ledarskap (QUL). These three very similar types of competitions organise contests amongst organisations in a specific quality management method. They can therefore rather be seen as stages, where the "best dressed" organisation, according to a certain collection is chosen and shown off as the good example, than catwalks. Still they spread fashion and make it more glamorous to be in vogue. These organisations even spread their "collections" by news-letters or magazines where the latest fads of the fashion are presented and success stories are told.

Even the ISO 9000 standards have a part in both creating and spreading the quality assurance/quality management fashion. ISO 9000 was created as a part of the EU collaboration and has thus a more international flair but at the same time it is also a more standardised "collection" meant to fit many.

Then there are consultants, conferences, workshops, media and even the trade unions and the health practice itself that have in different ways participated in promoting, discussing and trying out the different quality assurance models.

The stylists

In the Swedish health care sector the stylists, or the ones that search and choose amongst fashion ideas, have by and large been "idea-bearing" organisations like the Swedish Federation of County Councils, the Swedish National Board of Health and Welfare and Swedish Planning and Rationalisation Institute of Health and Social services, (Spri). These organisations have the role of advising but even of governing/monitoring the health care sector. The largest difference in the comparison between fashion in the public sector and both the private sector and the fashion industry in clothes, is the fact that the organisations in the health care sector are not always free to choose trends or fashions. On the contrary ideas about what is inn, right and modern can be forced upon them. Even the whole idea of having to be fashionable, defined by

the private sector, has been forced upon them by the comparison made by others. The public sector could maybe be described as having a more "classic" style before the New Public Management trend. Prior to the 1980s public sector organisations were thus not expected to follow all the turns of the fads and fashion of the private sector. The role of the public sector was simply not to be too fashionable or modern, but to represent stability and quality through a more long lasting, classic image. However the Zeitgeist changed and the public sector had to be "restyled".

Is there a Prêt a Porter quality assurance?

Not that the public sector does not care about fashion rather it is a question of what to do with fashion. The example of the Organisational Audit model is a quite typical example of how an organisation within the public sector can be suspected to react to external pressure of fashionable ideas: It will adapt them (wear them) on the surface as means of legitimisation at the same time as they are decoupled from the daily routines. This was not what the authorities had planned as they did want to change the practice. The reaction from the health care shop floor has been that there are no existing "models that fit us". Or at least there is no one model or technique that fits all practices within the health care sector even though some practices have used some models with some success. This further raises the question whether the models have been successfully adjusted to the health care practice. Is there a Prêt á Porter version of the quality assurance for the health care sector? And if not is it because the models are wrongly fitted or simply because the fashion as such clinches too much with the traditional style at hand?

The latest fads and fashion

At the turn of the millennium 80 percent of the clinical chiefs participating in a survey on quality management claimed they used some kind of models or techniques for managing systematic quality work in their clinics (Bejerot and Hasselbladh, 2001). However we know from other studies that some models and techniques in some places are not visible in the everyday routines on the shop floor (Erlingsdóttir, 1999, Bejerot and Erlingsdóttir, 2002). We also know that many of the management tools used in the name of quality assurance are rather new fads and fashions that are interpreted by the users as being quality assurances. Quality assurance seems to be reinterpreted in many different ways lately. The focus on the doctors, in some of those interpretations, can be seen as tokens of the quality assurance fashion, fading or transforming into the auditing fashion or trend (cf. Power, 1997). According to Powell the need for auditing was created partly by the way that quality assurance has been "transformed from an engineering to a management concept, a "managerial turn" (Power, 1994b) which has provided advisory opportunity for new generation of quality experts and an organizational shift in the

location of these experts, up and away from the shop floor" (p. 58). The quality assurance/ management has thus both initiated and become a part of the auditing trend. The typical features of the auditing trend as: the demand for transparency, the audit by a third part and the centralisation of power can be detected in the latest turn of quality assurance matters in the Swedish health care. Authorities are focusing much more on the doctors and aim at making their work more transparent and controllable.

Another trend that the quality assurance fashion has blended into is the "netscape trend". Patients/customers are encouraged to seek information about quality and results at websites, and to provide the information there are intentions to make medical registers and similar information official.

Did the metaphor fit?

We are quite convinced that the fashion metaphor is valuable in reflecting and discussing quality assurance in the Swedish health care sector. We have become more aware that sometimes fashion is neither Haute Couture nor Prêt á Porter, even though the question of what it then is, remains unanswered in this paper. We are also aware that the metaphor can be drawn further than we have in this paper. Old methods that suddenly become brushed of and brought out from the closet like old clothes that have become in vogue again, maybe fashion that is imposed in organisations can be described as obligatory (unpractical) school uniforms, maybe there are post-order catalogues with less fashionable ideas? We perceive this paper as a first step in what can surely become a much more elaborated use of the fashion metaphor.

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