Professionals and the New Public Management

Multi-professional teamwork in psychiatric care

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Abstract

This study examines the cooperative work of several professions in Swedish multi-professional teams in child and adolescent psychiatric open care units in an environment of strong economic and efficiency controls resulting from the so-called New Public Management (NPM) reforms. Previous studies indicate teamwork is a network of semi-independent professionals who tend to represent their professional organisations and groups despite sharing a mutual interest in the patients. The research problem deals with finding explanations for what promotes and what hinders cooperation in a multi-professional health care team.

A qualitative approach is used to study and interpret the individual *professionals'* actions. Data were collected in interviews and from observations of planning and treatment discussions where it was possible to witness team members' strategies and attitudes toward patients and their treatment.

The main theoretical concepts are *exogenous* and *endogenous institutions*, *boundary objects,* standardised *procedures*, *service ideal, discretionary power* and *professional dominance*. Two NPM elements are applied: *customised care* and increased *accountability*.

The study offers an actor perspective that complements the traditional cultural perspective. The latter perspective explains cooperation problems as the result of the professionals' confusion over their expectations of themselves in their team roles and their expectations of others in their team roles. The actor perspective shows that while norms may influence cooperation, they are not determinative. Actors are aware of the institutionalised conditions, and take them into consideration; however, their actions are not determined by these conditions, nor even primarily guided by them. The determinative factor for actors' actions is their context. Leaders and co-workers can create endogenous institutions that bridge their differences in professional norms and also bridge professional norms and NPM reforms. The institutionalised conditions are secondary factors that explain the outcome of cooperation efforts. This study offers an interpretation useful in understanding *how* the actors create endogenous institutions. Star and Griesemer's theory on boundary-spanning objects does not address this aspect of cooperation.

Unintended consequences of NPM reforms for patients are traditionally said to imply that NPM reforms are ill conceived and unrealistic. In the light

of this study the significance of such consequences may be reinterpreted to be a possible mechanism of driving the development of the public organisation.

Usually NPM reforms are regarded either destructive or harmless to professional autonomy. This is scarcely a realistic description of professionals' long-term behaviour. This study offers co-optation as an alternative explanation, defined as the process by which actors absorb external strategic elements in their policy decisions. Co-optation of NPM reforms explains the gradual institutionalisation of NPM reforms.

Research investigating professions has not dealt with the fact that multi-profession cooperation has the same character as mono-professional cooperation, to preserve collegiality through co-existence. Such professionals do not wish to challenge others' approaches and practices; nor do they wish to learn from them. This result challenges the general idea of professional dominance in theories on professions.

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Chapter 1
Introduction

This study concerns multi-professional cooperation work in health care practice in an environment of strong economic and efficiency controls, caused by the so-called New Public Management (NPM) reforms. The study especially deals with how several professions in a multi-professional team in Swedish children and adolescent psychiatric open care (CAP) units cooperate in patient care. Until a few years ago, such teams consisted of psychologists and counsellors. However, recently physicians and nurses have been added to the teams as the result of a national investigation of psychiatric care (SOU). This investigation recommended that children and adolescents with psychiatric problems needed early diagnosis and treatment provided by the collective competences of a team of specialists.

This research examines the teams in three such units. The composition of these teams seems to reflect the understanding that a team is the self-evident group to achieve cooperation between people in a work relationship that is involved with the same group of people (patients, clients, customers, etc.) What better solution is there, in psychiatric care, than to encourage different specialists to work together on behalf of a patient treated in common, especially when the psychiatric problems are related to the patient's severe psychosocial environment?

Nevertheless, it is something of an established fact that professional organisations are difficult to manage (Blomgren, 1999; Levay, 2003). Cooperation efforts between different professional and work groups often result in conflict and tension that are challenging from a management perspective. Not least, health care organisations have often been held up as an example of the difficult-to-manage organisation. Cooperation difficulties are thought to exist even when professionals work in team-like constellations, such as health care departments, and when the teams are composed of representatives from different organisations.

Many of these problems are assumed to be associated with certain work norms of professionals that are incompatible with the external norms that the various groups and individuals are expected to conform to (Payne, 2000; Larkin & Callaghan, 2005). In health care, the external norms have come mainly

from the National Board of Health and Welfare, the political boards for health care and the unions. When professional norms are prioritized over loyalty to the group mission and the goals set by management, it is possible that this situation damages the professionals' collective efforts. Additionally the NPM reforms in health care may not have improved the situation.

Given these conditions, there is good reason to think a tighter and more complete team construction would improve the cooperation between the different professions as they work together in the best interest of the patient. However, it is also possible that the continued influence of the professional norms and the increasing strength of management norms will result in continuing cooperation problems.

But if cooperation problems remain, is it really reasonable to explain them by the fact that work norms are prioritized over loyalty to the health care mission that all professionals are assumed to support? Can practical cooperation problems – for example, meetings that don't begin on time or that key people fail to attend – be explained by differences in work norms? In any case, why do many different solutions to the same problems come from different organisations with the same composition of professions?

This study, then, deals with multi-professional teamwork (MPT) in a complex and demanding context where the actors choose strategies in an uninformed way. Such choices may result in unintended consequences, including the failure to achieve management's intended consequences. In the study, the actors' actions are analysed and interpreted using several theoretical concepts. These concepts relate to the following: boundary objects, standardising methods from general cooperation theory, and the profession theories of service ideal, discretion and professional dominance. In addition, the concepts of exogenous and endogenous institutions from New Institutional Theory (NIT) are used (see Chapter 2 for definitions of these concepts). The most important features of NPM applied are customised care and increased accountability (see p. 7).

MPT from a business administration point of view

The interest in developing public sector governance appears to have increased greatly since the expansion of the public sector ended at the beginning of the 1970s (See Hasselbladh, 2008). Most public organisations still have their traditional hierarchic organisation structures with clear responsibilities and measureable targets framed within budgets. However, the development of a

new system of practise, the practice regime, has led to the development of a control regime defined as applied methods, professional knowledge, professional norms and ideas about how to control the practice regime (Ibid. 2008: 29). New control regimes tend to take advantage of employees by letting them evaluate and correct their actions. One result is the formation of new institutions in organisations (Ibid. 2008).

This development corresponds with Selznick's (referenced in Scott, 2003) recommendation that, instead of focusing on the many ordinary, daily decisions, leaders should pay attention to changes in structure that cause an organisation's character to develop so that the organisation, like an individual, can create its unique personality. However, rules and norms should not be viewed independently as the institution. Institutions may be defined in the following way: "Institutions are composed of cultural-cognitive, normative and regulative elements that, together with associated activities and resources, provide stability and meaning to social life." (Scott 2003: 134). Institutions consist of triads of rules, actors and activities. Tengblad (2006: 18) defines an institution as follows: "An institution consists of a production of socially constructed rules and activity patterns that are created by actors who in their turn create the actors." [Author's translation] This means that it is important to study how actors in individual organisations act as they make and follow rules. It cannot be assumed that institutions (e.g., social institutions for cooperation) will spread. "The actors' interpretations of institutional rules are thus decisive in how institutions reproduce, and this interpretation process should therefore never be seen as irrelevant or unproblematic in studies of institutional phenomena" (Ibid: 10). [Author's translation]

From a business administration perspective, the institutionalism of a multi-professional team seems to reflect modern and relatively untested systems of control that assume there is good integration between systems of control and the systems of practise.

Teamwork and multi-professional teams

Cooperation and teamwork

Cooperation and teamwork have similar meanings and refer to the joint work by a team that deals with the same group of clients (Payne, 2000). In the team there is a tight cohesion where the members have a common purpose and common values, assigned roles and tasks, and a sense of camaraderie and

mutual loyalty (Payne, 2000). The terms "cooperation" and "teamwork" are used interchangeably in this text.

Most people have a positive view of cooperation and teamwork. Just describing a group of people in an organisation as a team suggests a cooperative effort in which several people work together towards a mutual goal that could not be achieved by individuals working separately. However, some criticisms of teamwork have been raised. For example, the team can stifle personal and professional freedom, the team may become too concerned with its internal relationship building and its own tasks without proper reference to other actors, and the team may have too little interaction with clients/customers/patients (Payne, 2000). Another criticism refers to the myth that workers do not compete when working as teams and that there is no conflict of interest between employers (represented by team leaders) and co-workers (Sennet, 1999). Others feel that cooperation in a team is too difficult.

In general, the opinion in most organisations is that cooperation is possible. Referring to psychiatric teams, Shepherd (1995: 122-123) writes: "The care of individuals with serious mental illness *and* a potential for serious violence is simply too complicated to be carried out by one individual. Effective teamwork is regarded as the only means by which the range of necessary skills to address they can bring the problems together. Similarly, good teamwork is regarded the only way that they can share crucial information and made available in a crisis and that they can achieve some semblance of continuity of care." Teamwork is a matter of sharing of learning, transfer of good practice and moral obligation.

However, the concepts of "team" (or "teamwork") may have different connotations. For example, a team of doctors who work together at the same clinic differs from a team of surgeons who work together at the same hospital. The CAP teams of this study are close to the idea of an integrated, professional team because their members, led by a common manager, together take responsibility for the patient treatment. Thus, the CAP teams of this study are not under the authority of outside management separate from their own professions.

There are a few other concepts that deal with the work relationships between individuals in an organisation where the belief is that the group, rather than individuals working separately, is better able to achieve the organisation's objectives. Collaboration and coordination have similar meanings and refer to arranging the activities that influence the goals set by an organisation in conjunction with other organisations (Payne, 2000). It may also be said that the

concept of collaboration can be extended to clients and customers (Vigoda, 2002). If the collaboration is long-term and extensive, the term "partnership" is used.

Multi-professional, cross-professional and inter-professional teams

Distinctions can also be made between multi-professional, inter-professional and cross-professional teams. Payne (2000) believes that the word "multi" indicates a lower degree of interaction between members and that the professionals don't change their traditional roles, knowledge and skills. They don't seek to cross the professional boundaries. In the cross-professional team, information, expertise and skills must be exchanged so that the actors are prepared to take on other actors' roles for the benefit of the professional group. Cross-professional teamwork has a more practical nature and is less intrusive as far as the actors' understanding of their professional roles than inter-professional teamwork. It is only the term inter-professional that refers to the idea that the participating professional actors on the team are prepared to make adaptations in their own roles to better interact with other actors' expertise and skills (Payne, 2000). In this study MPT is used as the most neutral term to describe the cooperation among several professions although such cooperation has features that are similar to other forms of cooperation such as cross-professional cooperation or inter-professional cooperation.

Using this terminology for teams, the CAP units, with their tight organisational structure, are an attempt to establish integrative, inter-professional teams, which are probably the most substantive form of professional organisation. Whether the CAP teams are really examples of inter-professional teams is an empirical question. Thus, in this study, they are treated an examples of multi-professional teams.

General experiences of multi-professional teamwork

Multi-professional teamwork may be motivated by at least two factors in addition to the moral obligation to act in the patient's best interest. One factor is that theories support the idea. The Human Relations School, with its emphasis on the idea that specialized individual work meets neither people's social needs nor their personal development and self-fulfilment needs, opposes the Taylor Scientific Management School (Scott, 2003). The Human Relations School tries to introduce a balance between the meaning of tasks and the importance relationships have for individuals so that a group may become a fun-

ctioning work unit. Theories on democratic, participative leadership, with their ideological slant, strengthen the conviction that cooperation within groups is achievable. Failed cooperative efforts are attributed to poor leadership and unfortunate personnel combinations. An equally widespread view concerning cooperation is that people in public organisations, not least practitioners, prefer to go their own way rather than work together (Payne, 2000). The second factor is the political desire to see cooperation as resource-effective. Therefore, there is strong motivation to force similar groups and individuals to cooperate so that they can use their collective resources efficiently. The perception is that there is a great need for the professions to work together in a common effort.

Most studies of teams have focused on teamwork in production where everyone in the teams has essentially the same theoretical background and has adapted to the same hierarchical organisation structure. These studies have been applied, for example, to settings where concepts such as Total Quality Management, process control and self-controlling groups are used. A concept such as empowerment has been used to support the belief that even people lacking a theoretical education, in non-management positions, can think and plan. Researchers have also studied teamwork in so-called management groups using the term "a team of equals." Typically, in such groups, managers meet to exchange information and to ensure that no decisions are taken that could threaten their organisational turf. Thus the studied teamwork is concerned either with workers with routine jobs or with managers at equal levels. It may not be possible to apply such research to teams of autonomous professionals (Payne, 2000).

In health care, there are several examples of multi-professional teams. In fact, the idea of multi-professional teamwork between medical practitioners began with the development of hospitals in the nineteenth century (Pietroni, 1994). The concept is institutionalised in hospitals with its strong, hierarchical organisation where the doctors are at the highest level, supported by the nurses, the nursing assistants and the social workers. In recent years other models of multi-professional health care have been used. Payne (2000) describes such multi-professional cooperation models in primary care where primary health care teams (PHCT) are composed of general doctors, nurses from health care centres and social workers from the community. In Sweden, the CAP units are also modelled on the idea of multi-professional cooperation.

For various reasons, cooperation problems have arisen in such multi-professional experiences. Some studies indicate that the doctors try to dominate the teams in order to consolidate their professional position in the increa-

singly complex world of health care, while other professionals would like to see more consensus decision-making in the teams (Payne, 2000). Furthermore, contradictions arise between the medical logic that is based on the idea that psychiatric illnesses should be diagnosed, treated and cured, and the social outlook that views such illnesses as the result of patients' social situations. On the whole, it seems cooperation between the doctors and the social workers is a relatively marginal consideration in both groups' practice. PHCT teamwork is, by contrast, a network of semi-independent professionals who represent their professional organisations and groups (Payne, 2000).

Thus there are many studies reporting cooperation difficulties in multi-professional teamwork and describing such teams as working as networks. It appears that cooperation problems in professional health organisations in general are explained by the professionals' confusion over what is expected from them in their own team roles and what they can expect from others in their team roles (Payne, 2000; Larkin & Callaghan, 2005).

New Public Management and customised care

In this study the multi-professional cooperation in health care involves a meeting between an old governing philosophy, professional control, and NPM, a new philosophy. NPM is then regarded as the context for the professionals' actions (see p. 31 for a description of the NPM context).

In the last three decades, a number of attempts have been made in Sweden and in other Western countries to reform the increasingly complex and resource-intensive public sector. These attempts have reflected an ideological shift on how the public sector should be governed and controlled (Hood, 1991; 1995). NPM is the umbrella name for organisational reform methods that are strongly influenced by solutions derived from the private business sector based on trust in managers and markets rather than in senior officials and the professions (Clarke & Newman, 1997; Barzelay, 2001; Almqvist, 2004). Two forces in particular may have driven these reforms in the public sector: the need to balance the economy and the need for increased confidence in public administration (Pollitt & Bouckaert, 2000). In the last 15 to 20 years, politicians have faced increased demands by the public to deal with the economic situation. Even as they protest against reductions in key cost areas such as the schools, health care and welfare, citizens have not accepted an increase in taxes. Pollitt and Bouckaert (2000) believe that politicians have dealt with this situation by taking an outside position, at a distance from operational activities, in which their role is to control and account for the work of officials.

Competition, marketization and managerialism appear to be the guiding principles of the perceived need to improve control over the public sector. Competition and marketization have been achieved by decentralizing responsibility for disaggregated public organisations, by privatising and creating competitive profit centres, and by introducing a governing focus on the customer. Evidence of such managerialism appears in the improved performance standards performance, improved measurements of output and the expansion of organisational leadership to areas other than traditional administration (Hood, 1995), as well as in auditing and other forms of evaluation (Power, 1997). Each of these elements aims at making economic and efficiency improvements and at making the actors responsible for their achievements. There is an increased demand for accountability, but it is not enough to legitimize public sector activities with a mere account of the significant achievements made in various areas (Czarniawska, 1985). Thus, the achievements of the public sector, according to NPM reforms, should be transparent.

It could be anticipated that such a program, accompanied by an aggressive rhetoric (Czarniawska, 1985; Pollitt, 1993) using standardised management control models (Brunsson, 1989) would neglect the traditional values held by leading civil servants (Peters, 2001) and would be difficult to implement. Because control problems in the public sector have been described in general terms instead of professional terms, the setting and monitoring of goals have been affected (Hasselbladh, 2008). As a result, development efforts have been dealt with on the basis of administrative functions, economic measures and data systems without reference to the complexity of the operational work. This has created a gap between leadership and operational levels. Accordingly, NPM reforms have been heavily criticized (e.g., Laughlin *et al.*, 1992; Pollitt, 1993; Ferlie *et al.*, 1996; Clark & Newman, 1997; Oakes *et al.*, 1998; Llewellyn, 2001; Sehestad, 2002). In public sector health care, for example, the claim is that the inter-organisational division of labour has distributed the responsibility for patient care in a way that is harmful to the patients' overall care (see Scott, 2000).

The criticism is understandable since public officials and practitioners think their managerial space is threatened by the adoption of NPM. However, few critics of NPM are inclined to return to the old control models used before this new wave of management reforms. The NPM reforms, many of which are already institutionalised (Hasselbladh *et al.*, 2008), are designed to benefit patients, not just to reduce costs. It is necessary in health care to prioritize among the many diagnosis and treatment measures now available for illnesses

and injuries. Resource scarcity is intrinsic to the health care sector and is not merely the result of necessary management reforms that NPM introduces. It is unrealistic to question the reforms *per se*. It is time to move from challenging their legitimacy as public sector management tools (Christensen & Laegrid, 2002; Byrkjeflot & Neby, 2008) to focusing on their implementation and to dealing with the problems they create as they attempt to solve other problems.

The NPM reforms in health care require *customised care* as an expression of customer-orientation. The goal of customised care is that the different professions – sometimes at different organisations – in cooperation based upon their unique competences can create more customer-oriented care. The re-introduction of this norm in an activity operating under NPM reforms (increased accountability for waiting times, shorter treatment periods, more treatment sessions per mental health counsellor and stricter budget compliance) is suggested as a way to re-integrate customer-orientation in health care organisations with, for example, fewer referrals and shorter waiting times. Thus the concept of customised care involves reducing waiting times, protecting the patients' rights and privacy, increasing the transparency in treatment and organising multi-professional teams around the patients' needs.[1]

The creation of multi-professional teams can be seen as a way to create the necessary favourable conditions for cooperation among the professions in their work around patients treated in common. Such teams increase the chances of early diagnosis and proper treatment for patients. This very real need exists particularly in child and adolescent psychiatric care where mental illnesses often appear in combination with severe psychosocial problems. The idea is to build teams that consist of several professions with a common team leader – multi-professional teams – where the care is customised (i.e., patients are not referred between care givers and/or are not made to wait a long time for diagnosis and treatment). Multi-professional teams should be able to respond to patients just as businesses respond to customers in a way that meets the administrative demands originating in the NPM reforms. These demands are the following: Increased patient streaming, shorter waiting and treatment times, and more patients assigned per counsellor. Multi-professional teams should also provide more quantitative performance reporting on both the units and the health care providers, particularly since there is a greater emphasis on

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[1] There are two related but narrower concepts; patient centred care and person centred care. Patient centred care and person centered care are concepts where the relation between the caregiver and the patient/person in the consultations is in focus. The idea is to treat the patients as sovereign customers. These related concepts are introduced by the professions, unlike customised care, which is a concept introduced by politicians and managers.

staying within budget. The multi-professional teams are also expected to fulfil their traditional medical obligations as well. These include prioritization of direct patient care over reporting and other administrative tasks, greater concern for patient welfare than for economic considerations, and provision of therapy according to modern scientific methods that have a prospect of good success. In addition, patients at high medical risk must be assessed and given highest treatment priority. The multi-professional teams should apply management by objective principles to economic and performance matters and should be led by team leaders who can successfully combine their professional roles with their administrative roles.

With the stipulation of these demands, the multi-professional team is regarded an example of the NPM reforms in health care that require customised patient care provided in a resource-effective way.

Multi-professional teamwork in a NPM context

Cooperation projects between various work groups and professions seem to be problematic. There are few reported experiences of positive cooperation in multi-professional teams, regardless of whether such projects are undertaken in a NPM environment. It means we are aware of very few experiences of teamwork that reflect the influence of NPM. It is also unclear whether a specially created team for customised care can be regarded as an expression of NPM in health care or if the team will enforce a common professional service ideal strong enough to overcome the tendency of professionals to seek dominance (e.g., Abbott, 1988; Freidson, 2001).

However, it is possible to have some understanding of how multi-professional teamwork functions based on our knowledge of the more general experiences in the meeting between the professions and NPM. The professions' insistence on determining their own ways of working is assumed to create a control problem, from the perspective of both democratic governance and of resource utilisation (Ferlie *et al*., 1996; Freidson, 2001). As a goal of NPM reforms is to make the public sector more effective, accountable and customer-oriented, such reforms try to set limits on self-regulation by the professions while still respecting the fact of professional control (Eriksen, 1997; Svensson & Karlsson, 2008). In health care, for example, an increased concern for patient safety has led to demands for more transparency by the professions (Tsoukas, 1997; Strathern, 2000; Leway & Waks, 2007) and to more clinical guidelines and evidence-based health care (Power, 1997; Timmermans, 2008). However,

there are often *unintended consequences* when NPM reforms are introduced in professional groups (e.g., Freidson, 2001; Timmermans, 2008). Different explanations are offered for such unintended consequences. One category of explanation suggests there is a *decoupling* between the reform and the action, due to formal structures decoupled from core activities (Scott, 2003). For example, Orton and Weick (1990) and Erlingsdottir (1999) contrast decoupling and ritualistic adherence to reforms; Meyer and Rowan (1977) and DiMaggio and Powell (1991) write about the need to protect core activities from external disturbances; and Brunsson (1989) discusses organisational hypocrisy.

Another category of explanation is that hegemonic power *colonizing* causes the professions to implement new practice guidelines. Thus the professional organisation is permeated by an administrative control regime (Power, 1997). Kunda (1992) and Hasselblad *et al.* (2008) propose that such guidelines create multi-faceted responses; others describe the subtle *resistance* that arises in various forms (e.g., Bolton, 2004; Bolton & Houlihan, 2005; Thomas & Davies, 2005; Spicer & Fleming, 2007). In the discussion, all these organisation researchers take one of two contrasting positions about how professionals view the effect of NPM reforms on their professional autonomy – either the professionals think NPM reforms pose a powerful threat to their independence or they think such reforms have little influence on their independence.

Purpose and research questions

To conclude, the MPT situation under the influence of a NPM control regime is characterized by one or more of the following: a) A new model of multi-professional teamwork with a tighter structure of the professions working under a team leader: b) A strong national and local belief in the potential of multi-professional teamwork; c) A generally disappointing cooperative experience from the expectation that teamwork means something more than marginal cooperation, as in a network, regardless of whether such projects are undertaken in a NPM environment; d) A meeting between an old governing philosophy, professional control, and a new philosophy, (NPM); and e) The adoption of NPM reforms in the professional environment has clearly been problematic and not conducive to cooperation.

There is a need to study whether the specially created teams for customised care enforce a common professional service ideal strong enough to overcome the cooperation problems. It is also of interest to understand the negative, as well as the positive, outcomes in the previous explanations. If there are alter-

native interpretations to cooperation problems seen as the results of incompatible professional norms that determine the actors' role identities, making it difficult for actors to understand each other's roles.

There seems to be a paradox when we try to explain cooperation problems in health care. There seem to be more factors that unite individuals in health care than factors that separate them. One unifying factor is the mutual ambition to provide good health care with a high level of patient security and good treatment results. According to Jones and George (1998: 539), "Shared values and positive moods and emotions are manifested in interpersonal cooperation and teamwork and the strong desires of team members to contribute to the common good". Therefore co-workers in the health care sector could be expected to share values to a very large degree. Yet their cooperation problems are as severe as in other work sectors. Even role-oriented explanations do not tell us why there are differences in how everyday matters are handled in different wards in the same hospitals. For example, why is it possible to arrange timely, fully staffed ward rounds in one ward when it is impossible to achieve this in a neighbouring ward?

The paradox is that cooperation problems exist in multi-professional teamwork where the members, despite their different professional norms, share a mutual interest in the patients. Furthermore, Bowker and Star (1999) highlight the importance of constructing boundary objects to achieve cooperation. Boundary objects allow translations of other's actions between various social worlds and thereby enable individuals in separate social worlds to coordinate their actions (Star and Griesemer, 1989). Patients should be perfect boundary objects that connect people from different health care professions. The question then is: Why isn't the patient a boundary object that enables multi-professional cooperation? Ultimately, it is something of an accepted truth that multi-professional teamwork is difficult (Payne, 2000). Health care groups are often used as examples of such difficult-to-manage professional organisation (Blomgren, 1999; Levay, 2003). This is an empirical mystery, requiring theory development (see Alvesson and Kärreman, 2007).

Traditionally, the emphasis has been on institutional explanations with too little focus on actor-oriented explanations. The meeting between professional norms and NPM reforms may have both supportive and inhibiting consequences for cooperation in MPT. But professional norms and NPM reforms cannot determine actors' actions. Some co-workers may develop strategies that lead to unexpected problems for themselves, their colleges and the activity in general, especially if there is a lack of trust in the organisation and its current leadership.

Strategy here refers to an actor's actions that are intended to achieve a specific goal. Thus, a cooperation strategy is a pattern or a behaviour that is aimed at cooperation. The professionals' strategies, as they appear in this research, are regarded as emergent.

This study examines the causes of cooperation difficulties and cooperation in a multi-professional health care team. Examples of cooperation difficulties could be those reported by Payne from primary health care teams (see p. 5-7) with a low level of interaction, and sometimes manifested in a negligent attitude toward meetings. This investigation is undertaken from different theoretical perspectives on how professionals act under the influence of a NPM control regime by analysing their action strategies.

The research problem is as follows:

How does multi – professional cooperation function in practice in the investigated setting?

The following research questions are posed:

1. What strategies do different professionals develop in multi-professional teams that either promote or hinder internal cooperation in the teams?
2. What strategies do different professionals develop when dealing with external professionals and other work groups from cooperating organisations related to patient treatment?
3. What *unintended* consequences have emerged regarding multi-professional cooperation and how can these consequences be related to NPM-influenced organisational practices?

The aim of this study is to describe and analyse how professionals act under the influence of a NPM control regime and thereby to contribute to the international research on cooperation problems in multi-professional teams.

The focus of the study is not on the extent to which NPM reforms have been introduced. The individual *professionals'* actions are studied (the individual level), not the actions of the *professions* (the aggregated level). Thus the purpose of this study and the research questions are of a qualitative, rather than a quantitative nature. A qualitative approach is chosen in order to interpret the actors' actions.

Although the qualitative approach refers to the inductive nature of data analysis, the research process in this study alternates between inductive and deductive analysis (Denzin & Lincoln, 2005). Thus, this study is the result of an abductive process. It starts from empirical facts but they are seen as theory-laden, where different theories provide guidance for the interpretation

of the empirical material (Alvesson & Sköldberg, 2000). (See Methodology in Chapter 3).

Paper 1 and Paper 2 deal with the concept of cooperation and with cooperation difficulties as viewed from the perspective of professional norms and the demands of a NPM control environment. Paper 3 discusses how a NPM control environment can improve or worsen the conditions for cooperation. Paper 4 treats the causes of cooperation difficulties between the professionals and the team leaders and between the professionals in a multi-professional team. Two explanations for these difficulties – one from an actor perspective and the other from a cultural, norm-oriented perspective – are suggested. Paper 5 investigates cooperation problems and the sensemaking process among team members at a Treatment Conference as an assumed prerequisite for common, aligned action. Paper 6 discusses co-optation as a cooperation method between CAP unit managers and professionals in response to accountability pressures.

Background

The study is part of a larger research project conducted in a major health organisation for the West Coast of Sweden, called Västra Götalands Regionen (VGR). The purpose of the larger project was to examine professional relationships and cooperation among health care employees by studying the interaction between the various categories of co-workers and between the managers and the co-workers, specifically in psychiatric care.

In recent years it was observed that psychiatric care in the larger medical institutions, which has largely been phased out, required development as well as additional resources. The National Psychiatric Investigation in Sweden (SOU 2006) called attention to the fact that young children and adolescents who have psychiatric problems often have problems of a social nature. This observation has implications for the unified model that has been adopted for early treatment of such problems. Various recommendations have been made. For example, core activities, such as child and maternal health care, should be integrated with Social Services and primary care. *Primary health care* should be strengthened as the first line of health care, even in the case of mental illness. Child and adolescent psychiatric care should be a specialist activity with the major part of the mental health care resources allocated to the open care CAP units. Furthermore, the various authorities (e.g., the communities and the county councils) that are responsible for treating young people's complex and extensive health problems – currently organised on two levels (basic and

specialist) – should co-organise in order to provide coordinated psychiatric care. In recent years a related concern, owing to the increase in the number of patients applying for admission to the CAP units, especially those patients with severe problems, is that the waiting lists and waiting times at the CAP units throughout the country have steadily lengthened.

There have been significant changes in the CAP units in the last ten years. A decade ago they were advisory clinics that primarily offered counselling to parents on child rearing issues. Counsellors and psychologists in these clinics provided primary care, particularly preventive care, and consulted paediatricians as necessary. Recent research in developmental psychology and psychiatry and in pharmacology has caused the area of child and adolescent psychiatric care to grow significantly. In Sweden, as elsewhere, much more attention is now focused on the mental health care of young people. As a result, the CAP units have prioritized the diagnosis and treatment of psychiatric illnesses over a large part of their traditional work that involved treating psycho-social problems through home visits and preventive and consultative care. Now a physician (often a specialist in child psychiatry) and a nurse are usually members of a CAP unit's team.

Chapter 2
Theoretical concepts and previous studies

Theories and theoretical concepts

This study examines if there are situations interpreted by actors, based on the requirements of interested parties (e.g., institutions) that reflect their expectations and behaviours. The actors' strategies are "applied" to the situations, leading to new findings and reactions from their environment. The actors can then read these effects that become part of the next stage of interpretation, in a kind of continuous loop. The actors behave with limited knowledge of the results their strategies will produce or of the reactions they will provoke. In this way, they "play" against the other actors in order to test which strategies will produce the best outcome, taking the other actors' counter-strategies into consideration. This is way in which strategies and counter-strategies are tested and developed. The actor perspective is introduced as a complementary perspective to the traditional, norm-oriented perspective for the interpretation of professionals' actions. This perspective draws on rational choice institutionalism (Peters, 1999) and assumptions about actions allowing the logic of consequentiality (Hall & Taylor, 1996) (Paper 4).

In the analysis of the empirical material, the concepts from the theory of cooperation developed by Star and Griesemer (1989) in their Berkeley museum case research is also used. Their theory is built on the concept of boundary objects and standardised methods that promote cooperation. In the case of cooperation in health care, the patients are the obvious boundary objects; care plans seem to be good examples of standardised methods. There are, however, two complications in the studied setting that should be considered in relationship to Star and Griesemer's theory. The actors work in a NPM context where they face increased accountability demands. Their ideas are then applied in a situation when the patients are expected to become more context-dependent on the various professional contexts. Furthermore, the cooperating actors are professionals who act in accordance with their professional norms, a situation that possibly promotes as well as hinders their ability to cooperate. The specific expectations related to the professionals' actions are analysed using theories

on professions that permit discussion of the implications of the professionals' service ideal, discretionary power and professional dominance.

The actor perspective

The professional actors act under the influence of a NPM control regime. According to institutionalism (Diermeier & Krehbiel, 2003), it isn't just a question of how an individual plays by the exogenous rules of the game (e.g., professional norms), but of how they choose the rules they wish to play by. Individuals collectively choose institutions that are outside the organisation, the so-called exogenous institutions that through translation become inside institutions, the so-called endogenous institutions. By taking this approach, it is possible to understand that cooperation problems in highly controlled exogenous institutions are caused by individuals who have not chosen the rules of the game and therefore have not built endogenous institutions. They have no standardised procedures that facilitate cooperation (Hall & Taylor, 1996; Peters, 1999).

The following two examples illustrate the importance of endogenous institutions.

Example 1: The significance of the introduction of an endogenous institution
The daily rounds in a hospital department did not begin on time or were not conducted by the designated personnel. After the schedule of rounds was posted by the entrance door of the department, within a week the rounds started on time and with the right personnel. In this way, everyone could see who was not meeting his/her rounds duty, and a work dilemma was resolved. Also, people making the rounds could arrange their own workloads before the rounds began. In the long-term, it was clear such disturbances in the rounds routine, which were detrimental to everyone, could be dealt with using a simple measure. The increased degree of endogenous institutionalisation helped strengthen the activity.

Example 2: The significance of the absence of an endogenous institution
A company that manufactured mirrors richly rewarded its productive employees as well as its unproductive employees. This situation caused productivity to decline to the point where the company was forced to go out of business (Tengblad, 2006, refers to this example). The company lacked an endogenous, social institution that could create and maintain the rules of a reward system that was fair, reasonable and consistent with the employees' values.

The importance of endogenous institutions is evident also in the classic problem – "the tragedy of the commons" – posed by Hardin (1968). In Hardin's account, the collectively owned land was a limited resource that was exploited by shared use. Such

resources, Hardin concluded, are at risk of exploitation if users don't agree on a use plan, for example, a quota system. Elinor Ostrom, the 2009 Nobel Prize laureate, has analysed this Common Pool Resource (CPR) issue extensively (1998; Ostrom *et al.*, 1999). Ostrom *et al.* (1999, p. 280) identifies two forms of free-riding."Overuse without concern for the negative effects on others, and a lack of contributed resources for maintaining and improving the CPR [the common pool resource] itself". Drawing a parallel to the work situation at large organisations in which the question may be asked: Why be the only person to work hard? With the ground rules that apply to the "commons," "rational" people take a short-term perspective on the use of shared resources. However, the so-called social dilemma that arises is that everyone then loses in the long-term when the shared resources are depleted. It is possible to understand the situations where the resource exploitation occurs and where the actors have made mutually binding agreements, but it is more difficult to understand what is required when making the shift from exploitation to a regulated, sustainable use of resources.

Thus it is essential to understand how endogenous institutions are created. The actors' behaviour may be related to their strategic outlook when they define situations in terms of their own self-interests. One can study the behaviour of the actors in the context of their desire to take responsibility for patient assignments and to overcome the problems with colleagues and other cooperating partners. For example, the way to deal with patient risk can be studied, particularly the degree to which such risks are assumed by the individual or shared by the team. In addition, the presence of standard and routine procedures can be studied as evidence of the degree of endogenous institutionalisation. A specific micro-process, co-optation, may explain the gradual institutionalisation of NPM reforms. Co-optation in its basic form can be defined as the process by which leaders absorb external strategic elements in their policy decisions (Thompson & McEwen, 1958).

Boundary objects and standardised methods

Huxham (2000) has studied cooperation projects between organizations in public administration, including those where the representatives for different professions and organizational cultures have participated. She states: "Misunderstandings are likely to occur due to diversity in language, values and cultures. Perception of power differences can lead to aggressive rather than sympathetic stances towards each other" (Huxham, 2000: 351).

This is contrary to cooperation, which means a certain social order has been created in either a small or a large group of people by means of agreements, negotiations, individual power positions and interpretations embedded in practice (Schatzki,

2001). Know-how, skills and acknowledged expertise in practice especially constitute a common asset and lay the groundwork for what members collectively can achieve through cooperation and mutual compromises. Health care professionals have to exchange experiences in order to create this common asset in their own social worlds and with their own ways of approaching the patient as they solve problems in a cooperative effort,

Star and Griesemer's (1989) theory of how cooperation can work across context boundaries provides us with a framework for studying the development and analysis of boundary-spanning objects in relation to cooperation across professional boundaries. According to their theory, experience exchanges among professionals require communication that links experiences from certain places and certain times with experiences from other places and other times. For such exchanges, it is necessary that the experiences are a representation. These experiences must first be encoded and then decoded in the social worlds they are transferred to.

However, because people in a certain context create their understanding of their world from the people and objects in it, the information is context-dependent with different meanings in the two worlds. How can people communicate with each other if the information can be understood only in the different contexts? The key to transmittal of information is to situate it in more than one context on the assumption that communication will succeed if the object can be found in several contexts simultaneously and is given both local and shared meaning (Bowker & Star, 1999). Star and Griesemer (1989) believe individuals in separate social worlds coordinate their actions so that they have access to the so-called boundary-spanning objects that allow translations of others' actions between their various worlds. Bowker and Star (1999: 16) describe the characteristics of boundary-spanning objects as follows:

> In working practice, they are objects that are able both to travel across borders and maintain some sort of constant identity. They can be tailored to meet the needs of any one community (they are plastic and customisable). At the same time, they have common identities across settings. This is achieved by allowing the objects to be weakly structured in common use, imposing stronger structures in the individual-site tailored use. They are thus both ambiguous and constant; they may be abstract or concrete.

Star and Griesemer (1989: 407) also describe standardising methods as a way to promote cooperation: "By emphasizing how, and not what or why, methods standardization both makes information compatible and allows for a longer 'reach' across divergent worlds." In the CAP units of this study, in response to increased accountability demands, standardised measures were introduced (e.g., care plans, quality measurements forms and manuals for evidence-based treatment).

The concept of boundary object has a double meaning: it is both the raw material for a translation process and the result of such a process. Star and Griesemer (1989:393) use both meanings:

> They [the boundary objects] have different meanings in different social worlds, but their structure is common enough to more than one world to make them recognizable as a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds.

The presence of such an object in itself, seen as raw material, is not a success factor for cooperation but rather the very reason that the issue of cooperation is updated and embryonic. The boundary object needs to be constructed as Star and Griesemer argue. The main issue is how this creation occurs.

The theory is, however, unclear in its description of how the actors create these boundary-spanning objects. From an actor perspective, in the Star and Griesemer museum case the curator as museum head held a position of authority that he used to make actors work together. The curator demonstrated how the trappers and conservators could align their joint work with each other and with the objective of the museum. As a condition of their employment, the curator told the trappers that they had to complete forms that described where the animals (whose craniums had to be intact) sent to the museum for preservation were captured. Yet, according to the case description, the trappers and the conservators never met.

In the museum case, it is assumed to some extent that the curator guaranteed the willingness to cooperate that explained the emergence of boundary-spanning objects. When this prerequisite is not present, research in game theory has frequently concluded that if actors distrust each other, they won't want or dare to work together, which leads to a daily dilemma for them in the organization (Rothstein, 2003). When actors suffer from a lack of confidence in each other, this situation may consequently lead to a poor collective result that may further lead to long-term personal failure. Given this viewpoint – the idea (whether well-founded or not) that co-workers oppose each other – co-workers may naturally develop strategies that are directed toward defence of their own work group's interests, leading to an unfavourable work climate and low organizational efficiency and quality. Huxham (2000) emphasizes the importance of the attitude toward cooperation. Trust in relationships is built by previous successful cooperative efforts over long periods of time with the same partners. It is a matter of patient efforts where all participants must strive to understand others' intentions. Huxham (2000: 353) writes: "Trustbuilding seriously takes a lot of substantial compromise and the willingness and skill to see the world

from the perspectives of others." Therefore we argue there is interdependence between the attitude towards cooperation and the capability for cooperation; they are inseparable.

In sum, if cooperation is to occur, the actors must have the social and cognitive power to make translations of other worlds' actions as well as the will and daring to cooperate. They must want and dare to work together – they must trust each other (Jönsson, 1996). Next we discuss how these prerequisites of cooperation in theory are affected by increased accountability demands.

Cooperation in a NPM context

How then can theory explain the impact of increased accountability demands on cooperation?

Two explanations are suggested.

(1) The strengthened external requirements may cause actors to realize they share the increased risk of failure. They will then try to develop a common strategy for handling risk by constructing the patient as a boundary object since the increased level of risk promotes solidarity and cooperation in the team. The high level of risk fosters teamwork. From an organisational perspective, it seems the medical responsibility would bind a team and its work with patients together. An institutional measure, such as a supervisory authority to take the responsibility for patients' medical risks, is essential in an individual health care organisation. If all team members have a good understanding of patients' needs and are inspired to do their best for patients, this institutional governance responsibility may stimulate cooperation. Under such conditions, where the patients are boundary objects unifying the different professions, the organisation is characterized by team spirit, constructive leadership and co-workership. Institutional government would then support well-functioning work places.

(2) Risk strategies taken by individuals may become impediments to cooperation on the team. The strengthened external requirements may highlight the personal risk of each actor on the team, with the result that actors feel isolated by the risk they face. The patient becomes a risk object, at the expense of the team's cooperative efforts. The high level of risk causes the teamwork to deteriorate.

From a theoretical point of view the increased accountability demands may also affect team cooperation in two opposite ways. The capability for cooperation decreases when more difficulties are encountered in creating boundary procedures and boundary objects, for example, when an asymmetric, increased risk is imposed on one member of the team, the doctor. The argument is that, in this situation, patients as potential boundary objects will be more context-dependent in the medical practice

and less likely to become boundary-spanning objects between the different practices on the team. The same object, when naturalized in two separate communities of practice, removes anomalies at the juncture of these social worlds. It is the similar way of using an object that distinguishes a social world, and it is through the common object that individual and joint discussions are mediated. Even contact with other people is mediated through the object, even if not directly. "Acceptance or legitimacy [of actors as members] derives from the familiarity of action mediated by member objects" (Bowker & Star, 1999: 299). It takes time to learn the rules that constitute the logic of a social world. Such learning occurs in meetings with other people and in close contacts with objects that become so familiar that we share the members' understanding of which categories objects belong to. The actor is incorporated into the process of becoming a member, and the object and categories are incorporated in an intertwined process called naturalization (Bowker & Star, 1999). In the naturalization process, the link between categories and context is weakened. In this way, the object becomes much more familiar to the members. Membership is thus learned through the experience of encounters with the objects that are used in practice where people have an ever more naturalized relationship to these objects. This naturalization process is disturbed when an asymmetric risk is imposed on one team member. The patient as a category is made more context-dependent. The link between context and categories is strengthened when the doctor is reminded of the patient's relevance in a medical context.

In the relationship with the patients as objects, professionals who are not doctors exhibit another behaviour that doesn't agree with the doctor's experiences. This creates tension between the two interpretations; an anomaly arises that must be resolved. It is this dilemma that those who seek team membership generally find themselves in. This will discourage meetings between the members of the team engaged in common activities. Such meetings are necessary if team members are to learn which categories they belong to, that is to say, the categories that have the meaning shared by everyone in the team. This explains why the capability for cooperation will decrease.

But the capability for cooperation increases when greater accountability and transparency demands are accompanied by standardised procedures that have a boundary-spanning function. As accountability demands increase, care plans, quality measurements forms, manuals for evidence-based treatment and other standardising methods are introduced. This means that the tension between these various contexts resulting from the divergent viewpoints on information's meaning can be managed with the help of classification systems as agreed-upon standards that permit the movement of information from one context to another without changing its meaning – the information becomes context-independent. This explains why the capability for cooperation will increase.

The conclusion from a theoretical standpoint is that the asymmetric risk imposed on the doctors is a threat to the capability for cooperation because the children with psychiatric symptoms as potential boundary objects become more context-dependent in the medical practice. They are not available as boundary-spanning objects between the practices on the team. However, the introduction of standardised procedures may balance this effect, making it possible to establish cooperation within the team. (This research finds empirical evidence to support both statements).

However, a main problem with multi-professional cooperation may be that the professions, according to profession theory, seek professional dominance (e.g., Abbott, 1988; Freidson, 1970). Professional dominance results from the egocentric belief that a profession alone knows what is best for a client who is shared with other professions (Paper 1). On the other hand, the professional service ideal may promote cooperation. The question is whether the teamwork may benefit from the service ideal.

Cooperation among professionals

The feature that distinguishes a profession from other occupations is its degree of self-control (i.e., self-governance or self-policing) (Van Maanen & Barley, 1984). Ferlie *et al.* (1996) believe that the professions are work groups with especially large demands, not just for self-control – discretionary power – but also for a desire to dominate – professional dominance. However, professions are also associated with the service ideal (Wilensky, 1964). With this commitment to the best interests of their clients, there may be a counter to the professions' desire for independence and control. Thus we focus in the following analysis on the effect on teamwork of these three strands – *service ideal, discretionary power, professional dominance*

Profession theories can be used to explain cooperation as well as cooperation problems among the professions and between the professions and administrative management. The service ideal, which may imply integration, agrees with the NPM ideas behind customised care, while professional dominance may imply disintegration between different professions. Discretionary power maintains that the professions will find it difficult to cooperate with management. However, some research suggests it is doubtful that there is a natural conflict between the professions and management. This concept of the professions seeking *discretionary power* is contradicted more and more by the professions and their members who are employed in both professional and non-professional organisations (Greenwood & Lachman, 1996). Patients have become increasingly knowledgeable about the services provided. For example, clients can read on the web about treatment alternatives available for a particular diagnosis. Such increased knowledge among patients can undermine the authority of the pro-

fessions (Collins, 1990). Other management trends such as decentralization, flatter organisations, teamwork and more professional groups may influence the conditions of professional group work (Ackroyd, 1996). With these changes, it is natural to think that the professions, which depend on public approval, must adapt to working with other professions and work groups (Exworthy & Halford, 1999).

Thus, whether cooperation prevails or fails in a particular situation depends on the balance of the three profession theory strands. Profession theories, at least, allows us to believe that the professions can cooperate in providing customised care, which is a primary goal of NPM reforms. Nevertheless, all three strands support the existence of one profession's autonomy, which may cause cooperation problems.

The main conclusion is that the professionals may be influenced but not determined by their professional logics. That conclusion, combined with the idea that trust is an organised mechanism – the necessary factor required for cooperation in an organisation (Jönsson, 1996) – leads to the observation that cooperation problems arise because the actors have no reason to develop a cooperative attitude, in any event not with the present internal institutions that referee the rules of the game that promote cooperation. The key aspects of studying how trust is created are thus to understand which norms (i.e., the rules of the game) set the limitations and the rewards for organisation members, and to learn how endogenous institutions are created that uphold these rules that influence behaviours and produce consequences. The behaviour of actors can thus be analysed based on the endogenous institutions in the CAP units of this study that attempt to control individual self-interest. (See p. 26-29 and Paper 4).

The overall theoretical framework and the theoretical concepts

Star and Griesemer's (1989) cooperation theory with its main concepts of *boundary objects* and *standardised procedures* provides a starting point if we want to understand the problems with managing professional organisations and the interaction between the context and the actors in a NPM context. The theory is, however, unclear in its description of how these boundary-spanning objects are created. One cannot simply assume that a willingness to cooperate explains the emergence of boundary-spanning objects. If cooperation is to be realized, the social and cognitive power to make translations of others' actions is required. In addition, if cooperation is to occur, it seems unrealistic simply to assume they actually have the will to cooperate. Professional organisations must want and dare to work together – they must trust each other. Therefore it is argued in this study there is interdependence between the attitude towards cooperation and the capability for cooperation; they are inseparable.

It is plausible that both the will and the capability to cooperate are related to the involvement of professionals. Theories on professions support the idea that coo-

peration in the multi-professional team directed towards patients will work. Such theories also support the idea that problems will result from such cooperation. A strong argument can be made that professionals are motivated by the service ideal so that the patients become boundary-spanning objects whereby the professionals understand their own and others' work. A strong argument can also be made that professionals are motivated by a desire for discretionary power and professional dominance. Theories on professions provide the theoretical concepts of *service ideal, discretionary power and professional dominance*. These theories are useful for analysing the empirical evidence in the effort to understand the effect on professional cooperation.

Previous studies

Obviously cooperation is difficult. Studies describing successful cooperation are a rarity in the literature. The two following studies describe how successful cooperation is achieved, in both cases by the construction of boundary-spanning objects/ procedures. The first study is Star and Griesemer's (1989) Berkeley museum case that is almost essential for an understanding of the main concepts of cooperation theory. The second study is Lindberg and Czarniawska's (2006) research into cooperation among actors in a health care organisation and an elder care organisation that describes in greater detail *how* the successful creation of boundary objects was achieved. Both studies demonstrate the importance of a hegemonic idea. This idea is imposed by coercion in the first study, and by mimesis in the second study. As the impetus for cooperation, both studies found that an external norm was superior to other norms in establishing institutionalised procedures.

Many other studies describe a situation where there is no such hegemonic idea. These studies attribute cooperation difficulties to difficulties in disseminating new norms in professional organisations, especially in multi-professional teamwork in health care where there is role confusion.

Cooperation – Boundary objects

Lindberg and Czarniawska (2006) report on how cooperating organisations in health care (primary care, geriatric care and emergency care) and Social Services (elder care) perceived the care chain as a fashionable idea. The actors in charge of this care were influenced by NPM and its ideas about the organisation of production flow in manufacturing companies. Cooperation among these actors was strongly supported by external norms and by their own understanding of their goals and ways of working. However, a strong institutionalised form of cooperation developed that matched this external influence. Thus this study shows how an exogenous structuring element (the

care chain idea) is translated to an endogenous institution. Furthermore, the study shows how cooperation is created, in this case among several organisations. The actors spanned boundaries in order to link their individual actions to a collective action; they then stabilized this action so that institutionalised behaviour resulted. They conclude that the use of boundary-spanning connections creates cooperation between people, actions and organisations. These connections are created by the translation of an idea that is understood by the actors in their individual contexts.

This study shows that a hegemonic idea can lead to cooperation with institutionalised forms.

There is an assumption behind the care chain that maps the patient's path through care. It is assumed that a prerequisite for the initial cooperation is that the translation connects the actors and their actions in a boundary-spanning way. There is a connection to historic institutionalism that stresses the importance of ideas in shaping the policy preferences of structures (Peters, 2005). Ideas according to New Institutional Theory have a structuring effect on actors. In this study, an external norm was superior to other norms as the impetus for cooperation on how the work should be conducted so that institutionalised procedures could be established. Thus the difficulties that arise from conflicting external norms are eliminated. These are the difficulties that New Institutional Theory explains as cooperation problems.

Cooperation difficulties – role confusion in multi–professional teamwork in health care

The literature acknowledges the difficulty of multi-professional teamwork in health care that is explained by cultural differences rather than by rational differences associated with independent actors' perspectives, intentions and strategic thinking. The results from the *unsuccessful* examples explain cooperation problems in professional health organisations in general by the professionals' confusion over what is expected from them in their own team roles and what they can expect from others in their team roles. According to the literature, the different professional values and cultures (e.g., their outlooks, intentions and ways of strategic thinking) associated with the independent actors may make multi-professional teamwork difficult. When professionals are controlled by contradictory external norms, values and cultures, it is a challenge for them to work for the common good. If the norms that govern professionals differ, the resulting distrust in shared activities may inhibit the formation of positive, cooperative relationships. (For an overview of previous studies, see Paper 4)

Cooperation difficulties in mono professional teams

Several previous studies have shown how the relationships in a mono-professional work group seem to be about peaceful co-existence. Example of such studies on various work groups are the following: Arfwedson (1983) on teachers; Axelrod (1987)

on soldiers; Van Maanen (1992) on policemen; Morrill (1992) on accountants; and Trägårdh (1997) on product development managers. In his study, Trägårdh concludes that the spirit of community among production managers was weaker than their cooperation; while they guarded their own territories, they respected that of others. In this way, a form of peaceful co-existence resulted in which self-interest and others' interests were valued. Similarly, Friedson (2007) describes how doctors' professional ethics prevented them from examining and criticizing their colleagues' work – superiors offer advice, not orders. In the worst case, where two (or more) doctors have different professional standards, they simply avoid working together. A consequence is that there is no collegial cooperation among doctors that can correct misbehaviour; the professionals are expected to handle such problems themselves.

Implications of previous studies

The results of this study should be compared to the results from both the successful and the unsuccessful examples of cooperation.

The first two studies referred to describe *successful* cooperation. They show how the creation of a boundary object may be the driving force behind the creation of more boundary objects. When the translation process around a boundary object is capable of finding specific solutions to how cooperation can be achieved, then institutionalisation occurs that is strong enough to maintain the cooperation, regardless of the actors or incidents. However, there may be several differences in the CAP units compared to these studies.

It may be difficult to find a hegemonic idea in the CAP units. Through-streaming of patients and minimization of the waiting times increasingly are management's main considerations. In the spirit of NPM, the CAP units may try to define their mission ever more narrowly. In the CAP units there may be another and more problematic process that must be solved before a common idea about cooperation can be put into practice.

Another possible significant difference between the CAP units and other cases from the literature refers to the extent of the actors' involvement in the cooperation. In the CAP units the actors who do not cooperate with other professions are assured that their independence and individuality are not threatened. However, unlike their co-workers who come from various organisations, they have no home base to refer to if they discover that the cooperation model challenges their individualism. All their work concerns the CAP work. Their positions are unlike the positions of the Berkeley museum workers. Star and Griesemer (1989: 404) describe the museum working conditions where formal collaboration was only a small part of the work: "Only those parts of the work essential to maintaining coherent information were pooled in the intersection of information; the others were left alone".

Thus the CAP case describes a more embryonic stage of cooperation where a hegemonic idea that guides the cooperation is lacking. The CAP case, which may be seen as an example of the stage that precedes the stage presented in these related studies, may complement their tentative theory formulation. The CAP case provides us with an understanding of how boundary-spanning activities, such as the construction of boundary objects and the use of standardised methods, are worked out in the absence of a hegemonic idea. The importance of the intent and the capability to cooperate is recognized. The tentative theories in the referenced studies seem to conclude little about these aspects. The studies describing unsuccesful cooperation they simply suggest that there is something unattractive about working with standardised methods and with developing boundary procedures, in other words, being part of the "neighbourhood". Nevertheless, even the less successful cooperative efforts have boundary objects, seen as the raw material, if there is a reason to cooperate.

There is a need to examine the actor perspective, as a complement to the cultural perspective in order to learn whether this perspective contributes to a more comprehensive understanding of cooperation problems. (Paper 4).

Chapter 3
Methodology

Setting

The NPM control regime

A central goal of NPM reforms is to make the operations of organisations more economical and more efficient. The responsibility for achieving these results should be decentralized, and the output from the units should be transparent (see p. 7). The whole idea behind creating accountable multi-professional teams may in fact be regarded an expression of NPM. In the last five years, under NPM, the CAP units have gradually been evaluated by more and more performance measurements

In recent years economic governance in the CAP units has become increasingly important. As a result, they have been decentralised so that unit managers have the primary economic responsibility for the units. Possibly the most important requirement of a unit is that it should be managed within an approved economic framework (i.e., a budget of about six million Swedish crowns per unit).[2] About 90% of all costs in CAP units consist of personnel and office costs, while the other 10% are for training and purchased services. This means that total costs can be influenced only to a rather limited extent, primarily in connection with staff departures. Budgeted revenues are determined by the total volume of treatments and compensation, which are established by a purchasing entity. VGR, the parent organisation of the hospital organisations which the CAP units are part of, has implemented a system in which the economic and political responsibility is shared by two kinds of political bodies, according to the so-called purchasers-providers model. The politicians with responsibility for supplying health care to the population in the region are assisted by a management organisation that is able to purchase health care from the hospitals that are supervised by the politicians representing the providing units. This model, with its increasingly more sharply defined roles for

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[2] The numbers vary among the three units of this study. Section Setting presents approximate average values for the three units.

purchasers and providers, has been used for the last ten years. On average, a CAP unit accommodates about 3000 treatments (e.g., doctor visits, talk therapy sessions) a year. A substantial part of the economic control in CAP units is therefore linked to the management of the productivity in the activities. Control is exercised at the individual level so that each therapist records the average number of treatments given per day by professional category (about 2 patient treatments per day).

In recent years the requirements for *access* to care have become essential aspects of health care. A guarantee of care applies to the total organisation of which the CAP units are a part. Initially this meant that a patient's maximum waiting time for a first visit was 90 days, and the maximum time before treatment began was also 90 days. The maximum waiting time for a first visit was reduced to 30 days as of 1 September 2007. The decision by the CAP units' parent organisations (VGR) to introduce a care guarantee agrees with declarations at the national level. These declarations have since been clarified in such a way that targeted government support is now linked to a waiting time for the first treatment of 60 days (from 2010) and then to 30 days for both waiting times (from 2011). In practice, this means that the whole organisation for the CAP units follows the national guarantee of care standards in order to preserve its government support.

The requirements for *patient* security are stipulated by Socialstyrelsen (the Swedish National Board of Health and Welfare). The enforcement of these requirements rests with HSAN (the Swedish Health and Medical Responsibility Board). The main governing principle is that each treatment professional (counsellors, psychologists, nurses and doctors) has a responsibility for the care he or she provides in the individual patient cases. However, Socialstyrelsen and HSAN maintain that the doctors should be familiar with all patient cases and should make initial plans for their care. In addition, the doctors perform an important role in diagnosis and in evaluation of patient treatment. Socialstyrelsen states that as a rule there should be an attending doctor appointed for every patient. Thus, in recent years, health care legislation has meant that doctors have increasing patient responsibility (Swedish Association for Child and Adolescent Psychiatry, 2007). Punishments for doctors may be sanctions, warnings or license suspension.

The requirements for *quality* and the assurance of quality work in health care have held an increasingly prominent position in the last five years. VGR participates in a national quality registry with public transparency so that comparisons can be made between the country's health care systems (the equi-

valents to VGR). The business plans establish goals for how many customers (as the patients are identified) should report satisfaction with their treatment (a goal of about 85%). Dissatisfied patients can appeal to patient boards at the parent organisation (VGR) or to the external supervisory authority (HSAN). A general quality control monitoring using survey questionnaires is conducted with CAP unit patients. In these various questionnaires, the patients may evaluate their experiences with treatment and make self-assessment comments on their health before and after treatment. Since 2005, this method of quality control has gradually spread to all the CAP units.

The CAP units are expected to work cooperatively as *multi-professional teams*. However, there is no law that enforces this way of working as long as the patient security requirement, as described above, is met. Nevertheless, the CAP units are managed according to a specific national norm for open care child and adolescent psychiatry.

The mission and responsibilities of the CAP units

The mission of the CAP units – to provide coordinated, competent psychiatric care (for patients age 18 and under) – has expanded as the influence of the New Public Management (NPM) reforms that call for more focus on resources, more efficient production and greater accountability in health care has increased (Hood, 1995; Almqvist, 2004). In addition, the CAP units are required to take responsibility for managing the growing number of neuro-psychiatric examinations and treatments as well as for introducing new therapeutic methods, such as cognitive behaviour therapy. To provide the required coordinated care, team members in the CAP units must cooperate both internally and externally in the psychiatric treatment of young children and adolescents. Professionals in the CAP units have to combine their expertise and skills inside the team, and cooperate with the schools, Social Services and Habilitation outside the team.

The CAP units today have far more responsibility than they did when they were simply health care advisors. A CAP unit is at the centre of a health care environment where internal cooperation among its various team professionals is essential and where external interaction with outside organisations is increasingly important. The CAP units therefore are good subjects for the study of cooperation across professional boundaries. It is of both practical and theoretical interest to examine if, and how, such cooperation works.

Multi-professional teamwork in health care

In multi-professional health care teamwork, each professional practice has an independent and specialized competence in the shared patient treatment. Ty-

pically, after a diagnostic interview with the patient, the interviewer and the team manager decide whether to refer the patient to other authorities or to place him/her on the waiting list where he/she will be assigned counsellors. In some instances, other team members are also consulted on the admission decision. A mini-team of two counsellors – often a psychologist and a welfare officer – is assigned to an admitted patient. The mini-team's responsibility is to cooperate around the patient in diagnosis and treatment. While laws and professional standards regulate the team members individually, their successful cooperation requires a form of activity-spanning across the professionals' competence, a *boundary-spanning* activity around the patient. The principal boundary-spanning activity is the Treatment Conference (TC) where the various professionals – medical and non-medical – discuss the patient cases. At the TC, each counsellor presents a patient case. After each presentation, there is a discussion of the patient's current treatment, difficulties encountered and future treatment concerns. The unit manager acting as a *team leader* and other team members take part in a discussion, offer advice and ask questions. By the end of the TC, each counsellor is supposed to reach a conclusion about his/her patient's continued treatment. Then the next counsellor presents his/her patient case, and so on.

The CAP units differ from other Swedish health care units in one important respect: in the CAP units, the unit managers have no medical responsibility. A *senior physician* has medical responsibility and the unit manager (in this research, a psychologist in one unit and social welfare officers in two units) has economic responsibility. Thus, the senior physician takes responsibility for coordinating the patients' medical care and the unit manager takes responsibility for using the unit's resources to meet administrative goals such as patient flow, treatment time, etc. However, the two responsibilities often overlap, which means few responsibility issues are completely medical or completely economic. It is not always clear who is really in charge of a CAP unit.

Due to their relatively weak administrative position, it is difficult for unit managers to act in accordance with NPM criteria. As a result, there is "stress on private-sector styles of management practice" (Hood, 1995: 96). For example, the unit managers cannot use salaries to reward co-workers' achievements including successful cooperative efforts. Instead, the unit managers allow their co-workers to learn new treatment methods (on paid working time) that increase their professional competence but do not necessarily promote unit cooperation. It appears that unit managers, perhaps unavoidably, do not take an active leadership role, preferring instead to make changes by adopting new policies, encouraging education and improving communications.

Research design

The case study approach was chosen because of its obvious advantage in providing a deep, context-bound understanding of a situation or a phenomenon. Yin (2003:13) proposes the following definition of a case study that points to its special character as a research method: "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomena and context are not clearly evident".

Eisenhardt (1989, 1991) argues that the use of several case studies in a research project allows for extension and replication. Extension refers to broadening the findings to other situations and replication (see also Yin, 2003) refers to confirming expected results and of being able to explain differences when theoretically it can be shown that a particular outcome is expected.

It is sometimes argued that a *single case design* is preferable to a *multi-case design* since it provides a deeper, more context-rich description in the form of a better story where the implicit and less obvious connotations of a situation may be observed more clearly (Dyer & Wilkins, 1991). However, the advantages of comparisons are less evident with single case studies unless there is either a comparison between two time points for the same entity or an analysis of several units in the same organisation. In the former design, the study shifts to a focus on the before-and-after factors in a certain situation, and in the latter the study compares/contrasts certain factors in different areas. With reference to the second design, the difference between a single case study and a multiple-case study is not necessarily so great (Eisenhardt, 1991).

Yin (2003) clearly recommends, if possible, the researcher should select a multi-case design, even if only two cases are used, rather than a single case design. In multi-case research, if the researcher selects only two cases, a comparison is possible although it may be difficult to decide what is "normal" if he/she discovers significant differences in the two situations.

On the other hand, if the researcher selects a rather large number of cases, it is unrealistic to establish a presence over a long period of time. Thus my conclusion is three cases may be an optimal number. If the researcher selects three cases, he/she can establish a presence in the three situations that allows him/her to conduct in-depth investigations and to make tripartite comparisons.

The CAP units were clearly in this tri-partite population. After deciding to study three CAP units, a non-random selection of CAP units was made (Flyvbjerg, 2001). The possibilities were limited to units that functioned well, without any serious personnel or operational problems, since conflicts and

even organisational changes can influence the conditions under which managers and co-workers cooperate. All three CAP units were able, within budget, to meet the patient requirements for volume, quality and accessibility. Thus the selected units had optimal conditions for cooperation. It is assumed therefore that any difficulties in identifying cooperation problems at these three CAP units would be present in other CAP units, some of which undoubtedly function less well. This selection strategy of the most optimal conditions (the most likely cases where expressions of cooperation could be found) thus provides a basis for generalizing the results of the research to other CAP units in Sweden as well as to other inter-professional groups with similar or worse conditions (see Flyvbjerg, 2001).

The three CAP units are located in small cities in the same county, they have similar organisational conditions (e.g., staffing, size and budget), and their patients come from similar social environments. Thus there is a great similarity in their institutional and basic contextual conditions. Given these similarities, a common underlying logic in the three units can be identified that allows us to understand the differences in the cooperation by the team members as they engage in their normal practice. Their various cooperation strategies, to a large extent, may explain the differences in their work cooperation.

Two data collecting methods were used: interviews and observations. Using more than one method, a *multimethod* approach, provides the study with richer and more nuanced empirical data.

Data collection method

Interviews and observations

During 2007 and 2008 two researchers[3] conducted the research, concluding the fieldwork in August of 2008. The three CAP units were studied for about a year each, with the research spaced at intervals over a period of 15 months. Most of the data was collected in interviews and from observations of planning and treatment discussions where it was possible to witness team members' strategies and attitudes toward patients and their treatment. Observations of one or two persons – a day of shadowing (Czarniawska, 2007) at each unit – provided additional data. We also made observations at three interventions sessions. Below is a summary of the data that were collected at the three CAP units. We conducted 62 interviews, made 11 half-day observations and used shadowing on three occasions.

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[3] Thomas Andersson, one of the author's thesis co-advisor, and the author as a doctoral student. The main part of the interviews and observations were conducted by the author.

Data collection at the CAP units

CAP unit	CAP unit X	CAP unit Y	CAP unit Z
Interviews			
Internal	13	15	16
External	4	3	3
Managers	2	3	3
Observations			
TC conferences	5	3	3
Persons (shadowing) days	1	1	1
Interventions (days)	1	1	1

At the beginning of each case study, we interviewed some CAP unit managers and co-workers, including the supervisory managers of the units, in order to deepen our understanding of what we then observed at the TCs. We conducted other interviews in parallel with the observations in the TCs. In addition, we interviewed employees of the three units' cooperation partners (school psychologists, and representatives from Social Services and from Habilitation).

All interviews were audio-taped and later transcribed. Detailed field notes were taken at the observations at the TCs since audio and video recordings were not permitted. Notes were also taken on the participants' comments after the conferences (when they gathered for coffee) before leaving the setting (see Bryman, 2008). Each day's field notes were edited and printed the day after the observations (see Merriam, 1998). The written data totalled more than 300 pages.

The interview questions

We took turns as the principal interviewer in the interviews. While one researcher conducted the interview, the other asked unscripted questions as areas of particular interest arose. In this way, we maintained the thread of the interview since it can be difficult for the principal interviewer to stay focused while listening to a flow of responses. By contrast, in the observations, where we asked no questions, we could more easily concentrate on different aspects, for example, the discussion topics, the questions and the responses. Together, we analysed the data collected in interviews and observations.

In the interviews we used the qualitative interview in a semi-structured form (Merriam, 1998). According to Kvale (1997: 117), this data collection method results in "a qualitative description of the interviewee's life-world that allows an interpretation of it". We followed the ideal of the qualitative interview, which is to create a relaxed atmosphere where the interviewees' answers and interests guide the interview process. In this way, the tension inevitably produced by the interviewers' presence as outsiders was supposed to be reduced.

We began the interviews by asking the interviewees about their education and professional backgrounds and their experiences in psychiatric work with children and adolescents. The interviews were focused particularly on the cooperation in their work environments. While most of the interviews in one unit were conducted before our observations began, some observations and interviews were conducted in parallel in the three units. Thus, to a considerable extent, it was possible to ask questions in the interviews that related to some specific treatment discussion topic or to some particular (anonymous) patient. There is a definite advantage to discussing events that both the interviewee and the interviewer have observed (and in which the interviewee has participated). Discussions are richer when actual, rather than theoretical, events are analysed.

Intervention

Following the analysis of the data, an intervention was conducted with the team members in the three CAP units using findings from all the three units in each intervention session. Based on our findings from the three units, we presented three ideal types of risk management to the team members. In our presentation and the following discussion we compared each team's risk management strategy with the ideal types so that the team members could evaluate the pros and cons of their chosen strategy. We also asked the team members to read a description of how an ideal type CAP unit cooperates with its external partners (see Paper 1). We then asked them if they recognised any of their own cooperative activities in this ideal type CAP unit. Through this intervention, the team members saw how they needed to develop their activities. Moreover, the intervention allowed the researchers to observe how the team members made sense of what they had read.

Analysis of data

McCracken (1988: 16) writes:

> Perhaps the most striking difference between the methods [quantitative and qualitative] is the way in which each tradition treats its analytic categories. The quantitative goal is to isolate and define categories as precisely as possible before the study is undertaken, and then to determine, again with great precision, the relationship between them. The qualitative goal, on the other hand, is often to isolate and define categories during the process of research.

Thus the analysis is a process of interpretation and sensemaking. This process began in the interviews. One interview led to new questions in the next interview; in the interview/observations the findings and reflections were noted as we analysed them. These first- impression analyses were combined with earlier findings and interpretations from previous interviews and observations. The process was guided by Van Maanen's (1988:118) statement: "Events and conversations of the past are forever being reinterpreted in light of new understandings and continuing dialogue with the studied". By combining the results from interviews and observations, it was possible to gradually understand the CAP unit team members' sensemaking process in their work.

After transcribing the interviews and the observation field notes, we noted the interesting viewpoints/observations and reflected upon them in our commentaries. We read and re-read our transcribed texts and our notes in a search for themes that we could use to categorize the everyday work in each of the three CAP units. For each CAP unit, we categorized the empirical data we found interesting as a way to understand the team members' sensemaking process. This data analysis was benefited by our two-person research team since we naturally engaged in discussions with each other on the content and interpretation of the data collected in the interviews, observations and shadowings. Through this process, we reduced our empirical data to a fifth of its original volume. We also created a list of themes that related to the study's theoretical framework. The empirical data influenced our choice of theoretical framework and the theoretical framework guided the categorization process. For example when we found statements about perceived risk in the transcribed text we used a theoretical framework of risk concepts that guided us to expressions of different risk strategies. In this manner, we achieved an overview of the themes related to the theoretical framework of the study (these themes are the same ones discussed in the six papers of this thesis). This process of analysis allowed us to find suitable quotations to support our assertions.

Assembly of the results

The analytical work has an obvious inductive character. However, the assembly and analysis of the data according to the above-mentioned themes were guided by theoretical concepts from three related theoretical perspectives: boundary objects and standardising methods from Star & Griesemer's cooperation theory, service ideal, discretion and professional dominance from theories on professions and theories, and the concepts of exogenous and endogenous institutions from New Institutional Theory. In this way, the empirical data and theory have been joined in an analysis. As Alvesson and Sköldberg (2009:4) state, " The analysis of the empirical fact(s) may very well be combined with, or preceded by, studies of previous theory in the literature; not as mechanical application on single cases but as a source of inspiration for the discovery of patterns that bring understanding". In this sense the research process is an abductive analysis. The different theories provide different insights into the same empirical data based on the research questions of this thesis. This means that the variation among the papers/published articles depends on which theory (or combination of theories) has guided the analysis.

Publications and papers

This study consists of the following six papers:

Paper 1
Liff, R. & Andersson, T. (2011). Integrating or disintegrating effects of customised patient care – The role of professions beyond New Public Management (NPM). *Journal of Health Organization and Management*. Vol. 25, No. 6. Forthcoming.

Paper 2
Andersson, T. & Liff, R. (2011). Does patient- centred care mean risk aversion and risk ignoring? Unintended consequences of New Public Management (NPM) reforms. *International Journal of Public Sector Management.* Submitted in October 2009. In review.

Paper 3
Andersson, T. & Liff, R. (2011). Multi-professional cooperation and accountability pressures – Unintended consequences of New Public Management. *Public Management Review*. Submitted in November, 2010. In review.

Paper 4

Liff, R. (2011). Exerting control over professional organisations with external institutional norms: Creating endogenous institutions. *Qualitative Research in Organizations and Management.* Vol. 6, No. 1. Forthcoming.

Paper 5

Rovio-Johansson, A. & Liff, R. (2011). Sensemaking in a Multi Professional Team. *Journal of Health Organization and Management.* Originally submitted in August 2010. Revised paper submitted in March, 2011.

Paper 6

Liff, R., Andersson, T. & Tengblad, S. (2011). The co-optation of New Public Management: Professional and organizational responses to accountability pressures. *Conference paper prepared for EGOS Colloquium, Gothenburg, July 7-9, 2011.* Submitted in January, 2011. Accepted.

The actor perspective influences all the papers and facilitates the understanding of the conclusions in a NPM context. In Papers 2, 4, 5 and 6, the actor perspective is the dominant perspective used. Professions theory dominates in Paper 1 and a general theory on cooperation dominates in Paper 3.

Validity

Validity problems is not with trying to find a pure reality to compare with the reality the interviewee presents. Rather, it is a matter of the researcher's attempt to distinguish between the interviewee's *lived experience* (Van Manen, 1990) and the interviewee's *account* (Antaki, 1994) of a phenomenon that is intended to satisfy the researcher. According to Van Manen when an interviewee recounts a lived experience, the description is of a real life experience from the world that lacks reflection on what is socially expected or expected. According to Antaki (1994), when we hear interpretations and explanations of lived experiences, we are presented with accounts. Since the aim of qualitative research is usually to study lived experience, we need to differentiate between 'experience' and 'account'. It seems there are validity problems with both interviews and observations as data collection methods (see below). However, the validity of research may be strengthened if interviews and observations are used in combination.

Validity problems with interviews

There are several explanations of why interviewees give the impression that they are describing lived experience when they are in fact presenting a picture

of what they think is suitable for the occasion (Czarniawska, 1999). If the interviewer already has an inkling of the topic the interviewee is asked to explain, it is probable that the interviewer, more or less by directing the conversation, will create learning of the interviewee during the interview (Vygotsky, 1962; Säljö, 2005). Furthermore, there may be a power imbalance that causes the interviewee to want to be accepted on the interviewer's terms (Thomsson, 2002). A power imbalance may result because the interviewer is perceived as superior in some way, for example, when the interviewer uses an interview vocabulary more proficiently than the interviewee does. Also, the gender difference between the researcher and the interviewee may influence how the interviewee frames, even filters, responses (Ryen, 2004). The interviewee may also think that the interview situation is a chance to make a certain impression of him-/herself or of his/her activities (Alvesson, 2003).

Validity problems with observations

Observations in general are useful data collection methods because they are supposed to be a way to study what takes place rather than what is said to take place. However, the researcher's presence may affect the observed people and the phenomena. According to Fangen (2005), early anthropologists solved this problem by initially contenting themselves with simply reading accounts by missionaries and explorers, while later anthropologists interviewed local informants and so avoided influencing those they were studying. Possibly they made a virtue of necessity. Czarniawska (2007) challenges the existence of the researcher effect in connection with 'shadowing' or the so-called direct observation. In part, she argues that the problem is minimal, almost nil, in this situation since after a short time it isn't possible for those who are shadowed to present a false impression of themselves. In addition, Czarniawska says that "impression management" is always a part of social reality. Furthermore, the increasing reflexivity resulting from shadowing (observing) may benefit a study rather than harm it. Actions that the shadowed (observed) person takes can be interpreted differently when a shadow (observer) is present, even if the fly-on-the-wall metaphor doesn't hold. Such actions can increase our understanding of what is going on. However, Czarniawska emphasizes it is important for the researcher to blend in so that the observation activity has a low profile. Blending in involves being like the observed persons and being likeable. The 'likeable' researcher is not mysterious or threatening; his/her conclusions are not used to the disadvantage of the participating groups or their members. The 'likeable' researcher is also competent enough that the observed

persons find it worth their time to provide information on their work activities and processes (e.g., on their cooperation). Shadowing (observing) seems to have high validity if the researcher can manage his/her non-interventionism and can interpret the shadowed people's actions even when they know they are being shadowed. Ultimately, observations allow data to be collected over a long time period, in many different situations and with many different approaches (Garfinkel, 1967; Fangen, 2005).

Validity problems with this study

For this study, two methods were combined, observation and interviews, for depicting more than one ontological level in the investigation of the actors' sensemaking. With multiple research methods, it is possible for the researcher to separate accounts from lived experiences for the purpose of understanding the sensemaking.

A popular idea in qualitative studies is that it is more advantageous to combine several research methods, for example, interviews and observations, than to use just one method (Denzin, 1970). One argument for the use of several research methods is that together they may provide richer and more nuanced empirical material. Two (or more) research methods may complement one another. A second argument is that the results from one method can confirm the results of another (Johnson *et al.,* 2007). However, it is uncertain whether the use of several research methods in that sense contributes to the increase in the validity of the findings (Silverman, 2001).

Research validity is also increased when the risk of unsystematic mistakes is reduced, resulting in more reliable data. To achieve a high degree of reliability for our interpretation of the interview data, we audio-recorded all the interviews. To achieve a high degree of reliability for the observation data, we took contemporaneous notes that we expanded directly afterwards. We believe the use of two researchers for data collection and documentation also increased the reliability of both the interviews and the observations.

Generalizability

Czarniawska (1999) writes that language is the instrument by which reality is created. This means that generalizations can be drawn from case studies if readers perceive their context and the phenomena as realistic, and if the methods used to obtain the empirical data follow the conventions of good research methodology. Therefore, the researcher's analytical generalizations

need to build on a " detailed knowledge of the sociological phenomena studied" (Bjereld *et al.*, 1999: 79). Other researchers, practitioners and society in general can then accept the researcher's interpretations of his/her findings and his/her connections to theories and other case studies as acceptable generalizations that apply both to the researched phenomena of the study and the social construction of the context woven into the study (Czarniawska, 1998). Of course, readers need to trust that the context that the research describes is authentic or at least plausible.

This view of generalizability deals with the claims concerning the ontological assumptions on the stability of the world in time and space and the epistemological assumptions on the rationality of our knowledge. This research is based on case studies in which authentic empirical material is used. The findings are interpreted in accordance with the theoretical concepts presented. Given the strength of this empirical and theoretical approach, the claim is made that the conclusions of this research may be generalized to other professional units led by a team leader, working in a NPM health care environment.

Ethical principles

The research has been guided by the code of ethics for researchers in humanities and social sciences recommended by the Swedish Research Council, adopted in 1990.

The participants' interests have been protected in this study following the generally accepted rules for ethical research (see Kvale, 1997). The participants, who were informed of the study's purpose and design, agreed voluntarily to take part in the study. The anonymity of the CAP units and all participants was also guaranteed in the event of publication of the findings. Anonymity protection assured the participants that there would be no negative repercussions from their involvement with the study.

The researchers followed the secrecy agreement applicable to patient data that was obtained in the TCs and in discussions between co-workers in the CAP units. Generic descriptions were used to identify patients, for example, 'a 13 year-old boy'. The researchers saw no patient journals, did not interview any patients and made no observations of patient treatments.

Chapter 4
The six papers: A summary

This chapter summarizes the purpose, theoretical framework, results, conclusions and contribution of each of the six papers. All papers use the same setting and have the same methodology (See Chapter 3 for details).

Paper 1 - Integrating or disintegrating effects of customised patient care – The role of professions beyond New Public Management (NPM)

Journal: *Journal of Health Organization and Management.* Forthcoming.
Authors: Roy Liff and Thomas Andersson

The purpose of the paper is to describe how the professionals in a Swedish child and adolescent psychiatric (CAP) team cooperate with professionals from other organisations (the schools, Social Service and Habilitation) to provide treatment that meets the patients' needs. The paper describes how integration and disintegration effects are dependent on social embeddedness, where professional cooperation is required in a customised patient care work place. The theoretical discussion is based on three strands of profession theory – the service ideal, discretionary power and professional dominance – that support both integration and disintegration among the professions and between the professions and administrative management. Whether integration or disintegration prevails in a particular situation depends on how the three strands are balanced.

The CAP personnel in the studied team used three interactive strategies in their cooperation with the external organisations: delegation of certain task performance to the external organisations; refinement in the ways of working with therapy; and concentration on psychiatric patients. These strategies can be described in terms of the three strands of profession theory. The increased effort on proven treatment methods by the CAP professionals reveals their commitment to the service ideal. Their control of patient admissions and patient streaming and their decision to make diagnoses on the basis of specific criteria (replacing needs-oriented decision-making) offer evidence of their discretionary power. Their redefinition of their roles, in which they decided not to work with certain problems or use certain treatments, is evidence of their professional dominance.

Within the CAP units, as the professions adapted to NPM principles, there was integration between the different professions and administrative management. However, the CAP units exercised dominance over the external cooperating organisations; their resistance to customised care strengthened disintegration problems between different organisations. The social embeddedness of action is crucial to an understanding of the professions' integrating/disintegrating performance.

The practical implication of this paper is its call for greater contact between the cooperating organisations. In these contacts, the redefinition processes and mutual commitments can be discussed openly by all organisations. In this way, there would be a learning situation where the various groups would learn from, and about, each other.

This study brings new information on how professionals act in a NPM environment. This issue has been discussed in the fields of social service, policing and education but not in health care. Thus the study concludes that, contrary to findings in many other studies, neither the professional logic nor NPM/customised care reforms determines the action of professionals. The success of a normative reform measure may depend in part on its social context.

Paper 2 - Does patient-centred care mean risk aversion and risk ignoring? Unintended consequences of New Public Management (NPM) reforms.

Journal*: International Journal of Public Sector Management.* (In review).
Authors: Thomas Andersson and Roy Liff

This paper describes how the adoption of New Public Management (NPM) reforms in health care, that aim at increasing patient security and access, and increasing the accountability and transparency in patient care, influence health care providers as they try to provide patient-oriented, customised care. The paper reveals there are often unintended consequences when new management ideas are introduced in professional groups and when the institutionalisation of authority intended to control societal risk creates reputational risk among the people charged with that authority. The paper argues that the increased demand for accountability in health care increases professionals' awareness of their risk. The result may be the unintended consequences of risk aversion and risk ignoring when health care providers prioritize their professional security over the needs of the patient.

The paper is based on the H. Rothstein's concept of risk and Graham and Weiner's concept of risk trade-offs – risk transformation and risk substitution.

The main finding of the study is that, especially for "multi-patients", there may be a transformation of patients' medical risk to doctors' personal risk when high-risk patients have (and often conceal) suicidal tendencies. The treatment of such patients, who may require treatment over long periods of time, may result in budget overruns as well. Such financial pressures create professional risks for unit managers. Thus both psychiatrists and unit managers in the CAP units use certain strategies that involve avoiding and ignoring risk. They increase the patient waiting times for admissions and restrict the patient treatment. They prefer to take no responsibility for diagnosis, and instead admit patients only after an external psychiatrist's diagnosis and recommendation.

First, the paper contributes to risk theory by showing the relevancy of the macro level concepts of risk trade-off (risk transformation and risk substitution) and risk action (risk aversion and risk ignoring) in the individual actor's risk strategies. In particular, the paper shows *how* risk trade-offs function and influence each other when individual actors handle their personal risks through risk aversion or risk ignoring. The professionals use medical diagnosis procedures to construct the patients objectively to decide whether to admit or reject a patient.

Second, the paper contributes to NPM reform theory by explaining the paradox that the more accountable psychiatrists and unit managers are, the less their services meet the demands of an organisation oriented towards patients' complex needs. The paper shows it is difficult to reconcile two of the most popular current health care concepts – accountability and patient-centred care.

Paper 3 - Multi-professional teams cooperation and accountability pressures – Unintended consequences of New Public Management

Journal: *Public Management Review*. (In review).
Authors: Thomas Andersson and Roy Liff

This paper describes how the main reforms of New Public Management (NPM), when applied in health care, favour patient security and improve patient access by the increase in accountability and transparency while increasing the pressure on the cooperative efforts of multi-professional teams. The paper argues that increased accountability demands inhibit cooperation when an asymmetric risk is imposed on one team member (in this case, the doctors) in the multi-professional team. The research indicates that when increased accountability increases the risk of failure, the risk to the patients is transformed to a personal risk to health care professionals. The paper suggests that the risk

behaviour in multi-professional teamwork may damage the possibilities for cooperation around the patient.

The theoretical basis for the paper is Star & Griesemer's cooperation theory, which deals with the capability for cooperation. The paper addresses the capability for cooperation by examining two assertions of cooperation theory. First, the paper looks at whether this capability will decrease when an asymmetric risk is imposed on one team member as patients become context-dependent boundary objects rather than boundary-spanning objects between the different practices represented on the team. Second, the paper looks at whether increased accountability is linked to increased demands for transparency when such demands are accompanied by the introduction of standardised procedures that have a boundary-spanning function. The paper investigates both these assertions empirically in the setting of Swedish child and adolescent psychiatric care (CAP) units.

The paper shows that the three multi-professional teams, under similar conditions, chose three different strategies to deal with the asymmetric risk: risk avoiding, risk ignoring and risk-sharing. First, the professionals' personal risk perception took precedence over their action logic perception as they tried to reduce their personal risk, at the expense of the team cooperation. Such actions can be rationalized by using diagnosis and professional vocabulary. Second, in one CAP unit, the increased accountability did not seem to affect the teamwork since the professionals used classification systems and standardised methods that allowed them to transfer information from one context to another. The information became context-independent, separated from a particular profession or a particular context.

The practical implication of this paper is its recognition that increased accountability, especially when an asymmetric risk is imposed, may threaten cooperative team efforts. In particular, this threat exists when the team concept is new, when members have not yet constructed their common social world, and/or when the team has not yet implemented standardised methods.

The paper contributes to NPM reform theory by explaining why a patient does not become a boundary-spanning object that promotes multi-professional cooperation. The paper also shows that neither the professional logic nor NPM reforms determines the actions of professionals – in this study, all three CAP units had the same strategies options, but chose differently.

Paper 4 - Exerting control over professional organisations with external institutional norms: Creating endogenous institutions

Journal: *Qualitative Research in Organizations and Management.* Forthcoming. Author: Roy Liff

This paper discusses the factors that promote or discourage multi-professional cooperation. The literature, which acknowledges that multi-professional teamwork in health care may be difficult, traces cooperation problems to professional culture barriers. Strong, conflicting external norms is one explanation for such cooperation problems. Another explanation is the internalization of rules and of norms that are taken-for-granted. Since professionals are culturally constituted, they may resist the adoption of new norms when they join new teams. Such professionals are both over-institutionalised and under-institutionalised.

Taking an actor point of view, inspired by studies on the governance of the commons, this paper describes the cooperative methods that professionals devise to deal with situations where self-interest conflicts with the interest of the group as a whole. The paper looks at institutional cooperation (and its lack) empirically in the same setting in three child and adolescent psychiatric (CAP) units in Sweden.

The paper reports on four Ideal Type situations where uncooperative behaviour obstructs customised care and one Ideal Type situation where standardisation of work methods promotes cooperation. Based on the under-institutionalised perspective, the professionals' social relationships create the institutions for cooperation. These institutions arise from action models that create the rules system. Such action models have to be constructed to create a common practice that can create a common ideology. A common ideology alone is not sufficient. When such rules-creating action models are inadequate, management problems arise – one explanation of cooperation problem is under-institutionalisation.

The practical implication of this paper is its recognition that management has to prove that cooperation is beneficial to the team members and has to promote a cooperative spirit by instilling a common understanding of the concept of cooperation.

The paper provides an alternative explanatory framework for cooperation problems based on actors' perception of their own interests as producers. The paper shows that the implementation of new habits is more powerful in establishing new practices than ideologies.

Paper 5 - Sensemaking in a multi-professional team meeting

Journal: *Journal of Health Organization and Management*. (In review).
Authors: Airi Rovio-Johansson and Roy Liff

The purpose of this paper is to investigate members' sense making in a teamwork process to understand how the actors align their common actions with the team's goal and thereby pursue cooperation.

The sensemaking process reported on in this paper was from a multi-professional team meeting at a Swedish child and youth psychiatric (CYP)[4] unit. The analysis focused on institutional discourse and talk-in-interaction using locally situated communicative actions, where frames and categories are important aspects of sensemaking in social encounters.

Team members were interviewed before and after the meeting. The data were collected in the following sequence: preliminary interviews, observations and follow-up interviews, supplemented by observations of conversations among team members.

The findings of this study indicate two possible explanations for the cooperative problems. On the one hand, confusion occurs when the actors try to position their treatment methods. On the other hand, confusion occurs when the actors act strategically and relationally as they position themselves. Both explanations seem to exist and seem to be intertwined. An argument for a treatment method means that the identity of the actor and the method are integrated.

In addition, the paper establishes that the researchers' presence influenced the actors' discussion of their lived experiences but not their accounts.

From an organizational point of view, it seems that the team leader, who was in a weak administrative position, was more interested in strengthening his/her personal position than in preserving the integrity of the different treatment approaches. The team leader was therefore unable to maintain a cooperative sensemaking spirit that is necessary in a NPM context.

Paper 6 - The co-optation of New Public Management - Professional and organisational responses to accountability pressures.

Journal: Conference paper prepared for EGOS Colloquium, July 7-9, 2011. Accepted.
Authors: Roy Liff, Thomas Andersson and Stefan Tengblad

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[4] In the other papers and in the other chapters, the units are referred to as CAP (child and adolescent psychiatric) units.

The purpose of this paper is to present new information on how health care professionals and management interact in a complex NPM reform environment. Many studies claim professionals think NPM reforms are either powerful threats to their independence or administrative policies with little real influence. Professions research has found management's strategy of cooperation with professionals is a way to establish co-existence. Evidence has been produced to show this is the case among the various professionals in different multi-professional groups. The professionals acquire the required occupational closure and can exercise their professional autonomy.

However, under the increased accountability pressure imposed by NPM reforms, a profession may take a third position – co-optation – to be differentiated from the positions of decoupling and resistance. Co-optation is the process where external strategic elements are absorbed into policy decisions. For example, the medical profession has co-opted Evidence-Based Medicine (EBM) by which they have retooled their knowledge base and increased their legitimacy. In this study, the CAP unit manager co-opted the individual *professionals* strategies and vice versa. Here, we use co-optation as the descriptive term for the cooperation in an organisation between the professionals and an administrative manager.

The evidence shows how the CAP unit managers and professionals, in mutual agreement, attempt to meet their administrative demands and professional obligations. Through co-optation, the administrative reforms cause the managers to deny admission to patients evaluated as unsuitable for treatment. Such patients are referred to other care centres. This administrative policy then influences the professions' ability to provide better patient care.

The actors use *institutionalised tools* in the co-optation process. These tools include formal positions, medical responsibilities and patient diagnoses, all of which promote shared individual interests between the professionals and the unit managers who act as team leaders (creating efficient, frictionless production and high professional status in the units). Consequently, administrative demands and professional obligations are largely reconciled through mutual agreements. In this way, administrators and professionals work together using each other's reasons to validate their own positions without invaliding different reasons. In short, they use mutual co-optation.

In this alternative perspective, co-optation produces a form of cooperation between the relevant parties in a decision-making environment. It is problematic, however, whether this co-optation is in the best interests of the patients

since it seems to increase the risk that difficult-to-diagnose and difficult-to-treat patients will fall by the medical wayside.

Co-optation may be the mechanism that explains why and how NPM reforms actually are   institutionalised, rather than decoupled or resisted.

Chapter 5
Results

The research problem is:

How does multi- professional cooperation work in practice in the investigated setting?

This research problem is examined by addressing following research questions:

1. What strategies do different professionals develop in multi-professional teams that either promote or hinder internal cooperation in the teams?
2. What strategies do different professionals develop when dealing with external professionals and other work groups from cooperating organisations related to patient treatment?
3. What unintended consequences have emerged regarding multi-professional cooperation and how can these consequences be related to NPM – influenced organisational practices?

The six papers have addressed these research questions (See Chapter 4). The following section presents the main themes of the results of the research.

Cooperation difficulties

Research question 1

The studies indicate that the increased demand for accountability, an important aspect of NPM reforms, can cause professionals to use various strategies for managing their personal risk as a response to the demands for increased accountability (Paper 2 and Paper 3). It is possible, using Star and Griesemer's (1989) theory of cooperation, to understand how the choice of a risk management strategy affects cooperation in a team. When the actors try to avoid responsibility, the increased accountability is transformed to a personal risk, which in turn makes the categorization of the patient more context-bound for each actor. The professionals' behaviour toward the patients depends on various meanings that differ between their several separate social worlds.

The doctor, for example, has to be responsible for her/his patients and also be aware of medical risks. According to Bowker and Griesemer (1999), if the team members choose a strategy that makes the object more context-bound, their cooperation with other professionals will suffer. This counteracts the process of constructing the patient as a boundary object. Cooperation requires bridging these different meanings that actors observe based on their separate social worlds. Bridging means categorizing an object, both in its own social world and in a separate social world. Thus categorization requires an object in a weaker context to become naturalized in a new context. When naturalization processes cease, even reverse, so do the cooperation processes.

The professionals' actions were interpreted using an action-oriented perspective rather than the more traditional cultural, norms-oriented perspective (Paper 4). The professionals used institutionalised tools (e.g., diagnoses and treatment routines) to prioritize their professional interests over patients' well-being. From the Ostromian (1999) perspective, they overused the common pool resources and failed to contribute the resources needed for maintaining and improving the CAP units. The professionals appeared under-institutionalised in the sense that they had not yet developed the intra-organizational norms of institutional cooperation that were strong enough to counteract their self-interest that was caused by adherence to professional norms and NPM reforms. When such rules-creating action models are inadequate, cooperation problems arise.

It is possible to understand a conflict in a treatment conference on treatment methods on two ontological levels (Paper 5). First, the account explains that the difficulties with the actors' roles are socially constructed; cooperation difficulties seem to be the result of diversity in language, values and cultures. Second, the lived experience explains the difficulties observed when actors act relationally and strategically in the observed meeting (Van Manen, 1990) (Paper 5). The actors created their positions and roles during the meeting by interpreting and "misinterpreting" the situation. However, they positioned themselves using the treatment methods, which means that the identity of the actors and treatment methods are integrated (Schutz, 1967). The less the need for personal positioning, the easier the sensemaking process can achieve aligned action (i.e., cooperation). The need for personal positioning may be due to the social context (Garfinkel, 1967). This indicates the importance of the social context (i.e., the NPM context).

Research question 2

The results of the study show that there are cooperation difficulties between professionals in the CAP units and the professionals in the cooperating or-

ganizations (schools, Social Services and Habilitation Services) (Paper 1). These difficulties arise despite the fact that the professionals have been urged to provide more needs-oriented care (i.e., customised care) and despite the fact that the professionals' service ideal calls for cooperation across organizational borders in the patients' best interests. The professionals' logic fails to integrate these cooperating units. It appears that the professionals adapt some NPM principles, for example, resource restrictions that limit the scope of their work, and thereby strengthen their professionalism instead of adapting to the customised care requirements of NPM. NPM principles seem to influence (although not determine) how professionals act in accordance with their professional norms. The professionals act strategically, without consideration for the consequences these strategies have for the external organizations. Paper 1 shows the importance of viewing action as embedded in a system of social relationships, within a broad scope of norms and values (see Granovetter, 1985).

Cooperation

Research question 1

In the cooperation with the external units, the professions adapted more to resource restrictions than to the customised care, despite the fact that these professions are expected to act according to the policy of customised care and the common belief that resource restriction is a central conflict between management and the professions (Paper 1). Since unit managers wanted efficient patient streaming, and the counsellors and the physicians wanted to minimize medical risk, they mutually supported the policy of restrictive admissions. The CAP unit managers and professionals, in mutual agreement, attempted to meet administrative demands and professional obligations using three strategies: admission denial and referrals for unsuitable patients; concentration on psychiatric patients; and refinements in the patient treatment. The patients were thus constructed according to the limits of unit capacity and unit competence. However, the insufficiency of resources was not considered an acceptable argument for patient restriction. Denied admissions must be described "objectively". Medical justifications (e.g., diagnoses and medical jargon) rather than economic justifications were used. In applying these strategies, the actors used *institutionalised tools*. These tools included formal professional positions, medical responsibility and patient diagnoses. All the tools promoted shared individual interests between the professionals and unit managers (creating ef-

ficient, frictionless production and high professional status in the unit) (see Timmermans, 2008).

In such patient decisions, the unit managers co-opted the medical profession's diagnosis in order to achieve the units' financial goals while the counsellors co-opted the administration's budget and resource arguments in order to avoid admitting high-risk patients. Co-optation is a certain form of cooperation. In its basic form, co-optation can be defined as the process in which the team leadership uses external strategic elements in policy decisions (Thompson & McEwen, 1958) (Paper 6). Consequently, administrative demands and professional obligations were largely reconciled by mutual agreements. In this way, administrators and professionals worked together using each other's reasons to validate their own positions without invalidating those of others. In short, they used mutual co-optation. When management and professionals mutually co-opt strategies, it is possible to satisfy both the NPM reform demands and the professions' autonomy demands.

The professionals chose different strategies depending on the social context – one strategy in the internal context and another strategy in the external context. It is the social context (inside a CAP unit or all the cooperating units) that mediates co-optation. Co-optation causes certain NPM norms to be institutionalised (for example, resource restrictions), but not others (for example, customised care). This institutionalisation occurs despite the fact that the same professional norms are the active norms across organizational boundaries – these norms should be strongest and should dominate the cooperation pattern. Thus co-optation is an expression for agency and can be influenced by the social context rather by the change in professional norms or NPM reform principles.

Changes in the mission can also influence behaviour. The NPM demands for increased accountability and budget control, plus the medical profession's norm (to protect the patient), may result in the perception of increased personal risk related to the patients. Various risk strategies were created as the result of co-optation, that is, as a result of a stated need for a "rational" solution (Paper 2). Thus, co-optation resulted in the institutionalisation of NPM reform demands while, at the same time, the professionals fulfilled their professional responsibilities. In this way, all actors in the CAP unit defended themselves from criticism (Paper 1 and Paper 2).

However, the increased accountability requirements, resulting from the NPM reforms, did not seem to affect the teamwork in one CAP unit of the study (Paper 3). Risk management was incorporated into the regular routines

in a way that meant the risk was shared by the team members or by the team. The team used standardized procedures, such as classification systems, care plans, quality measurements and evidence-based medicine manuals, to manage the tension between these various contexts caused by the divergent viewpoints on the meaning of the patient information (Star and Griesemer, 1989). The care plan was presented to the team members and required completion. In making treatment decisions in this way, individual risk was shared by the members as well as the upper management that had approved the general guidelines for diagnoses and the recommended treatment methods. Probably the team members perceived the risk as reduced; in fact, the risk was reduced. The use of care plans mediated the contacts between the professionals and their joint actions, and allowed information to move from one context to another without changing meaning – the information became less context-independent. In this way, the actors contributed to the naturalization process even though the new demands strained their cooperation. Risk management, in this instance, seems to deal with minimizing the categories' (for example, diagnosis and treatment methods) context-boundedness (for example, a medical context) and accelerated the naturalization process needed for joint action. As a result, cooperation increased.

The study shows that endogenous (internal) institutions for risk management arise. The presence of co-optation strengthens the idea that endogenous institutions can create cooperation despite the influence of external norms, or even as a result of them. When actors develop new field norms, they do not seem to use cultural compromises; rather they use institutionalised cooperation by mutual agreements as required by the situation (Paper 4).

Unintended consequences of NPM reforms

Research question 3

Unintended consequences for patients are more the rule than the exception. It seems that the CAP units have restricted their work efforts more severely than ever although they are encouraged to practice customised care by complying with another NPM norm—internal resource restrictions (Paper 1).

Certain important and unintended consequences may also arise for patients when there is an increased focus on accountability and patient risk. The actors' actions may be interpreted as a reduction in their personal risk achieved by using their knowledge base and skills to construct the patient. This construc-

tion facilitates patient admission refusal and referral (Paper 2). The medical professionals, following an objective procedure, then use the patient diagnosis to decide whether to admit or reject a patient. Psychiatrists in the CAP units, in particular, use this mask of objectivity as a risk minimizing strategy. The explanation for such behaviour may be that the more clearly accountable the psychiatrists and unit managers are, the likely the patient's medical risk will be transformed to the professional's personal risk.

The most serious consequence is for patients with more than one diagnosis, the so-called multi-patients. There is a paradox. The NPM reforms aim to strengthen the patients' position, not least that of the multi-patients. Yet, because of the increased accountability demands linked to patient-centred care, there is a weakening of position for multi-patients (Paper 2). Thus it is difficult to reconcile two of the most popular current health care concepts – accountability and customised care.

The concept of risk trade-offs explains why unintended consequences appear. Furthermore, medical diagnosis procedures make it difficult for an outsider (for example, the principal) to criticize the team when a patient is unexpectedly referred between professional teams since everyone appears to be acting in the patient's interest. Consequently, NPM reforms may lead to the institutionalisation of unintended health care practices.

Some unintended consequences concern the cooperation directly and patient care indirectly. Increased accountability provokes the professionals to avoid personal risk by choosing strategies that may negatively affect both cooperation and the patients. Besides producing better health care, increased accountability may cause the team members to coalesce as they face an external "threat" (Paper 3).

Contrary to expectations the unit manager (when addressing the resource risk) and the physician (when addressing the perceived personal risk) – the two traditional factors in health care priority discussions – achieve cooperation (with new referral routines) in the CAP unit. In this way, they promote their shared individual interests as they solve resource problems (Paper 1 and Paper 4).

Cooperation and cooperation difficulties

This study shows how professionals act under the influence of a NPM control regime (see p. 31). The adoption and implementation of NPM reforms in an organisation may result in behaviours by organisational actors that influence

their internal cooperation, both negatively and positively. The use of risk strategies in this study, as a response to accountability demands, shows the influence of institutional demands. The chosen risk strategies, not the increased risk itself, determined the multi-professional team's ability to perform its duties. In this research, three similar multi-professional teams chose three different strategies to deal with the patient risk that resulted in different cooperation outcomes. A strategy of promoting cooperation that did not prohibit the professionals from working with standardised methods was available in all three CAP units, but only one unit chose to do so systematically.

An actor perspective shows that increased accountability demands will inhibit cooperation when the risk, instead of being shared by the team members, is imposed on one team member (Paper 3 and Paper 4). It is possible to establish cooperation within a team when the risk is shared because, in addition to facing increased accountability demands, standardised procedures are introduced. This can be a difficult assignment for a newly formed team that has, initially, asymmetric risk-sharing and that faces increased NPM reform demands. It is not inevitable, however, that multi-professional cooperation will fail as a result of the incompatibility of professional norms and NPM reforms. The outcome depends on different situational characteristics that can either foster or inhibit cooperation in multi-professional teams. Norms may influence cooperation, but they are not determinative. Since actors are aware of the institutionalised conditions, and take them into consideration, their actions are not determined by these conditions, nor even primarily guided by them. It is the context that is important in determining what actors choose to do. Leaders and co-workers can create endogenous institutions that bridge the differences in professional norms among themselves and between professional norms and NPM reforms (Papers 1, 2, 3 and 4). The institutionalised conditions are secondary factors that explain the outcome of cooperation efforts (Paper 4).

This chapter presents the strategies of the actors in multi-professional teams. Obviously the actors work in a complex and demanding context where their chosen strategies may result in unintended consequences. Cooperation and cooperation difficulties have been interpreted using several theoretical concepts. However, there is also evidence in the empirical data that helps us understand the causes of unintended consequences and the hindrances to closer cooperation. The mechanism of co-optation may be studied further in order to explain the difficulties of achieving customised care. MPT is a close structure that may, under certain circumstances, cause cooperation problems. Sometimes the actors seem to strengthen their professional boundaries and

personal boundaries when they avoid problems and act as if they are satisfied with achieving peaceful coexistence. The construction of boundary objects seems to require a certain neighbourhood to facilitate the creation of common and standardised routines. The question is what requirements are needed to establish that neighbourhood. It seems necessary to establish standardised work methods, but it also seems difficult to do so.

Chapter 6
Contributions and conclusions

Research contribution

NPM research

This study offers a complementary explanation to a paradox in NPM research. Several NPM research studies indicate (see Chapter 1) that NPM reforms either have negative effects or no effects. Other studies have shown that NPM reforms have not been implemented. Therefore, according to the literature, we could expect a decrease in the implementation of NPM reforms. However, Hood and Peters (2004) talk about *the middle aging of new public management*, and Olsen (2008) discusses the coexistence of NPM principles and the ideal, typical Weberian bureaucratic principles. Furthermore, it appears that after 30 years of unsuccessful implementations, NPM reforms are now institutionalised. For example, Dunleavy *et al.* (2006:468) state: "NPM practices are extensively institutionalised and will continue." (Christensen & Laegreid, 2007; Hasselbladh, 2008). This study supports the idea that NPM reforms have been institutionalised. The actors in this study, who found these reforms reasonable, recognized and responded to them. They treated these demands as routine aspects of their work.

One explanation is, as this study indicates, there is a context-dependent micro-process of cooperation among the CAP unit members that explains both the institutionalisation of NPM reforms and the emergence of unintended consequences (Paper 5 and Paper 6). This micro-process, co-optation, proposes that professionals use NPM reforms strategically to increase their power. The traditional view of the influence of NPM reforms on professional autonomy as either destructive or, at best, harmless, is scarcely realistic as a description of professionals' long-term behaviour. Co-optation of NPM reforms at least produces some form of cooperation between the relevant parties in a decision-making environment (Paper 6). Co-optation explains the gradual institutionalisation of NPM reforms.

Thus this study offers co-optation as a possible explanation that complements the two following explanations of why NPM research studies have not addressed this paradox.

One explanation is Hasselbladh's (2008a) discourse-oriented explanation. This explanation states that in most NPM reform studies, which take an organisation perspective, their concepts and design have caused researchers to look for direct effects related to the reforms' initial intentions, often in a short-term perspective. The complex effects of an overall societal control regime, emanating from national health agencies, may thus have been underestimated. NPM research has not understood the importance of the ever-present "background radiation" from control impulses. As a result, the influence of the societal perspective is underestimated.

A second explanation is that early NPM research was guided by normative, institutional concerns (Hood & Peters, 2004). The idea that NPM reforms colonize professionals' work by managerialism may have its roots in these concerns. According to the colonization thesis, it is expected that professionals will uphold the Weberian ideals of objective expertise. However, while professionals are forced to adapt, they do not really change their behaviour. This normative assessment of NPM reforms takes the bureaucratic moral and rational principles for granted. As Weber (1978; 1991) states: "The bureaucracy protects its identity and structure against outside, and the political 'master' finds himself in the position of a dilettante facing the expert." The NPM research has focused on an institutional perspective and has assumed that institutions do not adapt easily to reforms. Then the influence of the actor is also underestimated.

Unintended consequences

Furthermore the significance of unintended consequences may be reinterpreted in the light of this study. Considerable attention has focused on explaining what has caused the paradox from a methodological perspective (see Hood & Peters, 2004), while less attention has been paid to the significance of unintended consequences once the paradox was observed. This could be done by analysing the unintended consequences after they have been observed. With the analysis of an example (below) of an unintended consequence of a NPM reform, it is possible to recognise that unintended consequences exert a positive influence on the development of public organisations. The unintended consequences reported as a result of the introduction of NPM reforms are then not the end of the story. In the example, they provide the momentum towards

the next developmental step. An organisation cannot defend itself from NPM unless some other control regime extends the bureaucracy. It is even possible that the bureaucratic organisation is driven by NPM reforms' unintended consequences. These hypotheses follow from the following reasoning.

The emergence of unintended consequences is said to imply that NPM reforms are ill conceived and unrealistic. As Dunleavy *et al.* (2005) suggest, they should almost be seen as an unfortunate parenthesis in the history of public administration. By contrast Adam Smith, who thought unintended consequences motivate human development, claimed in his famous *The Wealth of Nations,* published in 1776, that the individual is led "by an invisible hand to promote an end which was no part of his intention" when new situations requiring action arise. Reforms would then breed reforms. For instance, those countries (e.g., New Zealand and other Anglo-Saxon countries) that were among the first to adopt and implement NPM reforms are also those who have supported those reforms most strongly (Pollit & Bouckhaert, 2000).

The emergence of unintended consequences may reflect a divergent evolutionary process rather than a convergent process that moves towards a decisive, hegemonic solution for the problem of control in the public sector. One explanation may be that the NPM reforms result in more complex control over public organisations despite the fact that the ideal goal of NPM is the opposite. Traditional public management has not been replaced by NPM (Olsen, 2008). For example, the introduction of performance management in public affairs, instead of the earlier focus on processes, has led to more evaluations of how public organisations perform their services and of how closely that performance follows the rules (Pollit *et al.*, cited in Hoods & Peters, 2004). Then an unexpected side effect has resulted that is the opposite of the effect intended.

In addition, the bureaucratic model has proven its value in handling the consequences of NPM reforms. When NPM reforms lead to market solutions that are fragmented and uncoordinated, a functional bureaucracy may be able to deal with these problems. In the example of performance management in this research, the intention is to give the professional practitioners greater opportunities for individual action, which means that variances in results will increase. In part, this is a desirable outcome if it fulfils a service user's need, that is to say, if it agrees with NPM's intentions. But a part of the variance is, or can be so interpreted, as arbitrary treatment or lack of professionalism, which conflicts with the ideal of the bureaucratic school. To avoid the variance that results from lack of professionalism, regulation of the ways of performing services is needed, followed by implementation of standardised procedures and

evaluations. The interpretation of this example is that both control logics are met.

With the increased demand for differentiation, it is obvious as well as essential that evidence-based professionalization (based on scientific theories) is needed to a greater degree than we have seen in the past. With such a development, public officials can increase their legitimacy and their scope for autonomous decision-making. Professionalization means then both standardisation, and again, paradoxically, discretion.

The interpretation may be that the meeting between different control regimes, with their specific rationales, will be a dynamic meeting causing unintended consequences. Regimes will react to these consequences, causing new unintended consequences from both regime perspectives. Unintended consequences are then part of a mechanism driving the development of the public organisations and not the proof that NPM reforms will soon end.

Theories on professions

The findings of this study indicate that the professions in a multi-professional environment seek to create relationships with the dominant profession. In this way, a form of peaceful co-existence results in which self-interest and others' interests are valued. The attitude was more or less: "Let me do my thing and you can do yours". In short, the professionals try to avoid relationship problems. In professions research, however, the relationship between the different professions is treated as a competitive one where the professionals try to enter other professions' fields of expertise in order to displace them (Parkin, 1979; Abbott, 1988). This is a dynamic relationship with the possibility of changes in jobs as a result of such negotiations (Liljegren, 2008), while problem avoidance is about coexistence instead of either conflict or cooperation. Co-existence seems to be the normal condition in the meeting between the professions in the CAP units that a tight organisational grouping as a team is unable to change. It seems to be an extraordinary and dangerous situation for the team coherence when the rule of coexistence is broken (see Paper 5). One may ask: Is it a paradoxical consequence of teamwork that the forced proximity results in a ritualized behaviour that increases the distance between team members? Do the professionals develop defensive routines in order to avoid problems in the team?

Professions research has not dealt with the fact that multi-profession cooperation has the same character as mono-professional cooperation (see p. 27). The primary aim of team members in the multi-professional environment is

to preserve collegiality through co-existence. They do not wish to challenge others' approaches and practices or to learn from them. This result challenges the general idea of professional dominance in theories on professions.

Theoretical implications and reflections

There are two steps in the theoretical implications of this research: Step 1. How to move from an external norm orientation to creating endogenous institutions promoting cooperation (standardised methods); Step 2. How to move from endogenous institutions promoting cooperation (standardised methods) to cooperation (construction of boundary objects). The studies that describe successful cooperation (see p. 26-27) reflect the process in Step 2. This is also the case with Star and Griesemer's (1989) theory. The studies that describe unsuccessful cases show that because of the difficulties in taking Step 1, that step is never taken. The explanation derives from the cultural approach of NIT (Paper 4). This study tries to bridge the two steps: how to move from external norm orientation to cooperation, via the creation of endogenous institutions. The explanations for how to move from Step 1 to Step 2 are based on the agent perspective. Thus, dominating theories explain either the unsuccessful or the successful cases but not how to make an unsuccessful case a successful case.

This study shows that the increased demands for accountability create different risk strategies when these demands are transformed to personal risk (Paper 2). This transformation, which may then make the categorization of the patient more context-bound for each actor, will inhibit cooperation. However, with the increase in accountability, standardising methods are introduced that promote cooperation (Paper 3). The three CAP units of this study face increased demands for accountability and have the same set of action alternatives. The actual alternative to meet these demands is not determined by the professional norms or the increased accountability *per se*, but by the way the standardised methods are introduced and incorporated: "Leaders and co-workers can create endogenous institutions that bridge the differences in professional norms among themselves and between professional norms and NPM reform" (Paper 4: 11). Thus the main results from Paper 2 and Paper 3 are linked in Paper 4.

The most theorised step is Step 2. Therefore, it is easier to begin with that step.

From endogenous institutions to cooperation

As Star and Griesemer (1989) argue, boundary objects must be constructed (p. 19-22). This study suggests that boundary objects in the sense of raw material (in this study, the children with symptoms) are insufficient to match the strong, external institutional controls that cause management and cooperation problems in professional organisations. However, when the translation process around a boundary object is capable of finding specific solutions for *how* cooperation can be achieved, institutionalisation will develop that is strong enough to maintain the cooperation, regardless of the actors or the situations. The example of multi-professional cooperation in this study suggests that this is achieved when more and more facts can be mapped for the boundary object, such as raw material (e.g., the child with symptoms) by those who need to cooperate. A boundary object with different meanings, which is understood by all actors, must first be discovered. Thus, as Star and Griesemer (1989) conclude, one has to find radically different meanings when they are incorporated. The goal is to discover such meanings! This study suggests that this discovery will occur when standardised methods that drive the translation process forward are introduced. While the boundary objects described in Star and Griesemer's well-known article are often cited, it is also important to call attention to standardised work methods in order to understand how cooperation can be achieved.

However, there is an essential assumption in Star and Griesemer's museum case (p. 21) concerning the introduction of standardised methods. In the museum case, the curator's position of authority in large part led to the actors working jointly. The curator informed the actors on how the actors were to align their work with others' work and with the objective. As a condition of their employment, the curator told the trappers that they had to complete forms that described where the animals (whose skulls had to be intact) sent to the museum for preservation were captured. According to the case description, the trappers and the conservators never met. By introducing such forms, cooperation is established. Star and Griesemer (1989: 407) state: "Part of this authority [the curator's] is exercised through the standardization of methods".

Obviously the team leaders of the CAP units are not in that position since the environment is non-authoritarian and is governed by professional norms. Thus it is essential to understand how endogenous institutions are created where the actors' behaviour is related to the idea of more strategic actors who define a situation in terms of their own self-interests. It is therefore important to emphasize the significance of action models in shaping the practice and

ideology of multi-professional cooperation. When such rules-creating action models are inadequate, cooperation problems arise – one explanation of cooperation problems is the under-institutionalisation of the actors. It may be assumed that a degree of trust in others has great importance in creating the neighbourhood required at work according to common and standardised routines and that the inherently risky transition from talk to action must be overcome with the help of trust-creating measures (Paper 4). A theoretical implication of this is that it may be necessary to interpret the actors' actions primarily using rational explanations and secondarily using cultural explanations, since the actors do not yet appear to have developed the intra-organisational norms of cooperation.

Thus this study concludes standardised forms are not an example of boundary objects. Standardised methods create boundary objects, and then cooperation has occurred. If a hegemonic idea of how to work with standardised methods exists, the idea becomes the mechanism for starting the process. (For example, the care chain: see Lindberg and Czarniawska, 2006). When such an idea is missing, this situation cannot be understood according to Star and Griesemer's theory. It is necessary to invoke explanations of how the actors develop the necessary endogenous institutions that support cooperation.

However, this study confirms that when the translation process around a boundary object actually is established and deepened, then the cooperation can be institutionalised in a form that is strong enough to maintain the cooperation, regardless of which actors are involved.

It is somewhat puzzling that the presence of children with symptoms is not strong enough as potential boundary objects due to the lack of a strong enough endogenous institutions to promote cooperation. The idea of creating a multi-professional team can be seen as the solution to just that sort of problem. It is than even more puzzling that the combination of a seemingly strong endogenous institution facing obvious potential boundary objects still doesn't make cooperation easy. This observation indicates that the preconditions for replication of the Star and Griesemer's results must be extraordinary.

From external norm orientation to endogenous institutions

Despite the MPT concept, this study provides evidence of two forms of free-riding that characterize the Ostromian Common Pool Resource Problem (Ostrom *et al.,* 1999), thus indicating a low degree of endogenous institutionalisation. The actors appear under-institutionalised in the sense that they have not yet taken part in the development of the intra-organisational norms

of cooperation needed for achieving the desired customised care. Their under-institutionalisation may result in control problems when structure and value institutions are insufficient.

To understand the professional's way of acting it seems important to understand the impact of the professional norms. The cultural approach of NIT provides the dominant norm-oriented explanation for cooperation difficulties. The norm-oriented explanation supposes that professional norms control professionals in what they do and how they do it – hence their need for discretionary power and professional dominance that allow them to perform their work in a way they think proper. They take a specific role that is independent of other professionals and of any context they find themselves in. These assumptions are too deterministic to provide any new understanding of why they do not understand one another. The *actor-oriented* perspective may provide explanations that are both different and complementary to the *cultural* perspective.

The difference between NIT and the findings in this study concerns *how* the endogenous institutions are created. According to the cultural approach, when rules are used over long periods of time, they are taken for granted by the actors; it is forgotten that the rules are created (Berger & Luckman, 1966). Such rules may serve as tools for further endogenous institutionalisation processes. Thus, the cultural approach predicts slow, institutional development in which the actors try to develop new field norms on cultural compromises but are restricted by norms conformance. In introducing new norms for new challenges, the existence of a taken-for-granted outlook may cause cooperation problems.

In the actor approach, the difficulties arise from the different strategies that co-workers and managers use in circumstances related to their own interests, tactical considerations and ambitions. The study focuses on how the cooperation discourse becomes instrumental and action-oriented and how new norms and ideas about cooperation are applied in the everyday practices and routines of the professional practice. The study shows that the implementation of new procedures is more powerful in establishing new practices than ideologies. Management has to prove that cooperation is beneficial to the team members and has to promote a cooperative spirit by instilling a common understanding of the concept of cooperation. With this approach, the institutional development may be rapid. The difficulties may be explained by the previous mentioned findings that confusion occurs when the actors try to position their treatment methods and when the actors act strategically and relationally as they position themselves in an intertwined process (Paper 5). This explanation

will be accentuated with a team leader in a weak administrative position who will be unable to maintain a cooperative sensemaking spirit that is essential in a NPM context.

Thus this study does not contradict the many studies explaining cooperation difficulties. Rather, it offers a complementing understanding that is necessary to understand how the actors in over-institutionalised organisations are able to establish cooperation, which, as previously noted, Star and Griesemer's theory does not provide.

Practical implications

External cooperation

The practical implications of this study may be valid for any setting of cooperating organisations. The study shows that cooperating units may continuously redefine their missions based on their own economic situations and recently acquired experience gained from their own practice, with little reference to each other. This behaviour is understandable considering the powerful controls on their resources, which result from NPM reforms. A practical solution to the external cooperation problem may then be to enter a cooperation agreement. But when cooperation agreements are applied individually to cases, there is no common system that views the consequences of such redefinitions from a holistic perspective. In a cooperation agreement in which each cooperating organisation makes its own interpretation, it is possible for every actor to maintain his/her own perspective. Furthermore, management is not required to present the organisational ideals and objectives that place the patient at the centre of treatment. Such cooperation agreements, then, are examples of reforms that have unintended consequences when self-interests are legitimized despite the intention to promote the interest of the entire treatment activity.

Instead, in situations where there is no overarching hierarchy, all actors need to communicate better with each other, especially concerning the consequences for others when they redefine their roles. Such improved communication may result if management in the cooperating organisations takes the initiative by making *meta-learning contacts,* meaning that the cooperating partners together reflect on how they have solved previous problems with common patients. A way to establish such contacts is to set aside resources to be used so that the cooperating organisations can meet and learn from each other. With these resources, organisations can work together on patient needs and, th-

rough imitation, develop ways to coordinate their treatments, even in patient cases that do not require cooperation. An increased understanding of other contexts would allow all actors to see the consequences of their own actions for other actors and for the patients. The advantage of this approach is that it allows the actors to voluntarily adopt a new way of working while reducing the risk associated with horizontal cooperation that may mean a potential change for them.

A practical implication of this study is therefore that meta-learning contacts between the professions in their external cooperation would help the actors to deal with the complexity of their multi-professional environment. There is reason to strength the user influence in order to promote this development that could balance the perspectives of the professionals.

Internal cooperation

The results of this study can be seen as an illustration of the effects of increased accountability, a central theme in NPM reforms, on multi-professional teamwork. It is believed, in psychiatric treatment and in health care in general, the risk for patients is reduced when individual responsibility for the patient is assigned. In order to safeguard patients, medical responsibility is assigned to doctors. However, the patient risk becomes a professional risk for the doctor in which, for example, the risk of formal reprimands in instances of proven malpractice may gravely damage careers. The medical responsibility problem is particularly acute when doctors have a somewhat peripheral role in the team activity with relatively little control over the treatment of patients. If a doctor feels he/she alone has the medical responsibility for the patents, but has limited control over their treatment, he/she will feel at personal risk. Taking responsibility for failed treatments is a significant professional risk. When the doctors were included in the multi-professional teams it seems an asymmetric risk distribution among the members was introduced. This situation will worsen with increased responsibilities for the doctors.

The study shows that risk minimization at the individual level (the levels of the doctors and the unit managers) creates problems at the system level and disadvantages the patients. A doctor may try to reduce this risk when dealing with so-called high-risk patients by referring them elsewhere. The study shows that possibly the greatest hindrance to cooperation in a team is the insecurity the doctors feel about their colleagues' patient treatments. Given such insecurity, a team cannot function!

A similar situation exists for the unit managers and their responsibility for resources. Unit managers run the risk of being charged with inefficiency and

waste if they overrun budgets. However, they should not be solely responsible for management of the resources – the entire team should be as resource efficient as possible. To resolve this problem, all actors should share the responsibility for managing resources. The unit managers' situation with resource risk is very similar to that of the doctors with medical risk.

All the actors' actions, in one way or another, relate to medical risk and to resource risk, regardless of whether they have the related formal responsibility. If accountability is viewed as a collective matter, then in large measure the weight of the responsibility is less for both doctors and unit managers. An assumption behind this *risk-sharing* idea is that changes in approaches will be necessary, both for those who have formal responsibility and for those who do not. The people who lack formal authority must realize that they are also at risk for failure to provide proper treatment and for misuse of resources. As far as the doctors and the unit managers, they must dare to trust their colleagues' contributions. When both groups – those with and those without formal responsibility – understand the others' situation better, there is a greater likelihood that trusting relationships will develop. Rather than focusing on the minimization of individual risk, all actors will support one another as a way to reduce their collective risk.

There are specific actions that a doctor and a unit manager can take to advance the *risk-sharing*. One action is to involve co-workers more in working toward the activity's goal – the care of patients. Often the discussion around the goal (the process around the goal) is more developed than the goal itself (the goal as a product); such a discussion involves a general reflection on the activity and its direction. If the discussion focuses more on the goal, based on a medical logic, a better understanding of others' roles is possible. This will lead to cooperation rather than conflict. Another action is to involve co-workers more in resource issues by prioritizing the discussion in the teams on how the team can be most efficient.

By taking joint responsibility for the risks associated with patient care and the efficient use of scarce resources, all actors will have an increased understanding of, and concern for, each person's role in the team. Since each team member will share in this responsibility, there is a greater possibility for cooperation in a team with less attention focused on individual responsibility and rewards that may be harmful to the well-being of others on the team as well as that of the patients.

Active leadership

The study shows that patient care according to a new norm (here, customised care that requires mutual cooperation) must be standardised through work procedures. It is therefore important to emphasize the significance of action models in shaping the practice and ideology in multi-professional cooperation. It is not enough to explain the reason for new norms, to answer the why-question, or to state what new norms should include. Nor is it enough to change the activity by adopting new policies, or to force cultural changes by negotiating, and/or by investing in new training programs. Implementing these measures will not produce cooperation among the actors. Although the actors are aware of the institutional conditions, these conditions are secondary factors in the explanation of the outcome of cooperation efforts. A spirit of cooperation should not be taken-for-granted. Management has to prove that cooperation is beneficial to team members. By instilling a spirit of cooperation among actors, management can create a common understanding of the concept of cooperation and can create institutions for cooperation in the professional relationships. Cooperation requires working in a way that allows the team of professionals to discover the patients' specific needs and to break away from their mono-cultural orientation of a profession-oriented way-of-working. A common ideology alone is insufficient to create a common practice. However, the implementation of a common practice can create a common ideology in an organisation under the strong influence of norms.

Future research

Hood and Peters (2004) have called for studies on the unintended consequences of NPM reforms in order to advance our understanding of how organisations function. One response to this call is to continue with the research into co-optation that Paper 6 deals with. Another possible response is to relate principal-agent theory to general explanations of unintended consequences as discussed by Merton (1936) and Sieber (1981).

This study suggests various explanations of why effective cooperation does not necessarily occur in multi-professional mental healthcare teams. The actors seem to strengthen their professional and personal boundaries, while they create mechanisms such as problem avoidance, politeness and ritualized and coded communication that prevent questioning and learning from each other's knowledge. The close structure may even prevent cooperation. Problem avoidance is about coexistence instead of conflict, but also instead of cooperation.

An area of interest for future research then is the study of defensive routines that are institutionalised and how this institutionalisation influences organisation routines and affects performance.

Researchers may also study more closely the role of the team leader in the multi-professional healthcare environment. When problems arise in the team, it is often difficult for the team leader to avoid the anger and/or hurt feelings of other professionals. This situation arises especially when questioning a medical approach since questioning a professional's approach may challenge his/her professional autonomy or may cast doubt on that professional whose personality is integrated with the approach (Paper 5). In our study we found administrative routines (e.g., standard treatment forms) provided an organization structure that promoted team cooperation. However, there is a concern that such ritualization of routines may lead to superficial cooperation without resolving deeper issues. We suggest that research into the role of the team leader in preventing such ritualized barriers is worth investigating.

The problem of ritualized communication may also be examined using the concept of boundary objects. The construction of boundary objects seems to require that a certain neighbourhood work according to common and standardised routines. It may also be assumed that the inherently risky transition from talk to action must be overcome with the help of trust-building measures. Coherency is required in the findings concerning the patients that have different meanings for the actors, but these findings must be discovered. More and more information can be mapped by those who need to cooperate. The impact of collaboration in creating institutions requires theoretical development (Phillips *et al.*, 2000).

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