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Professional Societies as Change Agents:
The Danish Medical Societies' Creation
of the 'Function-Bearing' Unit

Finn Borum

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This paper has been presented at the 16th EGOS Colloquium 2 – 4 July, 2000, Helsinki School of Economics and Business Administration, Finland.

Thomas Kolbye has provided invaluable, courageous and good-humored assistance with a detailed analysis of the three volumes of the medical specialties' reports.

Members struggled courageously with my Danglish formulations.of the FLOS research network and Sven Modell have commented very constructively on earlier and even more unfocused versions of this paper presented at seminars in Aalborg and Copenhagen. I have also received valuable comments from Richard Scott, Walter Powell and James March and participants in a SCANCOR seminar at Stanford University. Several actors from the Danish hospital field have provided much needed feed-back on earlier versions of my tentative understandings of complex processes, which also to participants remain open to different interpretations.

Marianne Risberg has, as usual, struggled courageously with my Danglish formulations.

Foreword

Research Center for Hospital Management and Organization (FLOS) will be publishing a series of working papers that in part aims to communicate preliminary results from the center projects, and in part will function as "food chains" for final books and articles.

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Professional Societies as Change Agents: The Danish Medical Societies' Creation of the Concept of the 'Function-Bearing Unit'

I. Introduction

Within organizational fields regulative, normative and imitative processes shape and standardize structural forms and practices (DiMaggio & Powell, 1991). In fields where professions control the core technology – as is the case of health care fields – normative processes are particularly important. This article will focus on normative processes and their interplay with regulative processes within the Danish hospital field, an institutionalized sub-field in the Danish society. This field includes key suppliers of hospital services, consumers of hospital services, regulating and resource allocating agencies, and educational systems that produce the actors in the field - cf. the classical definition of an organizational field:

'..those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products.' (DiMaggio & Powell, 1991:64-65)

More specifically we will analyze the role of medical societies in relation to shaping the future organizational structures within which members of these societies will have to perform their professional activities. Focus is thus not on how a profession exerts influence on what is considered to be its core services and how these are practiced, but on the design of the overall organizational structure within which these services are produced.

In other words the object of scrutiny is the structuration and management of organizations within which professionals perform their activities but of which they cannot claim competence monopoly. We will focus on a domain that has been especially contested in the current New Public Management (NPM) era – a domain in which managers, regulatory agencies, politicians, and other professions, such as economists, consultants and organizational advisers operate – each taking as their point of departure various logics (see Bentsen, 1996; Kragh Jespersen & Sognstrup, 1999; Vrangbæk, 1999). By focusing empirically on this grey zone within which professional services, regulations, politics and managerial activities intermingle, we hope to contribute to the understanding of the nature of normative processes, their functions in relation to members of the professional community, and their interplay with regulative processes initiated by other constituents in the field.

A new concept as a key to studying normative processes

The paper proposes to use new concepts as a point of departure for disentangling field dynamics. Emerging concepts, which contain 'novelty', attract the attention of important field constituents, and make these invest considerable energy in processing, pro-

moting

or opposing the new words, seem to offer insight into both the behavior of professions and into the structuration and dynamics of an organizational field.

Our empirical starting point is the appearance of a specific new concept for organizing clinical services – the function-bearing unit (FBU) - and its incorporation into the Danish hospital field. Our analysis will focus on the emergence of this concept, its contents, justification, connotations, inclusion in the field's discourse, and functions.

What a function-bearing unit implies will perhaps become clearer as the analysis proceeds – although the concept is still in the making. An initial definition provided by its theorizers, the Danish Medical Society, emphasizes that it is a professional organization resting on basic specialties, securing quality in both patient treatment, training of doctors, medical research, and rational patient flows:

'Based on the objectives of the Hospital Commission to increase the quality of hospital services, we suggest introducing the ***function-bearing unit*** as the basic professional organizational model. The function-bearing unit is defined as '*a professional organizational unit of high professional standards that can undertake the majority of the tasks related to a basic specialty, such as diagnosis, treatment, care, continuous training of doctors, and the research, professional development, and quality management related to these tasks, taking into consideration that there are tasks that can only be performed in a few national hospitals.* It is thus an organizational unit - and not a physical unit - which is intended to constitute the framework for the aggregated services of a basic medical specialty in a county or for a population of about 250,000 people, including clinical services, research and development and quality management. This size is chosen on the basis of reports from individual basic specialties and sub-specialties based on rational operations, including especially the coverage of sub-specialties, the organizing of emergency functions and not the least the cross-cutting specialties operating round the clock.' (Dansk Medicinsk Selskab, 1998:10)

Professionalization

A dynamic view of the hospital field emphasizes professionalization - a process that is reflected in normative pressures. This view of professions as ongoing projects under construction, and not as stable, achieved social constructs is compatible with DiMaggio & Powell's (1991:70) interpretation of professionalization as '…the collective struggle of members of an occupation to define the conditions and methods of their work, to control 'the production of producers'…'. However, the present interpretation necessitates some elaboration with regard to 'the collective struggle'.

First, classical professional theory tends to emphasize the profession as a collective actor. Although specialization within a profession occurs, emphasis is on the profession as an integrated unit able to coordinate its actions in relation to its environment, and characterized by a common project (Larson, 1977). Classical analyses of the medical profession (Freidson, 1971) has been promoting this view, which is supported by two recent analyses of the medical profession's development and influence within the hospital field. Scott et al. (2000) identify an 'Era of professional dominance' (1945-1965) in USA, while Vallgårda's (1992) analysis of the hospital system in Denmark reveals a period of professional dominance which reaches into the beginning of the 1970s.

However, the Scott et al. (ibid:186-188) analysis also argues for several factors contributing to reduce the power and unity of the medical profession:

1. loss of memberships
2. increase in the number of physicians
3. larger proportion of physicists employed in organizational settings
4. larger proportion of female and foreign-trained physicians
5. growing numbers and types of specializations.

In particular the latter factor seems to play an important role as each new specialty is accompanied by a new specialty association '…that competed with and undermined the power and centrality of the American Medical Association (AMA) and, thereby, the unity of the profession.' (ibid: 186). Thus the American medical profession is characterized as increasingly fragmented.

The analysis of Vallgårda (1992) does not to the same degree emphasize the medical profession's fragmentation, but nevertheless clearly supports three of the five above tendencies: increase in the number of physicians (2), larger proportion of physicists employed in hospitals (3), and growing numbers and types of specializations (5), as indicators of increasing fragmentation of the Danish medical profession.

'Profession' is thus not an achieved final state. It is an ongoing, neither fully, nor finally achieved project, which is confronted with both internal and external challenges. Normative processes represent the efforts of certain actors to (re)define the profession, taking into consideration conflicting interpretations of the profession's domain, methods of operations and regulation of activities. During these processes objectives, technologies or techniques may be displaced, and the structure of the professionel community may be confirmed or changed. Consensus and cohesion within the profession, and professional dominance of a field is thus not given, but temporary states that may be partially achieved through normative processes.

In this view, normative processes have both extra- and intraprofessional aspects - cf. Greenwood, Suddaby & Hinings' (1999:3-4) view '…that professional institutes legitimate jurisdictional migration and radical organizational change by hosting a process of discourse through which change is debated and legitimized: *first* by negotiating and managing the competing professional identities held by sub-communities *within* the profession; and, *second*, by reframing professional identities as they are presented to others *outside* the profession…'

The extraprofessional or field aspects are linked to the interplay between the professional community and other field constituents that as regulators, suppliers or clients constitute the profession's environment. In Denmark, the other field constituents have questioned the professional rationale as the basis for the field's practice (Vrangbæk, 1999, Kragh Jespersen, 1999, Bentsen, 1996, Borum, 1997). Politicians, administrators, the medias and patient associations have been contesting both the structure and the functioning of the hospital system (Bentsen, 1996; Vallgårda, 1992; Borum, 1997), and significant modifications have been introduced – albeit only implemented at a modest scale – such as private hospitals, and the principle of the citizens' possibility to choose

between hospitals. The present analysis will look into this aspect by virtue of the interplay among the Danish Medical Society, a national task group, commissions and regulating bodies.

The internal aspects are primarily linked to the creation of a common orientation through the processing of different orientations concerning the domain of the professional activities – how they should be conducted, and under what conditions (in terms of rules and regulations). Thus, neither internal consensus among the actors constituting the profession is assumed, nor internal cohesion. With increasing specialization the professional actors are assumed to hold divergent views of the profession and its future development. Some of the actors belonging to the profession may even develop split loyalties and adhere to groupings outside the profession. Take for instance medical managers who draw inspiration from NPM and orient themselves towards public reformators with a non-medical background.

The profession is an abstraction, not a collective actor. In order to analyze and explain field dynamics we need to identify actors in terms of specific individuals, groups, networks or organizations – in our case the medical societies.

II. Extraprofessional Aspects of Normative Processes

Precedents to the emergence of the FBU concept

The Medical Society's reference to the Hospital Commission (see above) indicates that the new concept is a response to issues within the Danish hospital field. The following brief outline of the context of the function-bearing unit has been constructed by tracking down discussions of the issues to which the medical societies have provided answers.

Hospitals represent a central service offered by the Danish welfare state, integrated in the public sector and financed via the general taxes. This context has provided favorable economic conditions for the medical professional logic as driving the development of the Danish hospital system. This is reflected both in the significant growth of the sector and in continuous specialization of hospital units along with the advancement of medical knowledge and research (see Krasnik & Vallgårda, 1998).

1970s
The logic underlying the growth in the hospital sector was first contested in the early 1970s (Perspektivplanredegørelse II, 1973) in connection with efforts to introduce long-range planning as the means of a more informed political prioritization of the welfare state activities.

This followed the Municipal Reform of 1970 which reduced the number of Danish municipalities to 275 and transferred responsibility for all hospital services to the fourteen counties plus Copenhagen and Frederiksberg municipalities (the latter two were merged into the Copenhagen Hospital Services in 1994).

1980s
Ten years later the Ministry of the Interior sat up the first Hospital Commission, which

in 1984 published the report 'The organization and economy of hospitals'. This report launched efficiency and effectiveness as being the most important issues challenging the Danish hospital system. It focused on management at the level of the individual hospital and proposed the establishment of a regular hospital management. The result was the specific Danish hospital management model - the troika - comprising three CEOs representing the physicians, the nurses and the administrators.

The medical specialization was allocated less space in this report, but in the chapter 'Utilizing medical specialization' (Sygehuskommissionen, 1984:101-110) the question of ward sizes was raised.

In 1987 the Ministry of Health was established, mainly based on the Department of Health from the Ministry of the Interior and supplemented with certain functions performed so far by other ministries.

1990s

Ten years later, the Ministry of Health sat up a second Hospital Commission – chaired by the same person as the first one. In 1997 this second commission released its report. This happened in an epoch of growing pressure from the New Public Management wave (see Vrangbæk, 1999) and from a more critical population that contested the profession-driven development and demanded quality and service-orientation viewed from the client’s perspective.

The composition of this commission deserves commenting: the Danish medical establishment was not represented, nor were the unions of physicians and nurses. The physicians’ viewpoints were only indirectly represented through Danish and a Swedish medical director. Three ministries - Finances, Interior, and Health - were represented, and a political scientist chaired the commission.

This second commission's report (Sygehuskommissionen, 1997) differed significantly from the first one in that it focused on the problems related to the continuous medical specialization, the consequences of which were increasingly complex hospital organizations, still more complicated pigeon-holing processes (matching patient and specialty), reduced number of patients per specialized unit (and hence a weaker basis for sustaining specialty competencies and quality), increasing difficulties in securing coordination between units, and absence of prioritization and hence increasing resource consumption.

The report laid the foundation for the concept of 'function-bearing units'. In the section 'Division of labor among hospitals' (ibid:132-138) the need for inter-county collaboration and for looking closely into the underlying rationales for the division of labor among hospitals is stressed, starting from securing quality in examinations and treatment. The section 'Number of hospitals' (ibid.:147-150) introduced two options: either to reduce the number of hospitals or change the division of tasks and roles among them. Focus had now changed from that of the first commission on the individual hospital toward the system of hospitals. Key challenges were collaboration and coordination among hospitals (small and large) and across county boundaries.

The report stressed judgement as playing a far too significant role (ibid.:136) in hospital planning, and asked for more evidence-based planning that took into consideration the

important differences between medicine and surgery (ibid.:137), and the need for uniting surgery tasks in certain hospitals in order to ensure quality and economize on resources. One of the recommendations (ibid.:155, item 1) was for the National Board of Health to instigate an inquiry into the relationship between patient basis and quality of services. These two central issues had been inadequately substantiated in earlier analyses, including a report from the Danish Surgical Society on patient basis (1996) that pointed to a population of 250,000 as being the most appropriate basis for a basic specialty.

Furthermore, the 1997 report recommended that 'collective management' (troika hospital management teams, comprising three CEOs: an administrator, a physician, and a nurse) be replaced by unitary management. The troika model was one of the options suggested by the first commission in its report from 1984, and it was subsequently adopted as a Danish standard model at hospital level.

The National Board of Health mobilizes the Danish Medical Society

The critical comments of the second Hospital Commission (1997) on the basis for planning and quality management of medical units and its direct appeal to the National Board of Health was soon followed up. In early 1997 the National Board of Health invited the Danish Medical Society to participate in a task group with the purpose of establishing a (medical) professional basis for hospital planning with regard to the management of the quality of professional standards and education within the medical specialties.

To define this issue as a task for medical professionals seems, one the one hand, to be the logical consequence of the commission's problem definition, and an earlier instigated procedure for the national planning of medical specialties. The task is an analytical one and can rightly be sealed off from political considerations and entrusted to the medical profession – as argued by the National Board of Health (Dansk Medicinsk Selskab, 1998: 17). On the other hand, this measure marks a break with the rationale underlying the composition of the Hospital Commission in that it excludes groups, such as nurses, health administrators and health economist who could have contributed with competencies and insights relevant to the analysis. In this way the task group represents a return to planning procedures based on the medical logic only and excludes the New Public Management premises that the Hospital Commission had introduced.

Based on contributions from the medical societies, the appointed task group published a summary report in the spring of 1998, introducing for the first time the concept of the 'function-bearing unit' (ibid.:10). The report and the concept are presented as generated by the medical societies alone: 'Induced by conditions outside the influence of the Danish Medical Society, the Danish Medical Society has, in concert with the National Board of Health, decided on its own to present an aggregate medical, professional account of the commission's items described above.' (ibid, p.9 & 20). The question is what this cryptic formulation conceals?

The National Board of Health goes solitary

The National Board of Health was established as early as in 1909 for the purposes of controlling the medical activities of hospitals and advise the Parliament and ministries. Until 1933 its status was that of a 'medical collegium', but it was then transformed into a supervisory board under the Ministry of the Interior. Traditionally, the National Board of Health has had close links to the medical profession. Its director has always been a physician – and the position has been independent of the ministry in charge of the hospital sector. This independence has been maintained after the establishment of the Ministry of Health in 1987, to which it is in principle subordinate.

Before the Danish Medical Society published its summary report on the FBU, the National Board of Health published a 'discussion paper' in March 1998 (Sundhedsstyrelsen, 1998) in which the concept of the 'function-bearing unit' was advanced. This paper was followed up by the National Board Director's visit to all the Danish counties (fourteen plus Copenhagen) during the spring of 1999. In the paper, the National Board of Health referred positively to all the involved parties, including the medical societies, but stressed its independent position in relation to these.

The discussion paper introduces and elaborates on the concept of the 'function-bearing unit' which (Sundhedsstyrelsen, 1998:9-10) is characterized as:

- the basic unit of the future hospital
- a unit with twenty-four-hour production, which can take care of 90% of a basic specialty's tasks
- population basis of 200,000-250,000 citizens. However, in a section 'Connection between patient basis and quality' the estimate of an appropriate patient basis is modified. The estimate of surgical specialties of between 200,000 and 250,000 citizens is supplemented with more than 100,000 for basic treatment within larger medical sub-specialties and with 50,000 for certain internal medical specialties.
- functional collaboration among hospitals across county boundaries
- coordination of tasks within a basic specialty in a larger admission area
- functions that can be geographically separated (examination and treatment functions, education and research)
- treatment teams across physical boundaries
- based on (an improved version) of apprenticeship and a higher degree of decentralized specialist education
- fewer large units and fewer emergency wards which require improved collaboration between the primary and secondary health sector
- electronic patient record as facilitator.

But the paper also raises a series of questions (ibid.:11) related to the broad and unspecified concept that is still open for interpretations. However, the paper does not raise questions related to efficiency, such as costs of establishment and coordination, necessary prerequisites, and potential implementation strategies related to FBUs.

But why does the National Board of Health abandon the original plan of a joint publication with the Danish Medical Society and choose instead to publish its own report? A closer look at the task force producing the concept of the 'function-bearing unit' is required.

The task force that conceived the concept of the 'function-bearing unit'

The Medical Society appointed five members – all highly qualified medical doctors one of whom was the newly elected chairman of the society - to the task group under the auspices of the National Board of Health, which provided the chairman and the secretary (both physicians). The task group started working in the beginning of 1997, and had seven meetings during which the term 'function-bearing unit' appeared at an early stage.

The Medical Society chose to mobilize all the forty-two Danish medical specialties in the investigations, and to coordinate the work of these groups through three coordination groups. This took place in two rounds. The first round consisted in a questionnaire survey to the forty-two specialties, the counties and patient associations and aimed at identifying and defining quality indicators of 'the good clinical unit'. The Medical Society in its summary report makes the interpretation that medical professional, administrative, and consumer views of good quality are highly uniform and emphasize four indicators (see later this article).

In the second survey all medical societies were asked to express their views of the relationship between the quality of medical units' treatment and related activities and the size of units in terms of patient basis. The answers were compiled (De medicinske selskaber, 1998) and formed the basis for the Danish Medical Society (1998) Summary Report and its recommendation of 250,000 as the population basis for a FBU.

The guiding principle of the Medical Society's work was to concentrate on the technical issues related to the medical professional activities, whereas political aspects, such as management and work conditions, were left to the professional associations (ibid.: 18). However, to isolate a 'non-political' area is difficult within a highly contested field, and is further complicated when dealing with an issue – such as the organization of professional medical activities – the nature of which is not strictly 'professional-technical'.

The shift in the composition of the task force at its meeting on December 1, 1997, which is reported with the mentioning of names and institutional affiliations (ibid.:18) may reflect the difficulties of separating technicalities from politics. At this final stage, an officer from the Ministry took over the secretarial function of the task force. Furthermore, two other officers from the Ministry of Health appeared as observers together with two representatives of the Association of County Councils in Denmark and the Copenhagen Hospital Services, respectively. Apparently the Ministry of Health ascribed great importance to the group's work, and wanted to observe the last phase closely. Whether the ministry's initiative to get involved was its own decision or stemmed from the National Board of Health – or whether the action was concerted is not deducible with certainty. In any case it testifies that the distinction between medical-technical and medical-political questions is not evident to the various field constituents, and that the role of the constituents in the field's decision processes is not unambiguous. The fairly new Ministry of Health seems to have contributed to the separation of the National Board of Health from the Danish Medical Society as reflected in the resulting two independent publications from the task force.

Taking a closer look at the Medical Society's summary report may contribute to elucidate the problems related to maintaining a legitimate technical-professional domain.

Theorization of the concept of the 'function-bearing Unit'

In order for concepts or ideas to become widely disseminated they must be 'theorized' (Strang & Meyer, 1994; Røvik, 1998). Strang & Meyer's (1994:104) formulation of the contents and role of theorization seems particularly relevant to the present analysis:

'By theorization we mean both the development and specification of abstract categories, and the formulation of patterned relationships such as chains of cause and effect. Without such general models, the question of similarity is unlikely to arise and gain force. And without such models, the real diversity of social life is likely to seem as meaningful as are parallelisms….
In part, theorization increases perceived similarity by simplifying the phenomena…And as organizational practices and structures are simplified and generalized, they can be more easily appropriated… Theorization also expands diffusion by providing causal accounts. Many theoretical models are effectively functional, providing explanations of why all sorts of components are necessary to each other and to actors and collective goals.'

Based on this conception, we will address three aspects of the theorization of the FBU concept: associative aspects of the general concept, definition of the desired effect (quality) of the concept, and cause-effect relation between quality and size of the function-bearing unit (expressed in terms of population basis).

The FBU concept evokes associations
Concepts evoke associations. The concept of the 'function-bearing unit' is first of all a *general* term. It is not tied to any specific medical specialty in that it claims to be a general model for organizing medical work. In relation to the complex world of medical specialties and the complicated regime and structure of the hospital field, the concept has important functions in reducing diversity. For once the medical specialties are able to provide one, unifying model that in addition seems to be applicable at national level, since it is detached from local variations and the existing physical structure that is closely tied to local and county interests. The concept is presented as an organizational unit, in contrast to a physical one, and is thus based on a matrix approach:

Physical units \ Medical Organizational units

Counties, Hospitals	**A**	**B**	**C**	
1	x	y	.	
2	x	.	z	(x, y, z = Function-bearing units)
3	.	y	.	

Next, the FBU concept points towards *functionality,* i.e., it postulates to be a rational means for pursuing given ends. Furthermore, it has the connotation of engineering, of bearing structures, and thus points towards unit dimensions based on *calculation* and not judgment. In this way the term seems to meet the call of the Hospital Commission

(1997:136) for more realistic planning in hospitals rather than basing it on weakly substantiated judgements. Whether or not this is the case requires closer scrutiny of the desired end (quality) and the argumentation for the means-end relation (quantity – quality).

The end: the concept of quality

Function-bearing units are meant to ensure quality both in medical treatments and related services. Based on the National Board of Health' definition of quality (which in its turn is based on the WHO definition), the Hospital Commission (1997) defines quality as:

- High professional standards in patient treatment (quality)
- Minimum risk for the patients
- Effective use of resources
- High patient satisfaction
- Coherent patient flows.

However, the Danish Medical Society views this definition as being based on '.. fairly broad and generally acceptable concepts but of a limited practical information value' (Dansk Medicinsk Selskab, 1998:21), and conducts a study of what characterizes the good, clinical ward, based on an open-ended questionnaire to doctors, county administrations, and patient associations.

The following new quality indicators are derived from the survey (ibid.:24):

- high professional standards, clear objectives, clear division of competence and clinical guidelines and instructions;
- coherent, rational patient flows, management by cross-boundary teams, good patient information, openness and respect;
- short (none) waiting lists, keeping appointments (no cancellation of planned procedures), and easy access to specialist diagnosis;
- clinical units must be active in research and oriented toward development and education.

In relation to the quality concept of the Hospital Commission, the Medical Society seems to exclude the efficiency (effective use of resources) criterion or only to deal with it in terms of 'coherent, rational patient flows' and 'keeping deadlines'. The other criteria seem to be included, but reformulated in terms of activities and standards that are closer linked to the medical professional practice. Research, development and educational activities have been added as one of the four main groups of indicators.

This new quality concept is still broad and incorporates research and educational activities as ends of the function-bearing units. It ties up with the general debate on effectiveness, service level, patient satisfaction, procedures, and development, but it is not clear to what extent it actually differs from or contributes to operationalize the definition of quality as stated by the Hospital Commission.

The means-end relation: quality as a function of the size of the function-bearing unit

Attempts are made to establish arguments for the FBU concept on a medical scientific basis as summarized in the Danish Medical Society's Report (1998:25-33). The

principal line of argumentation in this report stipulates a positive relationship between quality (as defined above) and size of the function-bearing unit referring to a population size of approximately 250,000. But how convincing is this argumentation? Has the Medical Society succeeded in creating '…a forceful textual structure, one that will carry weight when those who wrote it are no longer physically present to argue their case.' (Latour & Bastide, 1986:56)?

In order to answer this question we will make a reading of the Medical Society Report as a chain of operationalizations and translations along the line formulated by Latour & Bastide (1986:59): 'Does a scientific text tell a story like other kind of texts? No, because it stacks the traces in such a way that each one is a transformation of the last. So does it therefore constantly repeat itself since it talks about the same hamsters ten times in a row? No, because it adds something each time which is not really shown but then is not really unfounded either. The text puts together its elements as if they were stones in a primitive arch. Each one is supported by the last but leans out into the void. Yes, it is a construction. Is it fragile? Sturdy?

That depends upon the masons, the thrust it must sustain, and the fit. But mostly it depends upon the negotiations which guide the way in which each stone is balanced upon the last.'

Our reading will be supplemented by looking upon how readers are enrolled or excluded from the text as it unfolds – inspired by Law's (1986:80) proposal that 'Scientific and technical articles can be seen as translation operators which enroll their readers by moving them along a specified channel.'

From this point of departure, we will now take a closer look at the text produced by the Danish Medical Society, and at the series of translations on which its argumentation rests.

The first issue of the story, quality, is defined in a broad sense, comprising more than clinical aspects. This starts the story by appealing to the interests of a broad audience, including patients, administrators, and politicians. But broadly formulated ends make it difficult to identify means-ends relations and are not efficient tools for sorting out which means that will contribute more or less to realize the intended goals. Thus the first issue of the story, the idea of 'quality', opens the text by creating a loose coupling (Orton & Weick, 1990) to the second issue: 'function-bearing units'.

Next, the Medical Society scrutinizes the core relationship between 'quality' and 'number of medical operations', i.e., the frequency with which a medical unit or a physician performs specific treatments/operations. This step involves a drastic shift in the quality concept from a broad definition to a classical clinical one, where 'endpoints', such as mortality and severe morbidity are the established quality indicators. By this operation the audience of the text is narrowed down to medical professionals.

Reviewing the scientific literature, the Danish Medical Society Summary Report concludes (1998:31) that existing literature does not provide any unambiguous documentation of a positive relation between clinical quality and volume of operations. However, this seems more to be interpreted as a problem of the existing literature than as one pertaining to the nature of the relationship between the two factors in real life. By introduc-

ing this distinction between scientific, disembodied knowledge about practice and the knowledge of experienced practitioners, the text further narrows down its audience to experienced medical professionals.

On the following page (ibid.:32) two new elements are introduced as means of sustaining the weak link between quality and quantity: the proverbial common sense reasoning 'practice makes perfect' – which is modified by the statement that too much routine lowers the quality of performance. On this basis the relation between quality and quantity – not at the clinic level but at that of the individual specialist - is summarized in a free hand drawn normal distribution with no specification of the scales of the x- and y-axes. This technique of setting up an 'inscription device' (Latour & Bastide, 1986:54) can be regarded as another effort to reinforce the enrollment of the professional audience. If this operation works, it is in this case rather due to the symbolic than to the analytical function of the inscription device.

Finally, the report returns to the question of the size of the clinical unit (expressed in terms of population basis) that can secure appropriate balance between quality and quantity. The conclusion is that 'The size of the population basis is still dependent on a medical-technical judgment combined with practical and medical-political considerations.' (ibid.: 33). In other words, the text does not end up arguing convincingly for the relationship that it sat out to demonstrate, but points out that medical judgement and practical knowledge are necessary premises for determining the population of the function-bearing unit.

The chain of argumentation in the Medical Society report can now be summarized as follows:

1. The report stipulates a positive relationship between quality and size of the function-bearing unit and points to an appropriate population basis of approximately 250,000 for the FBU. This recommendation is de-coupled from the text's argumentation.

2. Quality is defined in a broad sense, comprising other than clinical aspects. This makes the text appeal to a wider audience, and reduces the possibilities of sorting out means-ends relationships.

3. Quality is then translated to be a function of clinical competence, which is equivalent to routine in performing clinical functions. By introducing this drastic shift in the quality concept, the audience of the text is narrowed down to medical professionals.

4. Performance routine is argued to be related to an adequate patient basis. This is based on some, but not convincing, evidence from certain surgical specialties. While the argumentation is not convincing, the narrowing down of the text's audience continues.

5. 'Common sense' and a hand-drawn normal 'distribution' are incorporated as elements to close the missing link of evidence of the relationship between number of patients and quality of treatment. The argumentation shifts level from the clinic/unit level to that of the individual operator. This operation does not prove the relationship, but

maintains to address the narrow audience.

6. An adequate patient basis is translated into an adequate population tied to the medical unit, a commonly used approximation.

7. Medical judgements combined with practical and medical-political considerations are the procedures by which the patient basis for the functional unit can be decided. In absence of proof or evidence the judgments and experiences of medical professionals are reinforced as necessary and inevitable means of establishing the relation.

8. The chain of argumentation does not point directly back to the (ibid.:10) recommended population basis of 250,000 individuals, which is the same figure as the Danish Society of Surgeons argued for in 1996 on the basis of insubstantial empirical evidence. Thus there is a loose coupling between what is recommended initially, and what has been argued through translations of the text.

In summary, the Danish Medical Society report does not tell the reader a very convincing story about the positive relationship between quality and population basis, which is the basic argumentation underlying the recommended function-bearing unit concept. Instead, the text narrows down the issue to pertain to the domain of experienced medical professionals as being the only audience that has the practical knowledge necessary for making the required judgments. In this way the text can be read as pleading for that only the medical profession possesses the knowledge base for acting as a legitimate decision-maker.

Explaining the 'break' between the Danish Medical Society and The National Board of Health

We are now able to advance two possible explanations of the 'break' identified earlier in this paper between the two parties that from the start composed the task force that was supposed to provide an answer to the issue raised by the Hospital Commission Report from 1997.

One is that during the process it became evident to the National Board of Health (where key positions are staffed with medical professionals) that the resulting advice from the Danish Medical Society would be difficult politically to process further. Either because it would still be based on judgment and not evidence, and the conclusion would be open to criticism - both for not being based on medical-technical expertise only, and for the medical societies promoting wider interests of the medical profession in relation to the future organizational structure of hospitals. Or because the Medical Society's argumentation did not to a sufficient degree pay due respect to other practical and political aspects, which the National Board of Health felt obliged to take into consideration.

This explanation points towards the National Board of Health experiencing problems with a report co-authored with the Danish Medical Society, and that independent publications would create more room for maneuvering. The decision of the National Board of Health to abandon the original plan of a joint publication and to send out a discussion paper could then serve several functions. First, it would demonstrate the independent position of the Board in relation to the medical profession. Second, it made

would make it possible to test the idea of 'function-bearing units' in relation to the wider hospital field. Third, it would allow for the presentation of a more differentiated version of the concept as reflected in the varied recommendations on the size of the function-bearing unit.

Another explanation is linked to the by the Danish Medical Society (1998:18) reported sudden appearance of representatives for the Ministry of Health – which traditionally recruits outside the medical profession – in the task group. As the task force had engaged into wider and politically sensitive lines of argumentation, and as the medical profession seemed to support unanimously a new and interesting concept, it was important for the Ministry and the counties to get informed and involved. Whether the recomposition of the task force happened in response to pressures put on the National Board of Health by other parties that initially had been excluded from the task force cannot be deduced from our sources. But in either case the result was that other interested parties were included – and hence non-medical points of view - in the last stage of the process. This may have served purposes of information and influence, but it also made the Danish Medical Society decide to publish its own report.

According to both explanations, the break can be seen as a consequence of, and an effort to cope with the impossibility of separating political and technical issues related to the organization of a profession-dominated field. And furthermore the impossibility of separating the issue of the future organizing of hospital services from the wider structural conflict relating to the roles of the regulating and resource allocating agencies: the Ministry of Health, the counties, the National Board of Health.

The Ministry of Health and the Government adopt the FBU concept

In May 1999, a year after the National Board of Health and The Danish Medical Society had published their reports, the function-bearing unit appears as an element in the government strategy plan (Regeringen, 1999) for the hospital policy year 2000 – 2002. After having participated in the last phase of the task force that conceived the FBU concept, and the National Board of Health's sounding out of the concept during 1999, the Ministry of Health ends up finding the concept useful in relation to its efforts to strengthen its role of regulating activities in the field – and in the counties.

The strategy plan states that the sub-goal of the Ministry of Health is to compile all basic functions in function-bearing units by the end of 2002 (ibid:25). This aim will be incorporated into the financial agreements with the counties.

The Ministry of Health is now offering (ibid.:26) a further modified interpretation of 'function-bearing units' by pointing to a population of 50,000 - 130,000 as the potential basis for the large area of internal medicine aside from a population of 200,000 - 240,000 per basic specialty mentioned by the Danish Medical Society. Furthermore, the concept is being combined with another concept – that of 'unitary management' (ibid.:26).

The Ministry of Health also points out that the concept covers an organizational unit, not a physical grouping, and that function-bearing units in many cases will 'tie hospitals together', conceivably across county borders.

In another section (ibid.:29), the ministry shifts to traditional concepts, such as 'the individual hospital and ward'. This is accompanied by changing from arguments of quality and professional issues to rationales of efficiency, incentives, and investment. The relationship between the planned function-bearing units and the hospitals is rather blurred, and an image of two crossing dimensions is emerging: a medical professional structure and an economic-administrative one. In the section 'Strengthening Management Functions' (ibid.:34) the need is stressed for a common management culture and unambiguous placing of managerial responsibility at all levels. However, the question of managerial positions and responsibilities in relation to function-bearing units is not addressed.

This concurrent and de-coupled talk about function-bearing units and hospitals leaves the impression of considerable uncertainty about the future general structure - or room for local improvisations.

The hospital field at large adopts the FBU concept

After the professional medical societies and two important regulative agencies have adopted the concept, and it has been tied to the allocation of resources from the ministry to the counties, it is hardly surprising that the concept of function-bearing units becomes an element in the discourse of the hospital field during the spring of 1999 (cf. the pilot field study of Kragh Jespersen and Sognstrup, 1999). This is also evidenced by the concept appearing in all the journals of the hospital field, and in documents. One example is a strategy document from the Funen County (May, 1999) which is a proposal for structural rationalizations of the hospital services in the county aimed to save DKK 90 million. In line with the government wish to incorporate FBUs in the financial agreements with the counties, function-bearing units occur as the key concept in this document and are used to characterize the seven options for rationalization presented. In the document references are made to locations, health professional aspects, buildings, and finances tied to concrete potential rationalizations. However, in terms of how to operationalize of the FBU concept, the document is not particularly explicit.

III. Intraprofessional Aspects of Normative Processes

The fact that the Medical Society choose to involve all the forty-two Danish medical specialties, and not only a few task groups in the process, can be seen as an indication of both the importance attributed to the task, and as the profession’s reaction to the pressures that had been building up against the institutionalized practices of the hospital field. The separation of medical-technical questions from medical-political ones can be interpreted as an effort within a highly contested field to maintain the delimitation of a professional domain, and to mobilize the medical profession’s knowledge and competencies.

A closer look into the responses of the various medical societies that constitute the basis for the Danish Medical Society’s formulations in the summary report on the fucntion-bearing unit may provide some insight into intraprofessional aspects of normative processes.

The responses from the forty-two medical societies

The contents, scope and ambitions of the contributions from the medical societies differ widely, varying from short status descriptions of the individual specialty to lengthy analyses that include data and literature reviews. Contributions from the societies can be divided into three main groups:

1. *Specialties refraining from taking a stand on the patient basis*
   and not producing any analyses that might substantiate the scientific basis for a relationship between patient basis, structure, and quality.
2. *Specialties offering an experience-based opinion on the patient basis*
   but not producing analyses that can substantiate scientifically the relationship between patient basis, structure, and quality.
3. *Specialties recommending patient basis based on analyses*
   and producing analyses in order to provide scientific basis for the relationship between patient basis, structure, and quality.

The detailed distribution of the forty-two societies is illustrated in Appendix 1.

1.
Seventeen societies refrain from suggesting any size of population basis. One society does not seem to have contributed with anything.

2.
Eighteen societies include recommendations for the size of a function-bearing unit. The arguments are based on a mixture of practical organizing and continuation of the current structure. The professional judgements of these societies are not based on evidence, but on estimates based on Danish and international experiences.

3.
Seven societies carry out analyses i order to substantiate the relationship between quality and quantity. They apply three different approaches in their attempts to find evidence of the correlation between quality and quantity: examples of individual treatments, quality data bases, or scientific publications. Only two of them – Børnekirurgi and Dansk Selskab for Intern Medicin – find it probable, though not proven, that there is a positive correlation between quality and quantity. However, based on the analyses they cannot recommend a specific patient basis, why their recommendations in the end are experience-based.

In their analyses the medical societies seem to pursue the traditional operating procedure as formulated by the National Board of Health in *'Vejledning vedr. Specialeplanlægning og lands- og landsdelsfunktioner'* [Guidelines for planning of specialties and national and regional functions]. These guidelines operate with parameters, such as frequency of diseases, number of involved specialties, and the need for technical equipment as the basis for planning where to perform which treatments. The fundamental principle is 'practice makes perfect' implying the need for a certain patient basis per unit/doctor. These are the very principles that are continued in the societies' analytical work with the function-bearing units.

What the Hospital Commission called for in its 1997 report, i.e., planning being less based on estimates and more on the provision of scientific evidence is thus not provided by the medical societies either. Thus, our analysis of both the Danish Medical Society Summary Report (1998) and the reports from the individual medical societies reveals that they are neither providing evidence nor convincing argumentation for the crucial relationship between quality and population size, on which the new concept is based. The medical societies do not provide a better substantiation than experience-based estimates, as asked for by the Hospital Commission (1997). The positive functional aspects of the FBU concept are ascribed rather than convincingly argued for through a means-end analysis.

The medical societies as producers of reports

The medical societies may be regarded as conducting their report writing within the *editing rules* (Sahlin-Andersson, 1996) of scientific communities: the activating of sub-comittees containing specialized professional expertise, and the publication of a report with scientific investigation and argumentation as model, and emphasis on causal explanations founded on evidence and analysis.

The fact that the medical societies provide no evidence of the relationship between quality and quantity in their sub-reports is explicable with reference to that no empirical evidence exists presently to substantiate this correlation. Attempts to establish evidence of the correlation would involve resource-demanding research. This both exceeds the very limited organizational resources available to the societies, and is contrary to their status of professional associations of specialized practitioners and not scientific associations. On this basis it is hardly surprising that only seven of the forty-two medical societies engage in this enterprise at a modest scale, and none of them succeed in substantiating the crucial relationship.

The large majority of the societies resort to what might be labeled instigated *'standard operating procedures'* for the national planning of medical specialties. Accordingly, most of the specialty reports contain a presentation of the given specialty, and more or less elaborated plans for its future development and collaboration with other specialties. Professional societies thus seem to act very much like formal organizations, which in general respond by utilizing established available routines as a means of mobilizing competencies while limiting resources spent.

The mobilization of a professional community around a new concept

As the functions of the FBU concept in relation to the medical profession cannot be explained with reference to convincingly argued means-ends relations, we will look into other possible functions of the concept: mobilization, responsibility allocation and legitimization (Brunsson, 1990). We will use the perspective for analysis of social movements developed by McAdam, McCarthy & Zald (1996) and Snow et al. (1986), which regards communities as containing sentiment pools or opinion preference clusters, from which support may be mobilized through *mobilization structures* in terms of SMOs (social movement organizations). Mobilization is occuring through *frame alignment processes* by which linkages are created between '…individual and SMO interpretive orientations, such that some set of individual interests, values and beliefs and SMO activities, goals, and ideology are congruent and complementary.' (Snow et al., 1986:464)

Based on the fragmentation tendencies identified earlier in this article, the Danish physicians are regarded as belonging to a *fragmented professional community***,** which contains sentiment pools or opinion preference clusters, from which support may be mobilized through *mobilization structures* in terms of professional movement organizations (PMOs – an equivalent to SMOs). In this case the Danish Medical Society functions as a PMO, which mobilizes support from the medical associations in relation to the *political opportunities and constraints*. These are the task force, the Hospital Commission's challenging the medical profession to substantiate the principles for organizing and managing medical activities, and the other field pressures confronting the professional community.

The community in terms of the medical societies become attached to a mobilization structure – the Danish Medical Society and the task force - through *frame alignment processes* by which linkages are created between '…individual and SMO interpretive orientations, such that some set of individual interests, values and beliefs and SMO activities, goals, and ideology are congruent and complementary.' (Snow et al., 1986:464). The frame created by the Danish Medical Society is the new concept 'function-bearing unit', which the forty-two medical societies later support almost unanimously in public.

'The term "*frame*" is borrowed from Goffman (1974:21) to denote "schemata of interpretation" … By rendering events or occurences meaningful, frames function to organize experience and guide action, whether individual or collective.' (ibid:464). For our analysis Greenwood & Hinings' (1988:295) offer a useful operationalization of the general frame concept in terms of *interpretive schemas* which contain '… beliefs and values about three principal and constraining vectors of activity:

(1) the appropriate *domain* of operations i.e. the broad nature of an organization's *raison d'être*;
(2) beliefs and values about appropriate *principles* of organizing; and
(3) appropriate *criteria* that should be used for evaluating organizational performance.'

The 'function-bearing unit' concept launched by the Danish Medical Society and the National Board of Health does not fundamentally contest any of these three principal vectors of *domain of operations, the underlying principles of operations, and the evaluation criteria.* Basically, the concept represents continuity in terms of modernization of the medical tradition for specialization. Specialties are still promoted as the basic organizing unit for the hospital field, but they must be adjusted to the general technical and medical development. The underlying operational principle is still based on specialization and assumed economies of scale. The evaluation criteria are broadened via the initial quality definition, but as demonstrated earlier in our analysis, they are narrowed down to more clinical quality criteria in the report's chain of argumentation.

Our case thus seems to reflect incremental and not fundamental changes in the medical interpretive schema, and leads to the concluding that the medical profession is remaining within its established frame in carrying out the task assigned by the Hospital Commission and the National Board of Health. This may result in the production of relevant advice on the planning of medical activities that rests on well-informed, practice-based professional knowledge. But it is in our case difficult to argue convincingly that this is an answer to a question, which questions the interpretive schema.

The framing process initiated by the task force can be regarded as '..conscious strategic efforts by groups of people to fashion shared understandings of the world and of themselves that legitimate and motivate collective action.' (McAdam, McCarthy & Zald, 1995:5-6). This mobilization of the medical societies seems to happen through *frame bridging*, i.e.' … the linkage of two or more ideologically congruent but structurally unconnected frames regarding a particular issue or problem.…' (Snow et al., 1986:467) in terms of the linkages between the FBU concept and the specialties' planning models.

The new FBU concept also initiates processes of *frame amplification* – '…the clarification and invigoration of an interpretive frame that bears on a particular issue, problem or set of events.' (ibid:469) – first with regard to *value amplification* around the new quality concept, which involves '…the identification, idealization, and elevation of one or more values presumed basic to prospective constituents but which have not inspired collective action for any number of reasons.' (ibid:469).

Furthermore, *belief amplification* seems to happen. Snow et al (1986:470) summarizes five beliefs, which from the literature on social movements seem particularly important for processes of mobilization and participation:
(1) the seriousness of the problem, issue or grievance in question
(2) beliefs about the locus of causality or blame
(3) stereotypic beliefs about antagonists or targets of influence
(4) beliefs about the probability of change or the efficacy of collective action
(5) beliefs about the necessity and propriety of 'standing up'.

Besides the Medical Society's efforts to amplify the belief of causality (2) in terms of the means-end relation between quality and quantity, upon which our analysis has focussed, also (1), (4) and (5) seem to be activated in the efforts to mobilize the professional community. The qualities of professional services are defined as being at stake (1), coordinated professional action is staged (4) and the necessity of the medical professions to articulate their view (5) is emphasized.

The 'function-bearing unit' can thus be interpreted as a response from the medical community to environmental pressures, and as an effort to both create professional consensus and mobilization. In relation to the ongoing reorganization of the hospital system, the medical societies launch a modernized medical logic and argue for the medical, experience-based expertise as the necessary and legitimate premise for decisions concerning the future organization of hospital services. The pressure and risk of exclusion from decisions on organizing, built up by the composition and critical questions of the Hospital Commission and by the intervention of the Ministry of Health and the counties in the task force, seem to represent an external threat that provides the basis for mobilization. The theorization process seems to be an element in the generating a professional movement led by the surgical societies as the early innovators.

The consensus apparently emerging around the new concept is far from usual in a fragmented professional community consisting of as many as forty-two specialties. However, our data do not provide a basis for evaluating the degree of internal consensus behind the medical profession's external support of the FBU concept.

IV: Conclusion

Linking intra- and extraprofessional aspects: field framing processes

As our analysis has revealed, the Danish hospital field is characterized by structural conflicts. Conflicts between the Ministry of Health, the National Medical Board, the Medical Societies and the counties, as well as between the medical profession and the 'New Public Management movement' personified by managers, economists and planners and the Hospital Commission. However, the field is also characterized by being integrated in the welfare state, by the almost absent competition from private hospitals, by the integration of the medical profession in the regulatory agencies – the National Board of Health serves as example - and last but not least by a tradition and shared interest among the field constituents to collaborate.

In this light, the normative processes may be regarded not only as responses by the medical community to pressures from other constituents with the purpose of strengthening its position, but also as reactions intended to contribute to create a platform for future regulation of the field's activities. This is what seems to happen by the launching of the new concept of 'function-bearing unit'.

The concept is novel, attracts attention and provokes curiosity: what is the concept meant to imply? It is only defined broadly as a 'professional organizational unit' (Dansk Medicinsk Selskab, 1998:34-45). As a concept that allows for diverse interpretations, it may have the potential for fulfilling certain of the three functions that Blumer (1969:157-159) ascribes to concepts: transcendence, content loading and verbalization:

(1) the concept liberates frustrated activity and enables new action – 'transcending the given perceptual world';
(2) the concept permits one to catch and hold some content of experience and make common property of it – 'the content conceived';
(3) the concept makes possible the communication of experience – 'the verbal character of the concept'.

First, the function-bearing unit draws legitimization from being supported by both all the Danish medical societies and the National Board of Health. Second, the concept has positive connotations and its intended ends are positive to all field constituents. The function-bearing unit is assumed to plan and perform outpatient tasks, emergency and elective functions - based on existing hospitals in the given county. Furthermore, the medical societies expect the function-bearing unit to plan functions in direct collaboration with the primary sector, and especially with a view to establish rational coherent patients flows (Dansk Medicinsk Selskab, 1998:35).

Third, even though the concept explicitly points towards the need for increased coordination and collaboration across county boundaries, it does not contest the counties' role as 'owners' of and responsible for the hospitals. In relation to local political interests, the concept does not question the maintenance of smaller hospitals in that it clearly respects current physical frameworks and only refers to the FBU as an ‘organizational unit that constitutes the framework for the aggregate services of a medical basic specialty…’ (Dansk Medicinsk Selskab, 1998:34). Instead, the concept advocates increased interor-

ganizational collaboration - both within and across county borders - and among hospitals. Thus, the concept complies with the pressures and discussions that are already part of current debates in the field.

In this light, the concept may provide, via *frame extension*, a platform for interpretation, dialogue and experimentation as it '…encompass(es) interests or points of view that are incidental to its objectives but of considerable salience to potential adherents. In effect, the movement is attending to or being congruent with the values or interests of potential adherents.' (Snow et al. (1986:472).

In this connection the concept's loose character and lack of hard evidence may be positive aspects that contribute to give it the status of not being a centrally designed and top-down implemented, restrictive organizational model. With its lack of specification the concept provides no restrictions. It allows all the different field constituents to engage in local processes of editing and translation, as witnessed in the continuous modification of the patient basis parallel to the adoption of the concept - and in the counties labelling local plans or practices as FBUs.

Methodological endnote

Our analysis has illustrated that a new, attention-attracting concept can serve as a productive point of departure for disentangling field dynamics. The concept of 'function-bearing unit' has led to the tracing of important historical field events, the structuring of the field, important field constituents, and structural conflicts. It has provided a preliminary insight into the central professional community, and provided an initial understanding of the organizational field. It has provided some answers, but created more questions to be pursued. These include a closer scrutiny of the roles of professional societies and associations, conflicts and consensus within the medical community, and variations and patterns in the counties' ongoing interpretation of the function-bearing unit.

In order for a concept to have this 'snow-ball' effect it is necessary to treat it not as a stabilized unit, but as a sign with multiple designations, a socially embedded object, and an emergent phenomenon.

References

Bentsen, E.Z. (1996) *Sygehusledelse i et institutionelt perspektiv – en analyse af trojkaledelsesmodellens opståen, spredning og funktion.* Phd-dissertation. Copenhagen: Institute of Organization and Industrial Sociology.

Blumer, H. (1969) *Symbolic Interactionism Perspective and Method.* Berkeley and Los Angeles: University of California Press Ltd.

Borum, F. (1997) *Transforming Hospital Management: The (Im)possibility of Change.* Papers in Organization. Copenhagen: Department of Organization and Industrial Sociology.

Brunsson, N. (1990) Deciding for Responsibility and Legitimation: Alternative Interpretations of Organizational Decision-Making. *Accounting, Organizations and Society*, Vol.15, No.:47-59.

DiMaggio, P. & W. Powell, (1991) The iron cage revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. In Powell, W. & P.J. DiMaggio (Eds.) *The New Institutionalism in Organizational Analysis,* Chicago: University of Chicago Press (s.63-82).

Freidson, E. (1994) *Professionalism Reborn – Theory, Prophecy and Policy.* London: Polity Press.

Freidson, E. (1971) *Profession of Medicine – A Study of the Sociology of Applied Knowledge.* New York: Dodd, Mead & Co.

Goffman, E (1974) *Frame Analysis*. New York: Harper & Row.

Greenwood, R. & C.R. Hinings (1988) Organization Design Types, Tracks and the Dynamics of Strategic Change. *Organization Studies* 9/3: 293-316.

Greenwood, R., Roy Suddaby & C.R.Hinings (1999) The Role of Professional Institutes in the Transformation of Institutionalized Fields. Paper presented at the EGOS 1999 Conference, Warwick University.

Kragh Jespersen, P. (1999) New Public Management reformers betydning for den administrative og lægefaglige profession i sygehusorganisationen, p.143- 169, in Bentsen, E.Z., F. Borum, G. Erlingsdóttir, K. Sahlin-Andersson *Når styringsambitioner møder praksis. Den svære omstilling af sygehus- og sundhedsvæsenet i Danmark og Sverige.* Copenhagen: Copenhagen Business School Press.

Kragh Jespersen, P. & Hanne Sognstrup (1999) *Politikdannelse og organisering i det danske sygehusfelt.* FLOS Arbejdspapir. Copenhagen: Department of Organization and Industrial Sociology.

Krasnik, A. & S. Vallgårda (1998) *Sundhedstjeneste og sundhedspolitik.* København: Munksgaard.

Larson, M.S. (1977) *The Rise of Professionalism: A Sociological Analysis.* Berkeley: University of California Press.

Latour, B. & F. Bastide (1986): Writing Science – Fact and Fiction: The Analysis of the Process of Reality Construction Through the Application of Socio-Semiotic Methods to Scientific Texts, p. 51-66, in Callon, Michel, John Law, Arie Rip: *'Mapping the dynamics of science and technology'.* Houndmills.

Law, J. (1986) The Heterogeneity of Texts, p. 67-83, in Callon, Michel, John Law, Arie Rip: *'Mapping the dynamics of science and technology.'* Houndmills.

McAdam, D., J.D.McCarthy & M.N.Zald (1996) *Comparative Persepctives on Social*

Movements. Cambridge: Cambridge University Press.
Orton, J.D & K.E.Weick (1990) Loosely Coupled System - A Reconceptualization. *Academy of Management Review*, Vol 15/2:203-223.

Røvik, K.A. (1998) *Moderne Organisasjoner. Trender i organisasjonstenkningen ved tusenårsskiftet.* Bergen-Sandviken: Fagbokforlaget.

Sahlin-Andersson, K. (1996) Imitating by Editing Success: The construction of organizational fields. In Czarniawska, B. & G. Sevón (Eds.) *Translating Organizational Change.* Berlin: de Gruyter.

Snow, D.A., B.Rochford, S.K.Worden & R.D.Benford (1986) Frame Alignment Processes, Micromobilization, and Movement Participation. *American Sociological Review*, vol 51: 464-481.

Scott, W.R., M. Ruef, P. Mendel, & C.A. Caronna (2000) *Institutional Change and Healtcare Organizations. From Professional Dominance to Managed care.* Chicago & London: The University of Chicago Press.

Strang, D. & Meyer, J.W. (1994) *Institutional conditions for diffusion.* In Scott, R.W. & J.Meyer (eds.) *Institutional Environments and Organizations.* Thousand Oaks, California: Sage Publications (pp.100-112).

Vallgårda, Signild (1992) *Sygehuse og sygehuspolitik i Danmark. Et bidrag til det specialiserede sygehusvæsens historie 1930-1987.* København: Jurist- og Økonomforbundets Forlag.
Vrangbæk, K. (1999) New Public Management i sygehusfeltet – udformning og konsekvenser, p.33-56, in E.Z. Bentsen, F.Borum, G. Erlingsdóttir & K. Sahlin-Andersson (red.): *Når styringsambitioner møder praksis.* Copenhagen: The Copenhagen Business School Press.

Data sources

Dansk Kirurgisk Selskab (1996) Kirurgisk organisation, udvikling og kvalitet. Århus: Lægeforeningens Forlag.

Dansk Medicinsk Selskab [the Danish Medical Society] (1998): *Lægefaglig basis for sygehusvæsenets struktur. Kvalitet, organisation, uddannelse og forskning i den funktionsbærende enhed.* Århus: Lægeforeningens Forlag.

De medicinske selskaber [the Medical Societies] (1998): 'Materiale fra de videnskabelige selskaber i forbindelse med Sundhedsstyrelsens arbejdsgruppe vedr. kvalitet i patientbehandlingen og deraf følgende problemstillinger'. Sundhedsstyrelsen, København.

Bind 1: 'Materiale fra de videnskabelige selskaber i forbindelse med Sundhedsstyrelsens arbejdsgruppe vedr. kvalitet i patientbehandlingen og deraf følgende problemstillinger - De kirurgiske grund-og grenspecialer.'

Bind 2: 'Materiale fra de videnskabelige selskaber i forbindelse med Sundhedsstyrelsens arbejdsgruppe vedr. kvalitet i patientbehandlingen og deraf følgende problemstillinger - De medicinske grund-og grenspecialer.'

Bind 3: 'Materiale fra de videnskabelige selskaber i forbindelse med Sundhedsstyrelsens arbejdsgruppe vedr. kvalitet i patientbehandlingen og deraf følgende problemstillinger - De tværgående specialer, Amtslige sundhedsforvaltninger, Patientforeninger'.

Fyns Amt [Funen County] (1999) *Strategi og modeller for fremtidens fynske sygehusvæsen*

Perspektivplanredegørelse II (1973)

Regeringen [the Government] (1999) *Regeringens oplæg til Strategi for sygehuspolitikken 2000-2002*

Sygehuskommissionen [the Hospital Commission] (1984) *Sygehusenes organisation og økonomi.* Copenhagen: Indenrigsministeriet.

Sygehuskommissionen [the Hospital Commission] (1997) *'Udfordringer i Sygehusvæsenet'* Betænkning fra Sygehuskommissionen. Copenhagen: Betænkning nr. 1329.

Sundhedsstyrelsen [the National Board of Health] (1998) *Kvalitet i sygehusvæsenet. Befolkningsgrundlagets betydning for kvalitet i patientbehandling, uddannelse og forskning.* Debatoplæg, Sundhedsstyrelsen