Implementing an hospital accreditation program in a context of NPM reforms: Pressures and conflicting logics

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This paper examines how an accreditation program emerged and developed in an hospital in the context of New Public Management reforms. A case study was conducted to investigate how a new logic coexisted with the prevailing logic.

Our findings suggest that accreditation programs, can provide the encounter between quality assurance practices and technical medical expertise, thus allowing the coexistence of different logics that traditionally conflict with each other. Accommodation occurs when the initiative does not interfere with professional identity and autonomy of professionals, and if collaboration that fosters trust and cohesion is promoted, thus preventing resistance to change.

Key Words: hospital accreditation; new public management; institutional logics; collaboration; health sector.

Introduction

NPM emerged in Europe in the 1980s. Under its scope, the public sector has been the target of major public management reforms. In Portugal, these transformations were felt in the public healthcare sector since late 1990s, when managerialism entered smoothly in the field and led to the emergence of health quality concerns (Correia & Denis, 2016). Since then, the need to achieve higher quality on healthcare and to enhance hospital's efficiency, became regarded as paramount. Accreditation programs for hospitals started to disseminate, introducing quality as a core concern. Accreditation, quality and continuous improvement have become usual terms in health services discourse (Greenwood & Braithwaite, 2008), but scientific research has not provided evidence about its impact towards NPM concerns. There are no clear results on the impact of accreditation programs on organizations and professionals, and how the initiative leads to a change towards a culture of quality, avoiding the possible decoupling that may occur between organizational performance and the representation by the audited system (Power, 1996; Robbins et al., 2022). To enhance understanding on how an accreditation program was introduced in a hospital and the dynamics associated to its adoption, we have conducted a case study in a Portuguese public hospital (Sant'iago do Outão's Orthopaedic hospital – henceforth called 'HOSO'). Our aim was to analyse how do professionals manage the dynamics associated with the development of a continuous quality system.

Traditionally there is a conflict between *professional* and *business* logics (Reay & Hinings, 2009, 2005) given the different identities, values and practices, the "frames of reference" (Thornton et al., 2012, p. 2), which guide physicians' behaviour. Most of the existing studies expose this coexistence of multiple logics in organizations as incompatible (Nicolini et. al, 2016; Siris, 2019). In our case, the two competing logics coexisted for a long period of time, despite the introduction of the accreditation program

has stirred the waters of the institutional arena. Applying the Besharov and Smith (2014) framework, we found that organizations characterized as *contested*, are able to self-transform into *aligned* ones. Our findings suggest that accreditation programs, can provide the encounter between quality assurance practices and technical medical's expertise, thus allowing the coexistence of different logics in situations where there is no interference with the medical staff's identity and autonomy. In such cases, resistance from doctors is overcome and collaboration is promoted. Literature on collaboration as a source of change in institutional theory is scarce (Lawrence et al., 2002; Thornton et al., 2012). Our empirical findings provide evidence on different mechanisms that can reinforce these collaborations.

The paper is structured as follows. Literature review on NPM and accreditation developments in the healthcare sector, as well the literature on the multiplicity of institutional logics is presented in Section 2. Section 3 describes the methodology adopted in the investigation. In Section 4, the empirical study is developed. The paper ends with the presentation of a discussion of the findings and conclusions in Section 5.

New Public Management and accreditation in the healthcare sector

Quality concerns in hospital setting can be tracked back to 1854, during the Crimean war, when an English nurse, Florence Nightingale, developed practices that decreased the mortality rate among wounded soldiers from sixty percent to a stunning one percent (Chassin & O'Kane, 2010). These sporadic and disjointed quality practices gained momentum over time when NPM spread throughout the healthcare sector. Under the scope of NPM, public sector faced a public management reform towards accountability and organizational best practices (Hood, 1995; Meyer & Hammerschmid, 2006). Public

sector legitimacy became to be judged on the basis of outputs (e.g., number of treatments), competitiveness and entrepreneurialism, outcomes (e.g., patients improved health status) and efficiency contrariwise to bureaucratic rules that were the focus until then (Andrews & Van de Walle, 2013; Meyer & Hammerschmid, 2006; Singh & Slack, 2020). These "[e]fforts to increase efficiency have involved new systems for organizing service delivery and managing organizations" (Angelis et al., 2021, p. 264). In healthcare sector, the hospital turned into a business, patients became costumers (Clarke et al., 2007) and professional boundaries of hospital managers and physicians underwent major changes (Lapsley, 2008; Reay & Hinings, 2009). "[T]he long-standing dominance of the biggest spenders within the National Health Service, the doctors" (Dent, 1995, p. 881) was eroded by the introduction of business elements emphasizing efficiency, hierarchy marked by line management, and economic and managerial control (Sirris, 2019). This resulted in tensions in healthcare as physicians felt their authority and power to be affected (Lapsley, 2008; Pollitt et al., 1988; Reay & Hinings, 2009; Robbins et al., 2022). Traditionally hospital decision making, was dominated by doctors, relegating managers to a subordinate position restricted to nonclinical and support functions (Carr & Beck, 2020). NPM gave rise to increased responsibility and accountability to hospital managers and the involvement of doctors in management decisions. In healthcare sector, typically dominated by professional discretion, NPM movement entailed the adoption of "explicit formal measurable standards and measures of performance and success" (Hood, 1995, p. 97). Trust in physicians' expertise was not enough, as they were required to provide "high-quality essential care, defined mostly by criteria of effectiveness, cost and social acceptability" (WHO, 2000, p. xiii). NPM aspired to provide public services with enhanced quality as part of its efficiency objectives (Andrews & Van de Walle, 2013; Singh & Slack, 2020). Along with these

efficiency targets, a series of measures were developed so that stakeholders (e.g., government and citizens) could assess the performance of public services. Different quality assessment systems were developed to ensure transparency, and one of these NPM-inspired reforms was accreditation programs.

Accreditation programs for hospitals started to disseminate and brought associated bureaucratic quality practices. The process is categorized as bureaucratic mainly due to the obligation to hold meetings and record data relating to the standards manual (cf. Pomey et al., 2004). Accreditation is a formal process of evaluation by which an external recognized body assesses the compliance of organizations with pre-existing standards (Cooper et al., 2014). It can be either a mandatory or a voluntary process, despite being more usual the voluntary nature as its effectiveness is enhanced if it stems from a non-threatening and interacting process (Montagu, 2003). Leadership and staff engagement are also considered key figures in its successful implementation as it enhances willingness of staff to undertake change (El-Jardali et al., 2008; Groene et al., 2014). The concept is well differentiated from inspection and performance management as focusing on continuous quality improvement rather than constituting a control measure (Pomey et al., 2005).

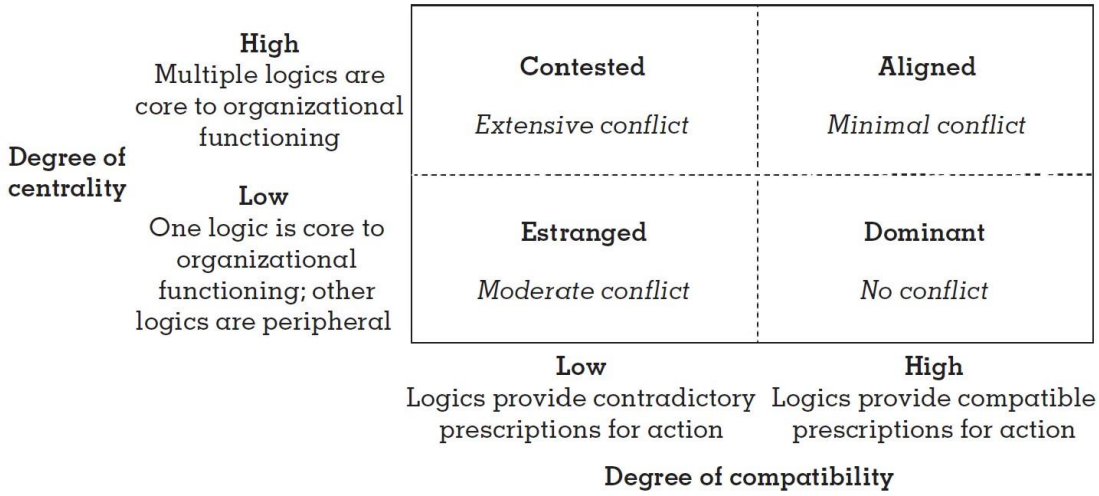
While accreditation has been recognized as integrating the NPM movement there are no clear results on the impact of accreditation programs on organizations and professionals, and how the initiative steer change towards a culture of quality. To enhance understanding on the topic we adopt the institutional logics perspective, which we revise now.

Institutional logics

Organizations such as that of hospitals, are often exposed to institutional complexity, being confronted to prescriptions from multiple, and sometimes conflicting, institutional logics (Greenwood et al., 2011; Scott et al., 2000). Some fields are more predestined to present enduring competing logics. This is the case of the health sector with a wide variety of professions, each conditioned by different logics (Reay & Hinings, 2009; Scott et al., 2000). Most existing studies expose the coexistence of multiple logics in organizations as incompatible and emphasize the replacement of one logic by another (Greenwood et al., 2011; Thornton & Ocasio, 1999). Despite this dominant discourse, more recent research suggest that organizations may exercise some level of strategic choice (Pache & Santos, 2010), also admitting the long-term coexistence of multiple logics (Besharov & Smith, 2014; Reay & Hinings, 2009).

Besharov and Smith (2014) proposed a framework to understand the heterogeneity in how multiple logics manifest within organizations, considering the centrality of logics ("the degree to which multiple logics are each treated as equally valid and relevant for organizational functioning" (p. 375)) and the dimension of compatibility ("extent to which the instantiations of logics imply consistent and reinforcing organizational actions" (p. 367)). Framed in these two dimensions, Besharov and Smith (2014) proposed four ideal types of organizations: *contested*, *estranged*, *aligned* and *dominant* (cf. Table 1).

Table 1 – Types of logics multiplicity within organizations



Source: Besharov and Smith (2014, p. 371)

Contested organization occurs when members are confronted with different goals, values and identities, and different ways of achieving them (low compatibility); and, the existence of multiple logics looking for dominance generates dispute (high centrality). In *estranged* organizations, as in *contested* ones, the goals, values and identities, and the ways to achieve them are different; but in this case, there is a dominant logic that stifles the other logics, thereby controlling conflicts (low centrality). In *aligned* organizations the organizational goals are consistent (high compatibility); and, multiple logics with strong influence on organizational functioning exist (high centrality). In this situation, conflict is minimal, creating potential for logic blending, combining multiple logics into a new one. Lastly, *dominant* organizations are characterized by high compatibility and low centrality, due to the fact that multiple logics are compatible in terms of goals, with a single dominant logic prevailing. The combination of high compatibility with low centrality results in the predominant logic being reinforced by one or more existing logics.

Institutional complexity became to characterize healthcare organizations particularly after NPM reforms (Reay & Hinings, 2005; van den Broek et al., 2014).

Hospitals have become hybrid structures as their legitimacy depends on balancing professional and business goals (Greenwood et al., 2011), shifting from a dominant logic, the *professional* logic, to the coexistence of multiple logics (Scott et al., 2000). This centrality of both *professional* and *business* logics which infuse core organizational practices in the field (cf. Reay & Hinings, 2009), combined with the institutional complexity, characterizes this healthcare organizations as *contested* ones (cf. Besharov & Smith, 2014).

Accreditation programs are inherent to *business* logic that coexists with the *professional* logic. *Business* logic relates market, but bureaucracy elements might make also part of the logic as is the case of the Portuguese healthcare sector. It emphasizes efficiency, hierarchy marked by line management, and economic and managerial control (Sirris, 2019). *Professional* logic respects specialized occupations, being characterized by "autonomy, discretion, and trust" (Sirris, 2019, p. 1). Self-regulation and autonomy is what differentiates professionals from other workers. Physicians have been seen as the paragon professionals (Abbott 1988; Freidson, 1986). The high degree of skills and technical knowledge, control of work, self-regulation, autonomy and independence, accepting only guidance and supervision from a respected peer, is what differentiates these professionals from other workers (Freidson, 2001). Professional autonomy and clinical freedom have been important in the construction of physicians' identity (Doolin, 2002), explaining physicians' negative reactions towards the efforts to control their clinical practice and behaviour. Institutional theorists have recognized the important role that identity plays in a process of institutional change; it can affect the process or even block it (Creed et al., 2010; Meyer & Hammerschmid, 2006; Thornton et al., 2012). In that sense, management initiatives, such as accreditation programs,

suffer resistance if perceived as a mere control instrument (Marquis & Lounsbury, 2007).

Reay and Hinings (2009) address this resistance, identifying mechanisms to manage the rivalry of competing logics. Thought collaborative relationships, concurrent logics can coexist for long periods of time. Collaboration may be defined "as a cooperative, interorganizational relationship that is negotiated in an ongoing communicative process and that relies on neither market nor hierarchical mechanisms of control" (Lawrence et al., 2002, p. 282; see also Castañer & Oliveira, 2020; Ingstrup et al., 2021). Collaborations can reinforce stability or become a source of institutional change (Lawrence et al., 2002). However, in hospitals one of the parts has specific knowledge that is crucial to reach the objectives, holds strong identities and the power to maintain their independence. In this type of collaboration, maintaining identities is essential for collaboration to happen. Beech and Huxham (2003) studied how identities affect collaboration in organizations and how trust, essential for those collaborations, is mined or incited. Trust is commonly associated as a precondition for successful collaborations (Huxham & Beech, 2003). According to Jones and George (1998, p. 532; see also Kostic & Sedej, 2022) "trust leads to a set of behavioral expectations among people, allowing them to manage the uncertainty or risk associated with their interactions so that they can jointly optimize the gains that will result from cooperative behavior". Notwithstanding the above, trust is not a pre-condition for cooperation "because cooperation does not necessarily put a party at risk" (Mayer et al., 1995, p. 712). These mixed results reflect different types of collaborations. As Reay and Hinings (2009, p. 633) argue "[d]ifferent intentions, different learning approaches and different goals are all associated with different patterns of collaborative activities, and ultimately different outcomes".

Methodology

Setting the scene

With the NPM ideology spreading in Portugal, the quality of public services became a concern. In 1993 the Portuguese Directorate General of Health (DGS), responsible for planning and programming the national policy for quality in the health system, created a norm that stated that "quality commissions should be established in all health facilities, with the aim of developing and implementing quality programs" (Pisco & Biscaia, 2001, p. 45). Although, initially, this norm had no practical effects, concern with the quality of healthcare began, in a very shy way, to take its first steps. Thence, during the period of 1986-1996, nearly a third of the health budget was directed towards health quality training. Despite all the investment, results were not visible, mainly because these quality trainings were carried out by multiple entities without a direct connection to specific quality programs (ibid). In 1999 the Court of Auditors, with jurisdiction on public expenses, recommended that "the accreditation of health institutions to users, by certifying the quality of the services they provide within the scope of the national health system should be promoted, as in other areas" (Tribunal de Contas, 1999, p. 34). From 1999 to 2003 quality on healthcare was boosted by the availability of European Union funds, with around € 3,5M (5% of the total amount) for quality improvement in healthcare (Ministério da Saúde, 2000). Aiming to provide better access and quality healthcare, certification and quality assurance were promoted under a strategy that was named Health Quality Portuguese System (HQPS). The development and implementation of this quality system involved several projects, one of them being a national accreditation program. Therefore, in 1999, a collaboration protocol for the

development of the Portuguese health quality system between the Ministry of Health (MoH) and the King's Fund's Health Quality Service (KFQS) was signed (IQS, 2005). Seven public hospitals were part of a pilot program to participate in this quality service accreditation (IQS, 2000), which was followed by the addition of sixteen other public hospitals that self-proposed to participate in this program (IQS, 2004). In 2004 a new hospital accreditation model was adopted, the Joint Commission International (JCI). Fourteen public hospitals initiated this new program but only five reached the accreditation (Health Quality Institute (IQS) Director 2000/05). In 2008, a third accreditation model was contracted, the Agencia de Calidad Sanitaria de Andalucía (ACSA). The general picture of accreditation of Portuguese hospitals, in 2019, reveals that the vast majority remains unaccredited. Out of a universe of 111 public hospitals, eleven are accredited by KFQS, five have the accreditation by JCI and twenty hospitals have some services accredited by ACSA. Currently it is mandatory that hospitals join a full accreditation program. However, after more than ten years of collaboration between Andaluzia and Portugal, there is only one hospital totally accredited by ACSA (www.dgs.pt accessed on July 2021). This is a consequence of the accreditation process being initiated by hospital services. Furthermore, notwithstanding the mandatory nature of accreditation, no penalty is considered in hospitals funding if they do not comply with that legal requirement. However, it is possible to say that "the culture has changed: in the past, the culture was doctor-centered, nowadays it is patient-centered" (KFQS auditor).

Research methods and methodology

A longitudinal and an exploratory case study (Eisenhard & Graebner, 2007; Yin, 2018) was carried in HOSO, which voluntarily implemented an accreditation program as a response to the challenges posed by the MoH towards these quality initiatives. A

research question was posed: how professionals managed the dynamics associated with this quality assessment system.

The research has followed the steps delineated by Eisenhardt (1989) and Yin (2018). In order to validate and triangulate the collected data, the study relied on diverse sources of evidence: documentation, archival records, interviews and direct observations (Yin, 2018). Documentation and archival records (among others official MoH reports, legislation, World Health Organization (WHO) documentation, European Union quality documentation, quality and accreditation manuals, IQS magazine), were an extremely relevant source of evidence. The collection of evidence also comprised interviews that were carried out in two parts: pilot study, from March 2012 to December 2013; and the main study that started in November 2017 and lasted until June 2019. In total, 32 interviews were conducted, lasting 55.5 hours. In the pilot study, interviews were directed to understand the environmental pressures that led HOSO to initiate an accreditation program and to get knowledge of HOSO processes and organization. The main study began in 2017 as it was necessary to deepen the investigation and understand the intricacies of the accreditation process. About 63% of the interviews were recorded, transcribed and triangulated with notes taken during and after the interviews. When the interview involved the observation of processes or when took place in the emergency room, preventing the researchers to tape-recording them, field notes were taken. Interviews were semi-structured using an adapted script for each interview, moving away from "one-fit-fits-all structured approach" (Mason, 2002, p. 64), but always anchored in the need to answer the research question. In addition to HOSO elements, politicians and responsible for the national quality area were also interviewed (e.g., former Minister of Health; former presidents of the IQS; auditor from KFQS, who is currently in charge of HOSO's re-accreditation; the director of DGS;

and, the coordinator of the health accreditation model for the national health service). The use of multiple sources of data and multiple methods allowed the researchers "to address a broader range of historical, attitudinal, and behavioral issues" but the major advantage was the data triangulation (Yin, 2018, p. 98). Miles et al. (2019) recommendations to analyse data were followed, allowing researchers to develop three concurrent flows of activity: data reduction; data display; and conclusion drawing/verification. By organizing data in a sensible way, researchers were able to tease out themes and find out patterns that summarized parts of the collected data, allowing them to sharpen, sort and discard information so that conclusions could be drawn.

Accreditation program at HOSO

HOSO origins date back to 1390, when it was built as a fortress. In the 20th century, after being converted into a prison and a residence for the Royal family, the fortress was converted to a sanatorium, the first in Portugal. More recently, with the drastic reduction of tuberculosis, it was transformed into an orthopaedic and traumatic referenced hospital. HOSO is located in the outskirts of Setubal (a city 50 Km South of Lisbon), having around 300 employees.

When the first ideas for HOSO accreditation began to emerge, this hospital was considered a small family hospital. Quality issues were not a novelty for HOSO. In the 1990s the hospital had already mandatory (e.g., infection control) and voluntary commissions (e.g., humanization) with the aim of improving the quality of the hospital's facilities and services provided. In early 2000, an orthopaedic physiatrist from HOSO, Dr. P, presented the potential (towards the area of general risk) of an accreditation program to the chairman of the Board of Directors of HOSO, who reacted

positively as it was a program that met his concerns. At that time, accreditation programs were more oriented towards general risk than to the clinical area, which was only developed later. While there was goodwill and, in some cases, voluntary commissions, quality and prevention programmes were in general regarded as secondary. However, for the chairman of the Board of Directors, accreditation represented being more capable than peers, embracing the sense of recognition of work done and of pioneering:

> [W]hen we launched the process, we had two objectives. The first one was the motivation of the professionals, which was fundamental (…). The second was the hospital to present itself to the community with a process that granted recognition and trust for users. They could feel safe using hospital services. (Chairman of the Board of Directors at HOSO)

A multidisciplinary committee (comprised by Dr. P as coordinator, a nurse and a hospital administrator) was created to launch the hospital accreditation program. As a result, in 2003 HOSO awarded a contract with KFQS, and the accreditation process formally began. The King's Fund was an English foundation recognized as having the best experts in some areas and this fact was seen as an asset to the program, having even been mentioned that it conveyed an "aura" to the initiative (Dr. P, Physiatrist). To coordinate the accreditation process, a KFQS client manager came to the hospital periodically (every three months) and a multidisciplinary Accreditation and Quality Improvement Commission (CAMQ) was established (with Dr. P as the coordinator).

A quality improvement strategy was established, remaining until present days, covering the accreditation process and all quality operations of HOSO. To operationalize this quality strategy, it was created: a Clinical Administration Committee, responsible for the clinical area; the Risk Management Commission, covering the areas of general and clinical risk; and, the Patient Experience Group,

which, together with the social services, focused on the patient's needs. This quality organizational structure had as coordinators, the chairman of the Board of Directors and senior heads of the respective technical areas. The choice of the main leaders intended to signal the relevance of the project, also aiming to facilitate the participation of professionals, which was considered as paramount. In addition, groups were created with representatives (physicians and nurses) from each service with the responsibility of transposing the quality norms and standards to the specific practices of each service. This was accompanied by clarifying and training sessions that took place mainly during the initial phase of the project. The development of these activities proved to be time consuming, especially with the new writing requirements implying the need for overtime work. As a result, resistance to this process of change became increasingly evident:

> In the beginning people refused to participate in commissions because it was not mandatory (…). It was a difficult process to manage (…). It involved a lot of time in meetings. We already had good practices, but they were not written procedures. (Service Director at HOSO)

The impact of managerial initiatives on practices of health professionals has not been uniform. In some cases, there has been an accommodation of doctors to the *business* logic while, in others, physicians have resisted to managerial and administrative tasks (Gebreiter, 2017). At HOSO, the full-time activity as technical specialists added to the management responsibilities that the service directors had, left little or no time for new assignments.

> [W]e always find that people can do everything, because in this hospital the service directors perform surgical operations, see patients, not having a dedicated time to the direction of the service (…). Often it is a personal choice, because they do not want to stop exercising, but other times it is out of necessity, due to lack of

> resources… and implementing such a process as this was [accreditation], is a huge burden for people. (Dr. P, Physiatrist at HOSO)

The first phase of the accreditation process, learning the KFQS manual, was ensured by the CAMQ. For each service, a document *Caderno de Encargos* was prepared, setting all the standards from the KFQS's manual that each service had to comply and the documentary evidence that should be prepared. To organize this volume of documentation, a Quality Documental Management System was developed involving the establishment of a circuit for the preparation, verification, rectification and dissemination of documents. 'Write what you do, and, do as you wrote' was one of the slogans of the program and a major transformation in HOSO's practices. However, this shift from a verbal to a writing culture was not a peaceful change. For instance, patients' clinical history had to be written daily in clinic diaries, a practice that was already usual for nurses, but not for doctors. At HOSO this culture change was felt more acutely, as specialties with lots of surgery practice such as orthopaedics, have not the custom of keeping records.

> [T]he more we migrate to specialties within surgical specialties the less records are made, because they are individuals trained to sew, tear and cut, not to write (…). A good surgeon wants to operate, does not want to write, and the last surgeons on this scale are orthopaedists. (Dr. P, Physiatrist at HOSO)

> Nurses are different from doctors. They are much better organized than doctors. They are used to schedules, records, and writing everything down. We doctors, do not. (…). For us physicians, it was very difficult not only to communicate, but to accept. (Service Director - HOSO)

In the self-assessment phase, current practices were compared to standards that reflected best practices. When there was no alignment of practices with standards, changes were implemented. For example, the discretionary nature of medical

procedures, where doctors used to visit the wards and 'their patients' when they wanted to, gave way to a standardization of the process. With accreditation, visits for clinical observation were scheduled for specific days of the week, covering all patients in that ward, not just the specific patients of each doctor.

> Doctors have a lot of autonomy. We have our hierarchy in hospitals, but each one of us is responsible for the acts performed and standardization is not easy. We have performance standards, and every doctor has to know the best practices for their profession and their actions - but that did not mean having a script. (Dr. P, Physiatrist - HOSO)

This standardization was limited to the general risk area. Clinical risk area was restricted to hygienic and safety norms, not interfering to the way doctors treat their patients. Specific rules for the orthopaedic area were not foreseen in the manual of specialized and clinical services (KFQS Manual for HOSO) guaranteeing the independence and autonomy of physicians in HOSO. For example, a specific standard indicates how medical equipment must be sterilized in the operating room, but the physician has the autonomy to decide which equipment he will use in each surgery.

Leaders of the project counted on the physician’s involvement and their collaboration in the process of transposing the standards from KFQS manual to the actual practices to be implemented at HOSO. This process involved an enormous amount of criteria that had to be discussed, and operationalized, also implying the need to produce evidence that the hospital was in accordance with the standard. This involved holding numerous multidisciplinary meetings, which brought together professionals from different classes. The exchange of opinions and the promotion of dialogue made possible to identify the need to change practices when they were in disagreement with the standards. These collaborative relationships occurred as a way of responding to all procedural writing obligations that the program required.

> [I]t was usual to have doctors on the one hand, and nurses on the other, but with this process we often had to join nurses with doctors and with other hospital professional classes. There was an approach and a sense of team spirit, even with other professionals. (Service Director-HOSO)

> This process brought greater team unity as it put people who spoke by circumstance sitting at a table discussing these issues. (Chief-nurse 2)

This collaborative working was extended to clinicians and the leaders of the accreditation process, being key for its implementation, overcoming initial resistance.

> The chairman of the Board of Directors has always been an administrator that I, as a doctor, realized that he saw HOSO as his second home. He gave himself up to this hospital… it was good for us, as doctors, to see the strength and commitment that he had in getting the hospital accredited (…). Things had to move forward, and they did. In a way there was collaboration from us by seeing the hard work they had; we felt that we should try too. (Service Director-HOSO)

The leadership of the process by the chairman of the Board of Directors and Dr. P was crucial. It took a lot of awareness campaign and a friendly speech for physicians to get involved. The President of Board of Directors was recognized for developing a close relationship, of empathy with all employees. For physicians, this relationship of respect, trust and proximity was as a facilitator of the accreditation process.

> We felt that the 'chief of the orchestra' really had a great commitment to the hospital being accredited (…). Seeing the chairman of the Board of Directors fighting for the hospital was a reason for me to fight (…). Leadership: when we have a leader, who gives everything for the hospital to be a reference, it means we all can do it! (Service Director at HOSO)

Dr. P, who the other doctors recognized as a peer, played also a key role in overcoming resistance.

> I think that if it was not a physician leading the process, if it was another professional but a physician, the resistance from medical class would have been much greater. Dr. P was extremely motivator and always available to answer our questions and help. (Physician at HOSO)

The HOSO accreditation project began in September 2003, the final date of the audit took place in November 2006 and in July 2008, HOSO reached its first accreditation. With the creation of Setubal's Hospital Centre, a new contract was signed with KFQS in 2010, and the hospital centre obtained its first accreditation in 2013, being re-accredited in 2016, 2018 and waits for a focalized auditory to complete the 2022 re-accreditation (www.chs.min-saude.pt, accessed on 21st July, 2022) .

Discussion and conclusions

Exogenous and internal pressures prompt HOSO to a voluntary implementation of an accreditation program. The emergence of the NPM in Portugal, led to a series of reforms in the health sector regarding efficiency and managerialism. It was with the dissemination of NPM values in the country that, in the late 1990s the quality of public services has become a major concern. The idea was that with the introduction of managerialism the delivery of high-quality healthcare had to be prioritized. In order to achieve that, it was required more and better information and "supporting mechanisms as clinical protocols, training, licensing and accreditation processes" (WHO, 2000, p. 137). This involvement with quality resulted in a new strategy for health. Hospital accreditation programs began to spread, introducing in Portuguese hospitals, including HOSO, bureaucratic and quality practices, which was in line with worldwide regulation trends regarding hospital accreditation (Touati & Pomey, 2009), although in Portugal it was manifested with a delay of more than a decade. Through this NPM movement, a

new logic gained space in the healthcare field, calling into question the hegemony of *professional* logic.

Professional and *business-administrative* logics became central in the field, as they infuse core organizational practices (cf. Reay & Hinings, 2009). This hight centrality of both logics, combined with their institutional complexity, characterizes healthcare organizations as *contested* ones (cf. Besharov & Smith, 2014). The belief systems of medical *professionalism* and *business-administrative* logics can imply conflicting demands, as doctors' goal is to provide the necessary medical care, while the goals of the *business-administrative* logic are the effectiveness and efficiency of procedures under a goal of continuous quality improvement. At HOSO, this conflict between institutional logics was reflected in the initial resistance on the part of physicians to the accreditation program. The implementation of an accreditation program is very time consuming and time is a scarce resource for physicians. Accreditation and the *business-administrative* logic include a set of bureaucratic-administrative tasks which, traditionally, are considered as secondary and relegated to nurses. However, at HOSO, the initial resistance from doctors was overcome. Among the practices that have been changed, was the mandatory daily clinical record. This was a common practice for nurses, but not for the orthopaedic surgeons who worked at HOSO. This shift from a *had-hoc* culture to a writing culture represents the materialization of practices, and therefore an important outcome of the work undertaken towards the new 'quality' institution (Friedland, 2012). This also meant a shift on the organizational culture centered on 'I', to a new organizational 'Us' culture. This coexistence of logics, which were competing at the field level, was enabled by the development of mechanisms of collaboration.

Applying the Besharov and Smith (2014) framework, we found that healthcare organizations characterized as *contested*, are able to self-transform into *aligned* ones. Our findings suggest that accreditation programs can provide the encounter between quality assurance practices and technical medical's expertise in situations where there is no interference with the medical staff's identity. The perseverance of the independent identities of collaborators is essential for collaboration to occur (Lawrence & Suddaby, 2006; Reay & Hinings, 2009). All the new procedures and standardizations of the accreditation program did not interfere with the medical act, respecting the physician's clinical freedom. The maintenance of physician's independence and identity enabled collaboration among actors, which is fundamental for the coexistence between the two logics (cf. Reay & Hinings, 2009).

Our research also found that trust was an essential mechanism of collaboration. This study also analysed how leadership fostered cohesion among collaborators and promoted close relationships (El-Jardali et al., 2008; Groene et al., 2014). The gain of trust, attention and adherence of physicians was highly reinforced by the President of Board of Directors who legitimized this process. This legitimacy was achieved: (i) by the solid image of a respectable, straightforward, and available President; and (ii) for his personal involvement in the program. Therefore, leader actions fostered unity and group cohesion, increasing "logic compatibility within the organization" (Besharov & Smith, 2014, p. 368).

Actor's commitment towards these quality issues was also driven by the action of Dr. P. Physicians proved to be the most resistant group and having Dr. P, a peer, as project leader, was an enabling factor. Dr. P's dedication and enthusiasm, the use of consistent narratives and rhetoric and the promotion of a sense of identity and community within the hospital's staff, managed to involve other physicians in the

accreditation project. The great attention to the choice of people who composed and headed the commissions that were created, also revealed the concern to legitimize the accreditation program, conveying the message that it was relevant to the hospital. The creation of multidisciplinary teams aimed to involve all areas in the process, promoting dialog and trust between the different professional classes, creating conditions for the convergence of different opinions (Grant et al., 2004). This dialogue was also enhanced by the numerous multidisciplinary meetings, which brought together professionals who usually did not sit at the same table.

Creating institutions by changing abstract categories of meaning presupposes the involvement of powerful actors on the field (Lawrence & Suddaby, 2006). These actors possess the resources and legitimacy to educate relevant actors in the organization (ibid). For Perkmann and Spicer (2008) they must be professionals with technical, technocratic or specialized skills, attributing rigor to institutions. The protocol with King's Fund helped to legitimize the accreditation program increasing physicians trust in this process.

The first contribution of this research is the insights it provides into how the politics associated with the NPM movement impacted hospitals and individuals, answering to calls from Hood and Peters (2004) and Kurunmäki (2004). This investigation showed that these accreditation programs were a result of the NPM movement and describes how these pressures were internalized by the organization and employees.

This study also contributes to literature concerning the coexistence of multiple logics in organizations. As the reality observed did not indicate conflict, our goal was to contribute to a non-mainstream explanation. In our case, the two competing logics coexisted for a long period of time, despite the introduction of the accreditation program

have stirred the waters of the institutional arena. According to Besharov and Smith (2014) close relationships create motivation to face multiple logics in more compatible ways. This compatibility minimizes or even eliminates conflicts between institutional logics. We have identified three mechanisms for managing institutional complexity through the development of collaboration between professionals: (i) maintaining professional's autonomy and identity; (ii) fostering trust between collaborators; and, (iii) enhancing cohesion through legitimacy and leadership. Collaboration as a source of change in institutional theory has not been widely examined (Thornton et al., 2012). Our empirical findings provide further insights in this area.

References

Abbott, A. (1988). *The system of professions: An essay on the division of expert labour*. University of Chicago Press.

Andrews, R., & Van de Walle, S. (2013). New public management and citizens' perceptions of local service efficiency, responsiveness, equity and effectiveness. *Public Management Review, 15*(5), 762–783. https://doi.org/10.1080/14719037.2012.725757

Angelis, J., Glenngård, A. H., & Jordahl, H. (2021). Management practices and the quality of primary care. *Public Money & Management, 41*(3), 264–271. https://doi.org/10.1080/09540962.2019.1689636

Beech, N., & Huxham, C. (2003). Cycles of identity formation in interorganizational collaborations. *International Studies of Management & Organization, 33*(3), 28–52. http://www.jstor.org/stable/40397570

Besharov, M., & Smith, W. (2014). Multiple institutional logics in organizations: Explaining their varied nature and implications. *Academy of Management Review, 39*(3), 364–381. https://doi.org/10.5465/amr.2011.0431

Carr, M., & Beck, M. P. (2020). Clinician responses to management control: Case evidence from a university hospital during the fiscal crisis. *Financial*

Accountability & Management, 36(3), 319–337. http://dx.doi.org/10.1111/faam.12224

Castañer, X., & Oliveira, N. (2020). Collaboration, coordination, and cooperation among organizations: Establishing the distinctive meanings of these terms through a systematic literature review. *Journal of Management, 46*(6), 965–1001. https://doi.org/10.1177/0149206320901565

Chassin, M. R., & O'Kane, M. E. (2010). History of the quality improvement movement, In *Toward improving the outcome of pregnancy III* (pp. 1–8). March of Dimes Foundation. https://www.marchofdimes.org/toward-improving-the-outcome-of-pregnancy-iii.pdf

Clarke, J., Newman, J., Smith, N., Vidler, E., & Westmarland, L. (2007). *Creating citizen-consumers: Changing publics & changing public services*. Pine Forge Press.

Cooper, S., Parkes, C., & Blewitt, J. (2014). Can accreditation help a leopard change its spots: Social accountability and stakeholder engagement in business schools. *Accounting, Auditing & Accountability Journal, 27*(2), 234–258. http://dx.doi.org/10.1108/AAAJ-07-2012-01062

Correia, T., & Denis, J. L. (2016). Hybrid management, organizational configuration, and medical professionalism: Evidence from the establishment of a clinical directorate in Portugal. *BMC Health Services Research 16*(Suppl 2), 73–109. https://doi.org/10.1186/s12913-016-1398-2

Creed, W., DeJordy, R., & Lok, J. (2010), Being the change: Resolving institutional contradiction through identity work. *Academy of Management Journal, 53*(6), 1336–1364. https://doi.org/10.5465/amj.2010.57318357

Dent, M. (1995). The new National Health Service: A case of postmodernism? *Organization Studies, 16*(5), 875–899. https://doi.org/10.1177/017084069501600506

Doolin, B. (2002). Enterprise discourse, professional identity and the organizational control of hospital clinicians. *Organization Studies, 23*(3), 369–390. https://doi.org/10.1177/0170840602233003

Eisenhard, K., & Graebner, M. (2007). Theory building from cases: Opportunities and challenges. *The Academy of Management Journal, 50*(1), 25–32. http://www.jstor.org/stable/20159839

Eisenhardt, K. (1989). Building theories from case study research. *Academy of Management Review, 14*(4), 532–550. https://doi.org/10.2307/258557

El-Jardali, F., Jamal, D., Dimassi, H., Ammar, W, & Tchaghchaghian, V. (2008). The impact of hospital accreditation on quality of care: Perception of Lebanese nurses. *International Journal for Quality in Health Care, 20*(5), 363–371. https://doi.org/10.1093/intqhc/mzn023

Freidson, E. (2001). *Professionalism: The third logic*. Polity Press.

Freidson, E. (1986). *Professional powers*. University of Chicago Press.

Friedland, R. (2012). Book review: Patricia H. Thornton, William Ocasio & Michael Lounsbury (2012) The institutional logics perspective: A new approach to culture, structure, and process. *M@n@gement, 15*(5), 582–595. https://doi.org/10.3917/mana.155.0583

Gebreiter, F. (2017). [online database] Accounting and the emergence of care pathways in the National Health Service. *Financial Accountability & Management*, in press. Retrieved from DOI: 10.1111/faam.12126, accessed 15th July 2022.

Grant, D., Hardy, C., Oswick, C., & Putnam, L. L. (2004). Introduction: Organizational discourse: Exploring the field. In D. Grant, C. Hardy, C. Oswick, & L. Putnam (Eds.), *The SAGE handbook of organizational discourse* (pp. 1–36). SAGE Publications Ltd. http://dx.doi.org/10.4135/9781848608122.n1

Greenfield, D., & Braithwaite, J. (2008). Health sector accreditation research: A systematic review. *International Journal for Quality in Health Care, 20*(3), 172–183. https://doi.org/10.1093/intqhc/mzn005

Greenwood, R., Raynard, M., Kodeih, F., Micelotta, E., & Lounsbury, M. (2011). Institutional complexity and organizational responses. *The Academy of Management Annals, 5*(1), 317–371. https://doi.org/10.5465/19416520.2011.590299

Groene O., Kringos D., & Sunol, R. (2014). Seven ways to improve quality and safety in hospitals: An evidence-based guide. DUQuE Collaboration. www.duque.eu. https://www.academia.edu/29441496/Seven_ways_to_improve_quality_and_safety_in_hospitals_An_evidence_based_guide

Hood, C., & Peters, G. (2004). The middle aging of New Public Management: Into the age of paradox? *Journal of Public Administration Research and Theory, 14*(3), 267–282. https://www.jstor.org/stable/3525837

Hood, C. (1995). The ‘new public management’ in the 1980’s: Variations on a theme. *Accounting, Organizations and Society, 20*(2/3), 93–109. https://doi.org/10.1016/0361-3682(93)E0001-W

Huxham, C., & Beech, N. (2003). Contrary prescriptions: Recognizing good practice tensions in management. *Organization Studies, 24*(1), 69–93. https://doi.org/10.1177/0170840603024001678

Ingstrup, M., Aarikka-Stenroos, L., & Adlin N. (2021). When institutional logics meet: Alignment and misalignment in collaboration between academia and practitioners. *Industrial Marketing Management, 92*, 267–276. https://doi.org/10.1016/j.indmarman.2020.01.004

IQS (2005). *Qualidade em Saúde, 12*. Collection Health Quality Institute, Lisbon, Portugal.

IQS (2004). Programa Nacional de Acreditação de Hospitais. *Qualidade em Saúde* (Special edition). Collection Health Quality Institute, Lisbon, Portugal.

IQS (2000). *Qualidade em Saúde, 0*. Collection Health Quality Institute, Lisbon, Portugal.

Jones, G., & George, J. (1998). The experience and evolution of trust: Implications for cooperation and teamwork. *The Academy of Management Review*, *23*(3), 531–546. https://doi.org/10.2307/259293

Kostic, N., & Sedej, T. (2022). Blockchain technology, inter-organizational relationships, and management accounting: A synthesis and a research agenda. *Accounting Horizons, 36*(2), 123–141. https://doi.org/10.2308/HORIZONS-19-147

Kurunmäki, L. (2004). A hybrid profession: The acquisition of management accounting expertise by medical professionals. *Accounting, Organizations and Society, 29*(3-4), 327–347. https://doi.org/10.1016/S0361-3682(02)00069-7

Lapsley, I. (2008). The NPM agenda: Back to the future. *Financial Accountability & Management, 24*(1), 77–96. https://doi.org/10.1111/j.1468-0408.2008.00444.x

Lawrence, T., & Suddaby, R. (2006). Institutions and institutional work. In S. Clegg, C. Hardy, T. Lawrence, &, W. Nord (Eds.) *Sage handbook of organization studies* (2nd ed., pp. 215–254). Sage.

Lawrence, T., Hardy, C., & Philipps, N. (2002). Institutional effects of interorganizational collaboration: The emergence of proto-institutions. Academy of Management Journal, 45(1), 281–290. https://doi.org/10.2307/3069297

Marquis, C., & Lounsbury, M. (2007). Vive la résistance: Competing logics and the consolidation of U.S. community banking. *Academy of Management Journal, 50*(4), 799–820. https://doi.org/10.5465/amj.2007.26279172

Mason, J. (2002). *Qualitative research*. Sage.

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An integrative model of organizational trust. *Academy of Management Review, 20*(3), 709–734. https://doi.org/10.2307/258792

Meyer, R. E., & Hammerschmid, G. (2006). Changing institutional logics and executive identities: A managerial challenge to public administration in Austria. *American Behavioural Scientist, 49*(7), 1000–1014. https://doi.org/10.1177/0002764205285182

Miles, M., Huberman, A., & Saldana, J. (2019). *Qualitative data analysis*: *A methods sourcebook* (4th ed.). Sage.

Ministério da Saúde (2000). *Saúde XXI, mais e melhor saúde - Programa Operacional de Saúde*, 3º Quadro Comunitário de Apoio 2000-2006. Collection Portuguese MoH, Lisbon, Portugal.

Montagu, D. (2003). *Accreditation and other external quality assessment systems for healthcare: Review of experience and lessons learned*. DFID Health Systems Resource Centre. https://www.heart-resources.org/wp-content/uploads/2012/10/Accreditation-and-other-external-quality-assessments.pdf

Nicolini, D., Delmestri G., Goodrick E., Reay T., Lindberg K., & Adolfsson P. (2016). Look what's back! Institutional complexity, reversibility and the knotting of logics. *British Journal of Management, 27*(2), 228–248. https://doi.org/10.1111/1467-8551.12156

Pache, A., & Santos, F. (2010). When worlds collide: The internal dynamics of organizational responses to conflicting institutional demands. *The Academy of Management Review, 35*(3), 455–476. https://www.jstor.org/stable/25682424

Perkmann, M., & Spicer, A., (2008). How are management fashions institutionalized? The role of institutional work. *Human Relations, 61*(6), 811–844. https://doi.org/10.1177/0018726708092406

Pisco, L. A., & Biscaia, J. L. (2001). Qualidade de cuidados de saúde primários. *Revista Portuguesa de Saúde Pública, 2*, 43–51. http://hdl.handle.net/10362/101394

Pollitt, C., Harrison, S., Hunter, D., & Marnoch, G. (1988). The reluctant managers: Clinicians and budgets in the NHS. *Financial Accountability & Management, 4*(3), 213–233. https://doi.org/10.1111/j.1468-0408.1988.tb00299.x

Pomey, M., François, P., & Bertrand, D. (2005). Paradoxes of French accreditation. *Quality and Safety in Health Care, 14*(1), 51–5. http://dx.doi.org/10.1136/qshc.2004.011510

Pomey, M., Contandriopoulos, A., François, P., & Bertrand, D. (2004). Accreditation: A tool for organizational change in hospitals? *International Journal of Health Care Quality Assurance, 17*(2-3), 113–124. https://doi.org/10.1108/09526860410532757

Power, M. (1996). Making things auditable. *Accounting, Organizations and Society, 21*(2-3), 289–315. https://doi.org/10.1016/0361-3682(95)00004-6

Reay, T., & Hinings, B. (2009). Managing the rivalry of competing institutional logics. *Organization Studies, 30*(6), 629–652. https://doi.org/10.1177/0170840609104803

Reay, T., & Hinings, B. (2005). The recomposition of an organizational field: Health care in Alberta. *Organization Studies, 26*(3), 351–384. https://doi.org/10.1177/0170840605050872

Robbins, G., Sweeney, B., & Vega, M. (2022). Hospital accreditation systems and salience of organizational tensions. *Accounting, Auditing & Accountability Journal, 35*(9), 57–80. https://doi.org/10.1108/AAAJ-04-2020-4500

Scott, W., Ruef, M., Mendel, P. and Caronna, C. (2000). *Institutional change and healthcare organizations: From professional dominance to managed care*. University of Chicago Press.

Singh, G., & Slack, N. L. (2020). New public management and customer perceptions of service quality: A mixed-methods study. *International Journal of Public Administration*. Advance online publication. https://doi.org/10.1080/01900692.2020.1839494

Sirris, S. (2019). Coherent identities and roles? Hybrid professional managers' prioritizing of coexisting institutional logics in differing contexts. *Scandinavian Journal of Management, 35*(4), 1–12. https://doi.org/10.1016/j.scaman.2019.101063

Thornton, P., Ocasio, W., & Lounsbury, P. (2012). *The institutional logics perspective: A new approach to culture, structure and process*. Oxford University Press.

Thornton, P., & Ocasio, W. (1999). Institutional logics and the historical contingency of power in organizations: Executive succession in the higher education publishing industry, 1958-1990. *American Journal of Sociology, 105*(3): 801–843. https://doi.org/10.1086/210361

Touati, N., & Pomey, M. (2009). Accreditation at the crossroads: Are we on the right track? *Health Policy, 90*(2-3), 156–165. https://doi.org/10.1016/j.healthpol.2008.09.007

Tribunal de Contas (1999). *Auditoria ao serviço nacional de saúde: Relatório final*, Lisboa. https://www.tcontas.pt/pt-pt/ProdutosTC/Relatorios/RelatoriosAuditoria/Documents/1999/rel038-1999-2s.pdf

van den Broek, J., Boselie, P., & Paauwe, J. (2014). Multiple institutional logics in health care: 'Productive ward: Releasing time to care'. *Public Management Review*, *16*(1), 1–20. https://doi.org/10.1080/14719037.2013.770059

WHO (2000). *The world health report 2000, health systems: Improving performance*. WHO Library Cataloguing in Publication Data.

Yin, R. (2018). *Case study research and applications: Design and methods* (6th ed.). COSMOS Corporation.