The current issue and full text archive of this journal is available at
www.emeraldinsight.com/0951-3558.htm

The persistence of the audit culture: supervision within Swedish ambulance services

Caroline Waks
Uppsala University, Uppsala, Sweden

Received 3 May 2007
Revised 1 April 2008
Accepted 9 June 2008

Abstract

Purpose – The purpose of this paper is to investigate whether, or to what extent, the audit society influences the professional context of Swedish pre-hospital care.

Design/methodology/approach – Data were collected through an in-depth case study of public supervision within ambulance services in Sweden. A three-dimensional framework departing from three analytical concepts (knowledge base, formal organization and operational process) was used as a tool for further analysis of the field material.

Findings – The paper describes ambulance services under the pressure of frequent audits in a context where the knowledge base of ambulatory work was contested. While some have argued this would make it more receptive to an audit culture, the relational distance between the auditor and the auditees was high, which should indicate the opposite.

Originality/value – The paper explores the audit society and its processes. In this particular case, it could be argued that the impact of an audit culture on professional activities was moderated by the dissociated approach of the auditing team.

Keywords Auditing, Ambulance services, Sweden

Paper type Research paper

Introduction

Health care constitutes a core activity of welfare states and as such has traditionally been of great public concern. National governments have had an interest in controlling and regulating this policy area, even though the means by which regulation has been carried out have varied over time. Today, a wider policy trend promoting transparency, accountability and democracy (Finkelstein, 2000; Hood and Heald, 2006) influences how health care services are regulated and controlled. New techniques that go beyond the logistics of service provision and cost control and aim at the very core of professional work are being implemented and promoted (Strathern, 2000; Blomgren and Sahlin, 2007).

Auditing is one technique for increasing transparency. The contemporary "audit society" (Power, 1997) has resulted not only in a greater number of audits and forms of audit within public and private companies but also in activities within organizations to prepare the organization for being audited. The traditional ways of controlling and evaluating professional activities (education systems, examinations and peer reviews) are today being complemented by more standardized systems of self-evaluation. These systems, with their insistence on traceability, are expected to create external legitimacy for the internal activities of the organizations.

Researchers have raised doubts about how these quality control systems influence a professional's identity and work. The governance of professional work through a logic

International Journal of Public Sector Management
Vol. 22 No. 1, 2009
pp. 35-45

0951-3558
DOI 10.1108/09513550910922388

of confidence and good faith (Meyer and Rowan, 1977) has been challenged by an audit culture of managerialism and accountability (Strathern, 2000; Shore and Wright, 2000). The more standardized techniques of quality control – often a precondition for extended comparisons between units – are also being questioned. The exercise of judgement has always been a central part of professional expertise (Groundwater-Smith and Sachs, 2002; Frowe, 2005), and thus formalizing professional performance is said to conflict with the very meaning of professional work. Shore and Wright (2000) question the inescapability and panopticon-like nature of the system of accountability, while Pentland (2000) asks whether auditors are taking over the world.

In order for an activity to become auditable, however, institutionally legitimate definitions of knowledge have to be negotiated. The legitimacy of both the auditor and the auditee are co-produced through the audit process (Power, 2003a). Taking a closer look at how professional work is actually inspected in specific contexts, we find the outcome of an audit may vary across different professional domains. The auditing practice and its impact will be influenced by variations in the "epistemic independence" (Power, 1997, p. 133) of the auditor, whether the knowledge base of the auditee is being contested and whether the philosophy behind the audit involves "blaming", "learning" or both (Power, 2003b). These circumstances raise questions about the persistence of the audit culture. This qualitative case study is an empirical investigation of its persistence in relation to public supervision within pre-hospital care.

The double nature of auditing

Michael Power has discussed how extensive mistrust in society has created a situation in which the concept of auditing has become the constitutive principle for almost all organizations. More and more organisations view themselves as objects for audits and, therefore, change their activities in order to become auditable (Power, 1997). This "audit explosion" is defined as "the transformation of existing and the emergence of new, formal institutions for monitoring" (Power, 2003b, p. 188). Auditing is not limited to financial matters but also includes inspections and evaluations. What is being audited by inspectorates and evaluative bodies is the organization's own internal control system. These audits enable authorities to govern professional activities from a distance.

The audit explosion has resulted in an audit culture and a set of technologies for constructing transparent organisations and making professionals auditable. Studies of efforts to become transparent within health care settings have shown how different technologies – monitoring, regulating and account-giving – are clearly intertwined and often feed off each other. Audits, for instance, create a demand for more account-giving and further audits in order to correct mistakes that have just been exposed (Sahlin-Andersson, 2006; Blomgren and Sahlin, 2007; Blomgren, 2007). The technologies are also said to bring with them a normative form of control that threatens to undermine trust and professional autonomy when applied to the public sector. Professionals are encouraged to internalize new norms of "empowerment", "self-management" and "quality control" and, with the assistance of new professional experts such as "quality assurance officers", to reflect on their own performance – not in an unprejudiced way, but rather within tightly fixed parameters (Shore and Wright, 2000).

Auditing is not a neutral and objective control technology for holding professionals accountable. Rather, it is a ritual of verification in which the auditor listens to

"inherently untrustworthy explanations" from clients, signs off on them and thereby legitimizes them in the public arena (Pentland, 1993, p. 613). Pentland (2000, p. 310) suggests that auditors act as brokers and compares them to movie or television critics. They provide an interpretation of accounting data so that others need not bother with the details. Building on Abbott's (1988) discussion of how the boundaries of a profession's jurisdiction are determined by competition within the system of professions about who should have the right to define, explain and take measures on a specific problem area, Pentland (2000, p. 307) opens up a new dimension of professional conflict. He argues that an emphasis on work content can lead us to overlook process – which is what auditors primarily control.

However, while the auditor plays a large part in constructing the conditions for monitoring professional work, the same could be said about the auditee. Since what the auditor infers depends on his or her knowledge of the context in a specific occupational community, the inspector is dependent on key persons in the audited organisation for definitions and interpretations of inspection data and results (Power, 2003a, b). The auditor, especially within an area such as health care, often has a similar professional background to the auditee and, therefore, shares the same knowledge and system of professional norms. It could even be in the interests of segments of the professional group to cooperate and form alliances with segments from other professional groups, e.g. auditors (Van Maanen and Barley, 1984; Abbott, 1988). Such alliances could, on the one hand, allow for "hybridized" professional expertise with roots in both medicine and public administration (Kurunmäki, 2004) but, on the other hand, it could also create jurisdictional disputes, leaving some areas of expertise more open to external interference. For a profession to have control over a certain area of knowledge and skill, it needs to have control of the abstractions that generate the practical techniques. The degree of abstraction necessary depends on the nature of the problem and how it is socially defined in time and place (Abbott, 1988).

The double nature of auditing described above was demonstrated in an anthropological study of the auditing activities of the International Monetary Fund (Harper, 2000). The auditing team became dependent on certain key persons in the country to understand the context of the data to be interpreted. Furthermore, the forum in which the results of the inspection team were to be presented was crucial to the outcome of the audit, for the authorities in the country had the power to reject the figures presented by the auditing team. It was not until the auditees accepted the figures that the numbers could be acted on. These circumstances reinforced a sense of mutual identity for all those involved. During the meetings, all the actors– both assessor and assessed – became experts working together on the same mission.

The relationship between the auditor and the auditee is, by definition, not hierarchical but is based on negotiation and compromises. Taking this into account as well as the struggle between and within occupational communities, it seems as if the impact of an audit is not written in stone. Thus the impact needs to be an object of empirical investigation.

Method and research design

A case study of public supervision in Sweden was used to document and analyse the persistence and scope of an audit culture within the setting of pre-hospital care. The relationship between a regional supervision unit of the National Board of Health and

Welfare (NBHW) and an ambulance unit in the region was subjected to an in-depth study. The majority of those who took part in the inspection were interviewed. They included physicians with a background in anaesthesiology and intensive care at different levels; nurses, both in managing positions and working in the field; and paramedics. In addition, three representatives from the inspection board were interviewed. One was a former anaesthesiologist and part of the supervision team. The respondents were asked questions related to the specific supervision. They were also asked open-ended questions, encouraging them to describe how they worked prior to, during, and after an assessment. The ambulance physician at the department functioned as an informant and doorkeeper. The interview material was supplemented with different types of documents such as inspection protocols and written correspondence between the ambulance unit and the inspection board. A three-dimensional framework was used as a tool for further analysis of the field material (Power, 2003b, p. 192-195): the knowledge base shared by both the auditors and the auditees, the formal organization of the evaluative body, and the operational process of the audit. Issues investigated and analysed included how quality criteria were set, how independent the inspectors were from the audited organization and the policy-making organizations, and the "relational distance" between the auditor and auditee.

Ambulatory care: a health service in transition

Ambulance services differ throughout the world depending on the historical, political and cultural context in which the practice of emergency medicine developed (Nurok, 2001). In order to fully understand the epistemic knowledge base of ambulance services in Sweden, it is important to grasp the context in which this knowledge has been built up and the fact that the conditions for ambulance services have changed over time.

The Swedish emergency care system was run by municipal fire departments before emergency care was taken over by the county councils in 1995. For a long time, the main responsibility of ambulance services was to provide transportation. Gradually, advances in medical treatment and surgical techniques as well as technical developments have led to pre-hospital emergency care being recognised as a vital part of the whole healthcare chain. Nurses with qualifications in anaesthesia, intensive care and cardiology have become engaged in pre-hospital work and a new profession – "ambulance nurse" – has become established as a speciality (Suserud, 2005). Since 2005, it has been mandatory to staff the ambulance with at least one registered nurse. The handling of drugs is no longer delegated to paramedics, who had previously been the dominant group within Swedish ambulance services. The new staffing of the ambulances has made the roles of the two groups more distinct (Suserud, 2005; Suserud and Haljamäe, 1997). Today, the trend in the counties throughout the country is to hire only ambulance nurses and not paramedics (Erlandsson, 2008).

Nurses working within ambulance services have a broad knowledge base. Their work is performed in different settings – in patient's homes or at an accident site – and the types of intervention vary. Only 10 to 20 per cent of the emergency call outs involve trauma victims, the majority involving elderly, multiply ill patients (Ahl *et al.*, 2005; Suserud, 2005). A phenomenological study of ambulance services in Sweden shows that the knowledge of the ambulance nurse or paramedic is largely implicit and experienced-based. The medical concepts that are a precondition for standardized

diagnosis and treatment do not fully fit this type of knowledge (Wireklint Sundström, 2005).

There has been international debate in emergency medicine as to whether trauma victims should be rushed to hospital ("scoop and run"), or whether they should initially be treated in the field ("stay and play"). Different emergency medical service systems in different countries vary in their approach. The approach chosen has consequences for how ambulances are staffed and also affects the influence of different groups, such as emergency physicians, surgeons and anaesthesiologists (Nurok, 2001). The Swedish ambulance service is a mixture of the two systems. Swedish ambulances are not staffed by physicians, but the nurse is able to consult the hospital staff by radio. However, this option is seldom used (Ahl *et al.*, 2005, p. 31). The decision whether to stay at the scene to treat the patient or rush the patient to hospital is affected by recognition that different medical conditions require different actions (Edström, 2005).

Emergency medicine is a new medical speciality in Sweden. Both medical and nursing professionals are discussing whether doctors should be present in the ambulance (Kongstad, 2007; Eklund, 2007). A special work group (SLAS) consisting of nurses and physicians is cooperating to create common clinical guidelines for all ambulance services in the country. These guidelines will cover a wide area ranging from respiratory care, medicine, surgery and trauma to psychiatry and paediatric care (Flisa, 2008).

The above description of ambulance services in Sweden suggests that the knowledge base of ambulance services is contested. The service draws on a wide variety of medical and nursing specialities as well as on the technical knowledge required to operate equipment in the ambulances.

Formal governance in Swedish health care

The National Board of Health and Welfare (NBHW), reporting to the Ministry of Health and Social Affairs, is responsible for monitoring and supervising Swedish health care at the national level. The board's activities are, to some extent, controlled by the government by means of standing instructions and annual assignments. However, ministries in Sweden have no legal right to direct health agencies in detail. At the national level, the relationship between the medical profession and the state is characterized by policy networks and mutual resource dependency (Garpenby, 1999).

The model for the administrative authority is based on the concept of professionalism. Civil servants with the right to make decisions and demands in the area of health care should possess expert knowledge within the same area. This does not mean, however, that the civil servant should become a change agent and a counsellor. A public investigation into the supervising role of the civil servant recommended that supervision should mean controlling through insisting on compliance with the law and not through advising (SOU, 2004, p. 100).

At the local level, six regional supervision units carry out health care supervision. Each unit has 10 to 15 officers with a background in either law or medicine/nursing. When needed, a special board of medical experts or other specialists is consulted. Supervision of specific health care areas or organisations is not performed on a regular and recurrent basis. Instead, the regional board performs spot-checks, often in reaction to input from other authorities or the media. They also perform supervision in response to direct governmental assignments regarding patient safety. Service providers are

also obliged to report to the NBHW incidents in which a patient suffers serious injury or illness while in their care. The board then opens up an investigation.

According to the NBHW, supervision should be predictable. The subject under supervision, such as a hospital, clinic or nursing home, should be informed about the purpose, focus and methods of an audit in advance. At the beginning of each year, the board publishes a list in which they state which areas they will be focusing on in the coming year. For the most part, supervision involves quality control of the quality system of each specific service. Interviews with employees in charge and at different levels in the organization are common, as well as examinations of medical log books. The assessment board then provides feedback in which it sets out the requirements for further improvement. In most, but not all, cases there is also a follow-up inspection. The final report from the board becomes a public document (NBHW, 2008).

Supervision at the department of ambulatory care

Because of the rapid medical and technical development of ambulance services, one of NBHW's regional units decided to perform quality control at all ambulance units within its area of authority. The board justified its decision by referring to earlier reports on mistreatments and the increased number of call outs. In terms of patient safety, the ambulance service was considered a high risk speciality. Its work involved many acute and unplanned advanced life-and-death interventions at locations that were sometimes difficult to access. The regional board carried out ten verbal quality inspections of ambulance services in seven different counties in the region. This paper offers a closer look at one of these inspections – an ambulatory care department acting as an integrated part of a large county hospital.

The supervision at the ambulatory care department opened with a letter from the National Board of Health and Welfare. It was addressed to the senior physician in charge of the ambulance services. In the letter, it was stated that the board wanted to review how the units' own quality control system was working. The board asked to meet different categories of employees in the department – the senior physician (an anaesthesiologist who also had medical responsibility for the department), the station manager (an ambulance nurse who was accountable for the organisation as such but had no medical responsibility in the department), the nurse responsible for education, an ambulance nurse and a paramedic. The senior physician at the department did not prepare himself for the inspection. He just informed the other concerned employees about the meeting with the board.

On the day of the inspection, two representatives from the board showed up – one doctor (a former anaesthesiologist) and one deputy director. The inspection team did not walk around the department or ride along with one of the ambulances in order to inspect actual work. Instead, the inspection took the form of a two-hour group interview. Apart from the employees that the board had asked to see, three other people also attended the meeting – the former chief of department, a senior physician from the supporting staff and a unit manager with a former background in anaesthesiology and intensive care. Most of the time, it was the anaesthesiologist from inspection team and the senior physician that were involved in a dialogue. It was an open dialogue. The inspectors did not tick off the questions from a questionnaire. Instead, they asked questions within six broad areas. The board wanted to know: how new employees were introduced to the work of the department; what type of further training was offered;

what type of routines the department had for documenting discrepancies in everyday work; how they cooperated with other institutions in the health care chain; the routines for self-evaluation; and, finally, they asked questions concerning risk assessments.

Most of the time, it was the senior physician that answered the questions but, when the discussion turned to routines for documenting discrepancies, the station manager also joined the conversation. It was difficult to define what a discrepancy actually was, he emphasised. It was one thing to define and to record a discrepancy concerning the ambulances' technical equipment, but it was a completely different thing to define a discrepancy in the treatment of a patient. He asked the board to help him with a definition or an example but did not get a satisfactory answer. The meeting ended after two hours and the senior physician was not comfortable with how the dialogue with the assessment board had evolved:

> There's really no reason for us not to want the work that we are performing to be as good as possible. That's obvious. Otherwise we wouldn't work here. But they come here with the impression that we are trying to hide something and that we are afraid to talk about it. That's my feeling. They are searching and they ask questions and sometimes you sit there and they ask a question and then, some time later, they ask another question and you answer that one and then they say, "But that's not what you said earlier..." They are looking for things as if we have something to hide. Instead, they should come here and ask, "Are there any problems that you need help solving?" (Senior ambulance physician)

The senior physician compared the board's approach with the approach of another large international auditing firm that had audited the department a few months earlier. He believed that the approach of the auditing firm was much more helpful, even though they were not specialists in pre-hospital care and even though their recommendations regarding areas for improvements were substantially the same as those put forward by the NBHW's inspection team. What was different was the way the auditing firm went about its work. They got more involved, were more supportive and came up with suggestions for how to improve the organisation.

The NBHW team, on the other hand, insisted on keeping their distance from the auditees. It was important to them not to "go native" and return to their former roles as practising nurses or doctors. They said it was important to be close to the auditees and to be knowledgeable in order to gain adequate and detailed information, but that working as a change agent was not part of their mission.

> We can identify problem areas and imperfections and we can try to reach agreement on what these imperfections are and that they need to be corrected, but after that – the solutions to the problems – for that we need to get suggestions from the professionals themselves. They have to present their views on what measures should be taken (Regional manager, NBHW).

Employees at the department were disappointed that the inspection team did not ride along with one of the ambulances in order to inspect their actual work. The team audited only paperwork and had no knowledge of the context in which services were performed, they argued. The ambulance team reasoned that, as a result, the inspection team did not fully appreciate the effect their demands could have on professional work.

> I would like to show them how we really work so that they can get some insight into the tough conditions we are wrestling with. You are sitting in the back of the ambulance nursing a very sick patient, and then they criticise you for not entering a few parameters in an electronic journal … If I had documented everything exactly the way they wanted me to do it, the

> patient wouldn't have survived anyway! But they still demand that you tick off figures every five minutes (Ambulance nurse).

Many of the employees also questioned why the board only asked questions "out of the blue" and had not worked from a questionnaire. They felt that the board's method of conducting inspections was not transparent. There was no way of knowing what criteria were being applied. The assessment board, on the other hand, defended the use of open-ended questions and their reluctance to merely tick off questions in a pre-written manual. They argued that a manual is only really useful when the area is new to the inspectors. The board also argued that, while it is always good to come prepared for an inspection, after a while the manuals become constraining.

After the inspection at the site, a quality report was presented to the ambulance department. It was three pages long and, among other things, it stated that the routine for documenting discrepancies in everyday work was unsatisfactory. Not enough discrepancies were being reported. The board demanded that the ambulance unit would define the term "discrepancy" so that the employees would be able to know what to report. They also wanted a detailed account of the methods through which the unit would enlighten the employees about the importance of reporting discrepancies. Further, they wanted the unit to develop systematic routines for self evaluations. This criticism elicited a frustrated response from some who wanted to know what the proper number of discrepancies was.

> They didn't have any opinion on how we handled our discrepancies – because that was my question. They just thought that we had a suspiciously low number of discrepancies per year . . . But what is a reasonable amount? That they didn't know (Station manager and ambulance nurse).

The inspectors, the senior physician and the station manager were corresponding through letters, phone calls and e-mails. The senior physician explained how he would handle the feedback from the inspection board:

> I'll write a memo stating that "we have to document discrepancies". And then that's out of the way. I'll send the memo to all station managers and they'll pass it on. It's ridiculous, actually. Then when I am out visiting the different ambulance stations, I'll talk about discrepancies anyway, because I have always done that (Senior ambulance physician).

After inspecting all seven counties, the inspection team prepared a comparative report on the quality of ambulance services within the whole region. An immediate consequence of this report was that the employees at the ambulance unit started to compare themselves to the services of the other counties. They were often familiar with the other counties' work and questioned the critique that they had got from the board by comparing their own activities with the ones of the other counties. In the report, the board concluded that the introductory training offered in all seven counties was satisfactory. This came as a surprise to the station manager at the ambulance unit who knew that the length of the introductory training could vary from two to six weeks, depending on a specific units' policies. He thus wondered what quality criteria the ambulance service was measured against. The board answered his question with a counter question: why did his unit need such long introductory training in the first place – were they possibly hiring people who did not have an adequate education to begin with? The board emphasized that their role, as a supervisory authority, was to

assure that the quality of health care was satisfactory, not to rank who had the best quality.

Discussion and conclusion

This paper originated from one basic question – to what extent is an audit culture present in the professional context of pre-hospital care? It is an easy question to ask, but a complex one to answer. One could argue that the very idea of an auditable organisation is present and internalized among the professionals at the ambulance department. The very fact that the organisation had been audited by both a private auditing firm and the national authorities in almost the same timeframe gives an idea of the frequency of audits in this specific context. Moreover, the professionals in the organisation did not question that quality inspections were performed but rather how they were being performed. They wanted close cooperation with the auditor and preferred the more counselling approach of the private auditing firm in which the quality of their work could be measured against previously set quality criteria. Thus, what they requested resembled the type of normative control system so typical of the audit culture described in earlier studies (Shore and Wright, 2000; Strathern, 2000). Furthermore, since the knowledge base of ambulance services could be considered a contested terrain as between medicine and nursing (Abbott, 1988), it might be more receptive to other ideas and logics, such as audit (Power, 2003b, p. 193). It could also be argued that the way Swedish health care is organized gives the supervision board flexibility to interpret policy mandates independently from the national government and, therefore, they would be freer to enter into negotiations with the health care professionals under scrutiny.

However, this closer look at the actual supervision performed by the NBHW suggests some tentative conclusions that point in a different direction. First of all, the inspection lacked some of the key tools for constructing auditable subjects (see Shore and Wright, 2000). Even if the professionals at the ambulance department really had a desire to become "empowered", this desire was not fulfilled by the NBHW's inspection team. Even though the members of the audit team shared a common medical knowledge base with the ambulance department, they were careful to affirm their "new" professional role as civil servants. They were quick to state that it was the obligation of the medical profession itself to construct its own quality criteria. The audit logic of "blaming" and "learning" (Power, 2003b) was thus not so accentuated in this case. The supervision by the authority was, moreover, dissimilar tothe auditing process described by Harper (2000) where the auditor and the auditee worked together on the same mission. By contrast, NBHW inspection was performed rather sporadically and, for most of the employees, it was an activity that was over in a couple of days.

From these rather ambiguous findings, one can ask whether the somewhat dissociated approach of the supervision board in this case study serves to preserve the professional autonomy of doctors and nurses more generally. The NBWH's mission was to assure that the quality of the ambulance services was good enough not that it was the best possible. This attitude may have created a relational distance between the auditor and the auditee that prevented a groupthink mentality and the type of normative control cautioned against by Shore and Wright (2000). A comparative study of this particular auditing style and the more consulting auditing styles of big auditing firms would therefore be valuable for future empirical investigations.

References

Abbott, A. (1988), *The System of Professions*, University of Chicago Press, Chicago, IL.

Ahl, C., Hjälte, L., Johansson, C., Wireklint-Sundström, B., Jonsson, A. and Suserud, B-O. (2005), "Culture and care in the Swedish ambulance services", *Emergency Nurse*, Vol. 13 No. 8, pp. 30-6.

Blomgren, M. (2007), "The drive for transparency: organizational field transformations in Swedish healthcare", *Public Administration*, Vol. 85 No. 1, pp. 67-82.

Blomgren, M. and Sahlin, K. (2007), "Quests for transparency: signs of a new institutional era in the health care field", in Christensen, T. and Laegrid, P. (Eds), *Transcending New Public Management: The Transformation of Public Sector Reform*, Ashgate, Aldershot.

Edström, M. (2005), "States, regions and EMS: levels of decision, funding and evaluation. A report within the Hesculaep Project", research project, European Commission, available at: www.hesculaep.org/fichiers_www.hesculaep.org/fichiers_documents/3/28/764_report_states_regions_and_ems.pdf (accessed, March 3, 2008).

Eklund, A-K. (2007), "Läkarmedverkan inte avgörande i ambulans" ("Doctor participation not crucial in ambulance"), *Dagens Medicin*, Vol. 40 No. 7.

Erlandsson, J. (2008), "Rött ljus för ambulanssjukvårdare" ("Red traffic lights for paramedics", *Kommunalarbetaren*, No. 4/08.

Finkelstein, N.D. (Ed.) (2000), *Transparency in Public Policy: Great Britain and the United States*, Macmillan, Basingstoke.

Flisa (2008), "Föreningen för ledningsansvariga inom svensk ambulanssjukvård" ("The managerial association within Swedish ambulance services") available at: www.flisa.nu/index (accessed 4 March 2008).

Frowe, I. (2005), "Professional trust", *British Journal of Educational Studies*, Vol. 53 No. 1, pp. 34-53.

Garpenby, P. (1999), "Resource dependency, doctors and the state: quality control in Sweden", *Social Science and Medicine*, Vol. 49 No. 3, pp. 405-24.

Groundwater-Smith, S. and Sachs, J. (2002), "The activist professional and the reinstatement of trust", *Cambridge Journal of Education*, Vol. 32 No. 3, pp. 341-58.

Harper, R. (2000), "The social organization of the IMF's work", in Strathern, M. (Ed.), *Audit Cultures. Anthropological Studies in Accountability, Ethics and the Academy*, Routledge, London.

Hood, C. and Heald, D. (Eds) (2006), *Transparency: The Key to Better Governance?*, Oxford University Press, Oxford.

Kongstad, P. (2007), "Behövs inte läkare i ambulanssjukvården?" ("Aren't doctors necessary in the ambulance services?"), *Dagens Medicin*, Vol. 38 No. 07.

Kurunmäki, L. (2004), "A hybrid profession: the acquisition of management accounting expertise by medical professionals", *Accounting, Organizations and Society*, Vol. 29 Nos 3-4, pp. 327-47.

Meyer, J.W. and Rowan, B. (1977), "Institutionalized organizations: formal structure as myth and ceremony", *The American Journal of Sociology*, Vol. 83 No. 2, pp. 340-63.

National Board of Heath and Welfare (NBHW) (2008), *Om Socialstyrelsen*, available at: www.socialstyrelsen.se/Om_Sos/organisation/Tillsyn/Enheter/regional/index.htm (accessed 4 March 2008).

Nurok, M. (2001), "The death of a princess and the formulation of medical competence", *Social Science & Medicine*, Vol. 53, pp. 1427-38.

Pentland, B.T. (1993), "Getting comfortable with numbers: auditing and the micro-production of macro-order", *Accounting, Organization and Society*, Vol. 18 No. 7, pp. 605-20.

Pentland, B.T. (2000), "Will auditors take over the world? Program, technique and the verification of everything", *Accounting, Organization and Society*, Vol. 25, pp. 307-12.

Power, M. (1997), *The Audit Society – Rituals of Verification*, Oxford University Press, Oxford.

Power, M. (2003a), "Auditing and the production of legitimacy", *Accounting, Organizations and Society*, Vol. 28 No. 4, pp. 379-94.

Power, M. (2003b), "Evaluating the audit explosion", *Law & Policy*, Vol. 25 No. 3, pp. 185-202.

Sahlin-Andersson, K. (2006), "Transparansens former" ("Forms of tranparency"), in Levay, C. and Waks, C. (Eds), *Strävan efter transparens: Granskning styrning och organisering i sjukvårdens nätverk* (*The Pursuit of Transparency: Auditing, Control and Organisation in Health Care Networks*), SNS, Stockholm.

Shore, C. and Wright, S. (2000), "Coercive accountability", in Strathern, M. (Ed.), *Audit Culture: Anthropological Studies in Accountability, Ethics and the Academy*, Routledge, London, pp. 84-5.

SOU (2004), *Tillsyn. Förslag om en tydligare och effektivare offentlig tillsyn* (*Supervision. Suggestions for a More Distinct and Efficient Public Supervision*), Frizes, Stockholm.

Strathern, M. (Ed.) (2000), *Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy*, Routledge, London.

Suserud, B.-O. (2005), "A new profession in the pre-hospital care field: the ambulance nurse", *Nursing in Critical Care*, Vol. 10 No. 6, pp. 269-71.

Suserud, B.-O. and Haljamäe, H. (1997), "Role of nurses in pre-hospital emergency care", *Accident and Emergency Nursing*, Vol. 5, pp. 145-51.

Van Maanen, J. and Barley, S. (1984), "Organizational communities: culture and control in organizations", *Research in Organizational Behavior*, Vol. 6, pp. 287-365.

Wireklint Sundström, B. (2005), "Förberedd på att vara oförberedd" ("Prepared to be unprepared"), doctoral dissertation, Växjö University Press, Växjö.

About the author

Caroline Waks is a Lecturer in Organisation Studies at the Department of Business Studies at Uppsala University, Sweden. Her research and publications focus on analyses of professional work organisation and auditing within the public sector. She is currently involved in a research project that explores the role of the teaching profession in ongoing institutional changes in primary education. Caroline can be contacted at; caroline.waks@fek.uu.se