INTRODUCTION

As information systems increasingly are employed in hospitals and primary care, they are dependent on standardisation. From a technical point of view, standardisation enables integration of information systems based on various infrastructures, developed with different tools and running at different locations. Related to use of the information systems (the social aspect), standardisation serves as means for collaboration, shared meaning and far-reaching coordination among different health care professionals.

Standardisation efforts are, however, often promoted in a top-down and uniform manner with weak local influence. This is unfortunate as standards are not merely a technical or neutral device ready to be put into use. Rather they are socially constructed, achieved as results of

ABSTRACT

Traditionally, uniform and standardised IT-solutions in health care are considered mechanisms for increased control, efficiency and quality. Unfortunately, in spite of existing studies of the actual experiences of standardisation, such as how they come into being, and how they are intertwined with local practice, unreasonable belief in standardisation seems to prevail. Acknowledging the origin of standardisation and its local character, however, does not mean that standardisation is futile or should be avoided. It rather means that standardisation efforts should balance the management level’s need for increased coordination and control, and the local level’s need for flexibility. The aim of this paper is to strike this balance as it elaborates the implications and the ‘costs’ for local practice in order to make a standard work. Empirically, the paper draws on a standardisation effort of discharge letter production in the University Hospital of Northern Norway.

Keywords: standardisation; information infrastructure; workflow; work-practices; quality; healthcare

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negotiation processes (Bowker and Star, 1999; Lachmund, 1999; Rolland and Monteiro, 2002; Hanseth and Monteiro, 1997). Failing to acknowledge how standardisation comes into being often results in lack of adoption, resistance in use or only temporary validity (Bowker and Star, 1999, p. 293). As a standard is intertwined with local practice, it both shapes local practice and is being shaped by it. Consequently work is required to reach agreement about a standard and, subsequently, maintenance-work is required to keep it ‘alive’.

Acknowledging the local and partly unpredictable character of standardisation does not mean that standardisation is futile. It rather means that standardisation efforts must be targeted to a level that is acceptable for those involved. In this paper, I define this to be striking the balance between the management level’s need for increased coordination and control, and the local level’s need for flexibility. I underscore that this balance is not just ‘out there’, ready to be revealed by scientists. Rather I choose to construct it as a way to emphasise the different interests and the negotiations around the two different perspectives outlined above. More specifically, the paper will elaborate the ‘costs’ in a standardisation effort, not as an argument for discarding standardisation, but as an argument in the process of defining a balanced solution between the management and the different local contexts. This paper argues that the ‘costs’ involve both additional work for some actors, restructuring of work and implications for quality. I also elaborate the implications for the management of standardisation efforts.

Empirically, the case draws on the work of physicians at the University Hospital of Northern Norway, with special focus on the production of discharge letters. The discharge letters are summaries of patients’ stays and play several roles. Firstly, they inform general practitioners and local hospitals what has happened during the stay, current status and prognosis. Secondly, they distribute responsibilities for follow-ups between the hospital and the general practitioner. And thirdly, the hospital physicians themselves frequently use these letters whenever the patients return to the hospital, or when they for other reasons need to reconstruct the case.

The management at the hospital aimed at both increased efficiency and improved quality through standardisation of the discharge letters. The motivation behind this was that sometimes the discharge letters could be delayed several weeks in the university hospital. This became a reiterating problem for the local hospitals and the general practitioners who needed the letters as soon as possible as a part of their ongoing work with the patients. There was also expressed concern about the lack of readability, and there were even complaints about discharge letters that actually lacked important information. As a part of this effort, it was necessary to instruct the physicians to work in a routine way. This turned out to be difficult because work practice in a large university hospital is extremely heterogeneous. Heavy resistance surfaced among the physicians who felt that the interests of the management were not aligned with their own. As a result, the initial strive for
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